STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

MARKET CONDUCT EXAMINATION

NUMBER 2014C-0062

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TARGETED MARKET CONDUCT EXAMINATION REPORT

OF

Globe Life and Accident Insurance Company

Omaha, Nebraska

NAIC COMPANY CODE 91472

For the Period January 1, 2012 through December 31, 2013

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I. EXECUTIVE SUMMARY

Globe Life and Accident Insurance Company (the Company) is an authorized Nebraska domiciled company. This examination was conducted by the Department of Insurance and Financial Services (DIFS) in conformance with the National Association of Insurance Commissioners (NAIC) *Market Regulation Handbook* (2013) (*Handbook*) and the Michigan Insurance Code, MCL 500.100 et seq. (the Code). The purpose of the exam is to evaluate the compliance of the Company with applicable Michigan statutes, NAIC Guidelines and DIFS regulations. The scope of market conduct examination includes the Company's activities related to the handling of: (1) Operations/Management, (2) Marketing and Sales, (3) Underwriting and Rating, (4) Claims, (5) Complaint Handling, and (6) Producer Licensing. The examination covers the period January 1, 2012 through December 31, 2013.

This summary of this targeted market conduct examination of the Company is intended to provide a high-level overview of the examination results. The body of the report provides details of the scope of the examination, findings, DIFS recommendations, and Company responses.

DIFS considers a substantive issue one in which a "finding" or violation of Code was found to have occurred, or one in which corrective action on the part of the Company is deemed advisable.

Findings:
DIFS has one finding which requires a Company response. In one instance, the Company appears to have mistakenly released private medical history to an unauthorized individual who was in no way connected with the policy of insurance. DIFS requests that the Company provide a Corrective Action Plan that explains how this improper release was allowed to happen, and how the Company will ensure that it does not happen again in the future.

Recommendations:
DIFS has multiple recommendations for the Company, which include the following: verify the functionality of the system which generates grace period and lapse notifications, to investigate and eliminate unexplained delays and processing errors in the mail room and other claims processing systems, to better inform applicants that their complete and truthful medical disclosure may not disqualify them for insurance, and to take additional steps to gather all necessary information before denying an application for incompleteness.

II. OBJECTIVES, SCOPE AND METHODOLOGY

This report is based on a targeted market conduct examination of Globe Life and Accident Insurance Company. The examination was conducted at the DIFS office, 611 West Ottawa St., Lansing, MI 48909. DIFS conducted this examination in accordance with statutory authority of MCL 500.222 et seq. All Michigan laws, regulations and bulletins cited in this report may be viewed on the DIFS website at www.michigan.gov/difs.

The purpose of the exam is to evaluate the compliance of the Company with applicable Michigan statutes, NAIC Guidelines and DIFS regulations.

The examination covers the period January 1, 2012 to December 31, 2013. This examination was conducted under the supervision of Sherry J. Bass-Pohl, Manager of the Market Conduct Company Examination Unit. The Examiner-in-Charge was Zachary Dillinger, MCM.

This examination includes reviews of, but not limited to, the areas of (1) Operations/Management, (2) Complaint Handling, (3) Marketing and Sales, (4) Producer Licensing, (5) Underwriting and Rating, and (6) Claims. The examination covers the period of January 1, 2012 through December 31, 2013.

The examination was called due to a referral from DIFS Consumer Services.

The examination team sampled Company records in the areas of (1) Underwriting and Rating, and (2) Claims. The analysis and examination of these areas were conducted and measured according to the Standards and practices in the NAIC *Handbook*, the applicable statutes in the Code, and the Company's internal guidelines and procedures.

Three types of review may have been utilized for the above standards. Certain standards were examined with a single review, and others were examined using one or more type of review. The NAIC *Handbook* calls for a random sample of 100 files when the examination population is greater than 5,000. This statistical sample applies to the Company as follows:

A. Generic Review: A standard test was applied using analysis of all files written by agents at the specific branch office for the time frame of the examination. The Company provided the general file information as a response to examiner questions.

B. Sample Review: A "sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC *Handbook*, Chapter 14. The samples included all files within a specific subgroup. The sampling techniques used are based on a 95 percent (95%) confidence level, meaning there is 95 percent (95%) confidence that the error percentages shown in the various standards so tested are representative of the entire set of records from which it was drawn. An error rate in excess of the tolerance level in these sections of the report is indicative of a general business practice of engaging in that type of conduct. Note that the statistical error tolerance is not indicative of the actual tolerance of DIFS for deliberate or systematic error.

C. Census Review: Operations and Management, Marketing and Sales, Complaint Handling, and Producer Licensing were not subject to the sampling procedure, as the number of relevant files did not warrant taking a sample. Therefore, every relevant marketing piece, Michigan-licensed producer and complaint file for the examination period was reviewed by the examination team for compliance with applicable statutes, regulations and internal company guidelines.

This examination report is a report by test. The report contains a summary of pertinent information about the lines of business examined. This includes each NAIC *Handbook* source

and Standard, Code citation, any examination findings detailing the non-compliant or problematic activities that were discovered during the course of the exam, the Company response proposing methods for correcting the deficiencies, and recommendation for any further action by DIFS.

III. COMPANY OPERATIONS AND PROFILE

Globe Life and Accident Insurance Company began operations in 1951, as an Oklahoma-domiciled company. It is a stock company. It was formed to provide life insurance to rural Oklahoma communities. It is currently licensed to market its products in 49 states and the District of Columbia. The Company's top line of business is individual life.

Its size category is X ($500 million to $750 million), and the Company is rated A+ (Superior) by the AM Best Company. Its outlook is stable.

IV. EXAMINATION FINDINGS AND RECOMMENDATIONS

A. OPERATIONS AND MANAGEMENT

Standard 7: Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. NAIC *Handbook,* Chapter 16.

Standard 8: The regulated entity is licensed for the lines of business that are being written. NAIC *Handbook,* Chapter 16.

Standard 9: The regulated entity cooperates on a timely basis with examiners performing the examinations. NAIC *Handbook,* Chapter 16.

Standard 12: The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers. NAIC *Handbook,* Chapter 16.

Findings:
In one file reviewed (Policy Number 004N20964), the Company appears to have mistakenly released to one claimant's attorney the confidential medical records for a different insured. Although one instance of this does not rise to the level of statistical significance, this violation of the privacy provision of the Health Insurance Portability and Accountability Act (HIPAA) is a serious concern.

To address this, DIFS requests that the Company please provide a response that explains how this improper release was allowed to happen, and please provide an action plan to ensure that it does not happen again in the future.

Company Response:

> "On the policy referenced in the Report, no medical records were erroneously sent to the claimant's attorney. An application for coverage for a different policy was inadvertently

sent to the beneficiary due to the process being manual and Analyst oversight. When the error was discovered, the Analyst who included the incorrect application was counseled on ensuring that all outgoing correspondence contain the correct information and applicable documents. Follow up training was then provided to all Analysts to validate that they understand the process and necessity of making sure the documents sent out are correct. In order to help ensure this does not happen again, we implemented a process whereby our Claims Auditor randomly selects a sample of rescission letters on a daily basis and reviews them to ensure the information in the letter corresponds to the documentation being included in the letter."

Recommendations:
DIFS has two recommendations relevant to the area of Operations and Management.

1) A number of complaints alleged that no notice of the expiration of the policy's 31 day grace period or the ultimate lapse of the policy was received. The Company maintains records that show the required notices are automatically generated by an internal computer system and sent to the address of record, but that no phone calls are made by the conservation unit. While this practice appears to be in compliance with the Michigan Insurance Code, DIFS recommends that the Company verify that the above-referenced system is functioning properly in accordance with the requirements of MCL 500.4012(b) and that the conservation unit considers making phone calls to inform policy owners when policy lapse is imminent. Although this is not required by the Michigan Insurance Code, it would likely reduce insured complaints.
2) Unexplained errors, delays, and mailroom problems were blamed in at least three of the complaint files DIFS examined. This includes at least one instance of the Company being required to pay punitive interest to the beneficiary for a claims processing delay. It is recommended that the Company examine their mailroom practices and address these delays. DIFS will follow up with the Company at a later date to verify that this recommendation was adopted.

Company Response:
"Recommendations found within the area of Company Operations and Management found the Examiner recommending the conservation unit consider making phone calls to inform policy owners when policy lapse is imminent. The Company will make this recommendation to the conservation unit to determine if there are other areas of opportunity to reach out to policy owners prior to the lapse of the policy. The second recommendation made to the Company is to review the mail room practices and address any delays that may be causing claim processing. The Company will be advising the mail room of this recommendation for review."

B. MARKETING AND SALES

Standard 1: All advertising and sales materials are in compliance with applicable statutes, rules and regulations. NAIC *Handbook*, Chapter 16.

MCL 500.2007:

> The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station, or in any other way, and advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

Findings:
There are no findings relevant to the Company's marketing and sales. The Company's procedures appear to be in compliance with the Michigan Insurance Code.

Recommendations:
There are no recommendations relevant to the Company's advertising practices.

C. UNDERWRITING AND RATING

Standard 2: All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations. NAIC *Handbook*, Chapter 16.

Standard 4: The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statues, rules and regulations and regulated entity guidelines in the selection of risks. NAIC *Handbook*, Chapter 16.

Standard 7: Rejections and declinations are not unfairly discriminatory. NAIC *Handbook*, Chapter 16.

Standard 8: Cancellation/Nonrenewal, discontinuance and declination notices comply with policy provisions, state laws and regulated entity guidelines. NAIC *Handbook*, Chapter 16.

Standard 9: Recisions are not made for non-material misrepresentation. NAIC *Handbook*, Chapter 16.

MCL 500.2019:

> The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life

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

MCL 500.2027:

Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance include:

(a) Refusing to insure, or refusing to continue to insure, or limiting the amount of coverage available to an individual or risk because of any of the following:

(i) Race, color, creed, marital status, sex, or national origin, except that marital status may be used to classify individuals or risks for the purpose of insuring family units.

(ii) The residence, age, disability, or lawful occupation of the individual or the location of the risk, unless there is a reasonable relationship between the residence, age, disability, or lawful occupation of the individual or the location of the risk and the extent of the risk or the coverage issued or to be issued, but subject to subparagraph (iii). This section shall not prohibit an insurer from specializing in or limiting its transactions of insurance to certain occupational groups, types, or risks as approved by the commissioner of insurance. The commissioner shall approve the specialization for an insurer licensed to do business in this state and whose articles of incorporation contained a provision on July 1, 1976, requiring that specialization.

(iii) For property insurance, the location of the risk, unless there is a statistically significant relationship between the location of the risk and a risk of loss due to fire within the area in which the insured property is located. As used in this subparagraph, “area” means a single zip code number under the zoning improvement plan of the United States postal service.

(b) Refusing to insure or refusing to continue to insure an individual or risk solely because the insured or applicant was previously denied insurance coverage by an insurer.

(c) Charging a different rate for the same coverage based on sex, marital status, age, residence, location of risk, disability, or lawful occupation of the risk unless the rate differential is based on sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience in the case of new coverages. This subdivision shall not apply if the rate has previously been approved by the commissioner.

MCL 500.4012:

> Each life insurance policy shall contain the following provisions:
>
> (a) a grace period of 1 month for the payment of every premium after the first year, which may be subject to an interest charge, during which month the insurance shall continue in force and which provision may contain a stipulation that if the insured dies during the month of the grace period, the overdue premium will be deducted in any settlement under the policy.
>
> b) That written notice shall be sent by the insurer to the policyowner's last known address at least 30 days prior to termination of coverage. This subdivision does not apply to an insurer that collects a majority of its annual premium in person.

MCL 500.4016:

> There shall be a provision that all statements made by the insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall avoid the policy unless it is contained in a written application and a copy of such application shall be endorsed upon or attached to the policy when issued.

The examiners requested the population of cancelled policies written in the State of Michigan for the period under review.

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Cancellations	326	7	74	7/11/2014	0

Findings:
There are no findings with regards to cancelled policies. The Company appears to be in compliance with the Michigan Insurance Code.

Recommendations:
There are no recommendations relevant to the Company's cancelled policies.

The examiners requested the population of denied applications processed in the state of Michigan for the period under review.

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Denied applications	1,463	9	95	7/11/2014	0

Findings:
There are no findings relevant to the Company's denied applications. Of the 95 sampled files, 59 applications were denied for valid medical underwriting reasons, 27 were incomplete applications or failure to provide required information, 6 were withdrawn by the applicant, and 3 were denied when the applicant chose a product for which they were not eligible.

Recommendations:
After reviewing the sampled denied applications, DIFS has two recommendations:

1) Due to the high cost of medically underwriting each policy, it is recommended that the Company take additional steps to ensure that all applicants are informed that their complete and truthful medical disclosure may not make them ineligible for coverage, but that failure to be completely honest about their medical history almost certainly will. This may save expense and effort overall, as well as help ensure that the proposed insured receives the best possible insurance product available to them.
2) Most of the 27 incomplete applications were denied simply because the information needed to write them was not provided after the Company made efforts to obtain that information. It is recommended that the Company take additional steps to obtain that information before denying the application.

Company Response:

"While no findings were cited within the Underwriting and Rating section of the Report, the Examiner did make two recommendations to the Company. The Examiner recommended that the Company take additional steps to inform applicants that complete and truthful medical disclosure may not make them ineligible for coverage, but that failure to be completely honest about their medical history almost certainly will. A similar recommendation was also found in the Claims section of the Report, where the Examiner has recommended that the Company make it more clear to its applicants that disclosing pertinent medical information at the time of the application will make it less likely that any future claim will be denied for material misrepresentation. The Company will advise both recommendations to the New Business and Marketing departments for further review. The Examiner also noted within the Underwriting and Rating section that a portion of applications were denied due to failure to obtain additional information in order to complete the application process. The Company is currently working on ways to facilitate communication with applicants who have failed to adequately complete the application for underwriting."

D. CLAIMS

Standard 2: Timely investigations are conducted. NAIC *Handbook,* Chapter 16.

Standard 3: Claims are resolved in a timely manner. NAIC *Handbook,* Chapter 16.

Standard 5: Claim files are adequately documented. NAIC *Handbook,* Chapter 16.

Standard 9: Denied and closed without payment claims are handled in accordance with policy provisions and state law. NAIC *Handbook,* Chapter 16.

MCL 500.2006:

> (1) A person must pay on a timely basis to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant the benefits provided under the terms of its policy, or, in the alternative, the person must pay to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant 12% interest, as provided in subsection (4), on claims not paid on a timely basis. Failure to pay claims on a timely basis or to pay interest on claims as provided in subsection (4) is an unfair trade practice unless the claim is reasonably in dispute.
>
> (2) A person shall not be found to have committed an unfair trade practice under this section if the person is found liable for a claim pursuant to a judgment rendered by a court of law, and the person pays to its insured, individual or entity directly entitled to benefits under its insured's contract of insurance, or third party tort claimant interest as provided in subsection (4).
>
> (3) An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss shall be considered paid on a timely basis if paid within 60 days after receipt of proof of loss by the insurer. Any part of the remainder of the claim that is later supported by proof of loss shall be considered paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant contains facts that clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim shall be considered paid on a timely basis if paid within 60 days after receipt of necessary medical information by the insurer. Payment of a claim shall not be untimely during any period in which the insurer is unable to pay the claim when there is no recipient who is legally able to give a valid release for the payment, or where the insurer is unable to determine who is entitled to receive the payment, if the insurer has promptly notified the claimant of that inability and has offered in good faith to

promptly pay the claim upon determination of who is entitled to receive the payment.

(4) If benefits are not paid on a timely basis the benefits paid shall bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum, if the claimant is the insured or an individual or entity directly entitled to benefits under the insured's contract of insurance. If the claimant is a third party tort claimant, then the benefits paid shall bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith and the bad faith was determined by a court of law. The interest shall be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, interest shall be payable based upon the limits of insurance coverage rather than the amount of the loss. If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest is not due. Interest paid pursuant to this section shall be offset by any award of interest that is payable by the insurer pursuant to the award.

(5) If a person contracts to provide benefits and reinsures all or a portion of the risk, the person contracting to provide benefits is liable for interest due to an insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant under this section where a reinsurer fails to pay benefits on a timely basis.

MCL 500.2026:

(1) Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, other than isolated incidents, are a course of conduct indicating a persistent tendency to engage in that type of conduct and include:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.
(b) Failing to acknowledge promptly or to act reasonably and promptly upon communications with respect to claims arising under insurance policies.
(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
(d) Refusing to pay claims without conducting a reasonable investigation based upon the available information.
(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

* * *

(h) Attempting to settle a claim for less than the amount to which a reasonable person would believe the claimant was entitled, by reference to written or printed advertising material accompanying or made part of an application.

* * *

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

MCL 500.4014:

> There shall be a provision that the policy, together with the application therefor, a copy of which application shall be endorsed upon or attached to the policy and made a part thereof, shall constitute the entire contract between the parties and shall be incontestable after it shall have been in force during the lifetime of the insured for 2 years from its date, except for non-payment of premiums and except for violations of the policy relating to naval and military services in time of war, and at the option of the company provisions relative to benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident may also be excepted.

MCL 500.4030:

> There shall be a provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death, or not later than 2 months after receipt of such proof.

<u>Denied –Life</u>

The examiners requested the population of Michigan Denied Claims.

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Denied Claims	134	4	56	7/1/2014	0

Findings:
Standard 2: The sampled files reflected a 16.5 day average, with a maximum of 49 days, from receipt of proof of loss to claim denial. This is well under the 60 days mandated in MCL 500.4030. There are no findings relevant to Standard 2.

Standard 3: The sampled files reflect an average of 184.6 days from claim notification to notice of denial, with a maximum of 1,798 days. However, in every instance where the claim took longer than 60 days to resolve, the proof of loss was not provided by the beneficiary in a timely fashion. In fact, the average waiting time to receive the proof of loss is 175.6 days, and a maximum of 1,790 days. There are no findings relevant to Standard 3.

Standard 5: All sampled files provided sufficient information to verify the decision to deny the claim was appropriate. There are no findings relevant to Standard 5.

Standard 9: The 56 sampled claims files were handled in accordance to the Michigan Insurance Code. The most relevant section of the Code to these files, MCL 500.4014, requires that all policies be held incontestable after a two year period. However, during that period, any claim that might arise can be denied for undisclosed medical history, which is in fact material misrepresentation on the part of the applicant. 94.6% of the sampled claims cited this as the reason for denial, with adequate documentation included in the file to support this decision. There are no findings relevant to Standard 9.

Recommendations:
In 53 of the 56 sampled claims, the stated reason for denial was “Undisclosed Health History Prior to Policy Issue”. This indicates that the applicant committed a material misrepresentation on the application, namely failing to answer in the affirmative to the range of medical questions present thereon. This also means that the Company failed to identify these misrepresentations prior to the insured’s death despite the Company’s apparent best efforts to medically underwrite the application.

DIFS recommends that the Company make it more clear to its applicants that disclosing pertinent medical information at the time of application will make it less likely that any future claim will be denied for material misrepresentation. This will have a twofold effect; first that the Company will potentially see a decrease in denied claims, which may lead to fewer customer complaints. Second, the consumers who have a policy with the Company can be more certain that, when they purchase a life insurance policy, their wishes will be carried out and the beneficiary will receive the death benefit they are owed, not simply a return of relevant premium and cash value.

Company Response:
Examiners Note: The Company did provide a response to this Recommendation but it was incorporated into the response provided to the Underwriting and Rating section recommendations.

E. COMPLAINT HANDLING

Standard 1*:* All complaints are recorded in the required format on the regulated entity’s complaint register. NAIC *Handbook,* Chapter 16.

Standard 2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. NAIC *Handbook*, Chapter 16.

Standard 3: The Company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. NAIC *Handbook,* Chapter 16.

MCL 500.2026:

> (2) The failure of a person to maintain a complete record of all the complaints of its insureds which it has received since the date of the last examination is an unfair method of competition and unfair or deceptive act or practice in the business of insurance. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition thereof, and the time it took to process each complaint. For purposes of this subsection, "complaint" means a written communication primarily expressing an allegation of acts which would constitute violation of this chapter. If a complaint relating to an insurer is received by an agent of the insurer, the agent shall promptly forward the complaint to the insurer unless the agent resolves the complaint to the satisfaction of the insured within a reasonable time. An insurer shall not be deemed to have engaged in an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of this chapter because of the failure of an agent who is not also an employee to forward a written complaint as required by this subsection.

Findings:
There are no findings relevant to the Company's complaint handling practices. The Company's procedures appear to be in compliance with the Michigan Insurance Code.

Recommendations:
There are no recommendations relevant to the Company's complaint handling practices.

F. PRODUCER LICENSING

Standard 1: Regulated entity records of licensed and appointed (if applicable) producers and in jurisdictions where applicable, licensed company or contracted independent adjusters agree with insurance department records. NAIC *Handbook*, Chapter 16.

MCL 500.1208a:

> (1) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.
>
> (2) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the commissioner, a notice of appointment for the qualifications held by that insurance producer within 15 days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint an insurance producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

> (3) Upon receipt of the notice of appointment, the commissioner shall verify within a reasonable time not to exceed 30 days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the commissioner shall notify the insurer within 5 days of that determination.
>
> (4) An insurer shall pay an appointment fee and a renewal appointment fee as provided under section 240(1)(c) for each insurance producer appointed or renewed by the insurer.

Findings:
There are no findings relevant to Producer Licensing. It appears that the Company was in compliance with Michigan's producer licensing requirements during the review period.

Recommendations:
There appear to be duplicate records within the Company's system for certain producers appointed in the State of Michigan. The Company may wish to verify this information to ensure that all records of appointment, continuing education, and all other requirements are the most current and in order.

Company Response:
> "The Examiner cited duplicate records within the Company's system for certain producers. The Examiner recommended that the Company may wish to verify this information to ensure that all records of appointment, continuing education, and all other requirements are the most current and in order. The Company reviewed the data it had given the Examiner and found that the duplicates were due to agent termination and re-hire. In addition, some agents have different contracts which would require different licensing numbers. All data provided to the Examiners are confirmed to be current and in order for the period of the exam."

V. ACKNOWLEDGEMENT

This examination report of Globe Life and Accident Insurance Company is respectfully submitted to the Director of the Department of Insurance and Financial Services, State of Michigan.

The courteous cooperation and assistance of the officers and employees of the Company extended to the examiners during the course of the examination is hereby acknowledged.

Zachary J. Dillinger, MCM
Examiner-in-Charge
Department of Insurance and Financial Services
Market Conduct Section