REPORT OF TARGETED EXAMINATION

OF

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS

NAIC# 60380

AS OF

June 30, 2014

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Market Conduct Section
Arizona Department of Insurance
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Douglas A. Ducey, Governor
Keith A. Schraad, Interim Director

Honorable Keith A. Schraad
Interim Director
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Schraad:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, a targeted examination has been made of the market affairs of:

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS

NAIC # 60380

The above examination was conducted by Sandra Lewis, CIE, MCM, Examiner-in-Charge; James R. Dargavel, CIE, MCM, Senior Market Conduct Examiner and Data Specialist; Mel Mohs, CIE, Senior Market Conduct Examiner; Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner; and John Kilroy, Market Conduct Examiner.

The examination covered the period of July 1, 2013, through June 30, 2014.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Maria G. Ailor, AIE, AMCM
Assistant Director
Market Regulation and Consumer Services Division

FOREWORD

This targeted market conduct examination of the American Family Life Assurance Company of Columbus ("the Company"), was prepared by employees of the Arizona Department of Insurance ("the Department") as well as independent examiners contracting with the Department. A targeted market conduct examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Arizona. The Examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158, and 20-159. The findings in this report, including all work products developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of all aspects of the Company's operations in Arizona, including but not limited to: Advertising, Sales and Marketing, Underwriting, Forms, Claims, Appeals and Grievances, Policyholder Services, and Terminations.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market conduct examination of the Company covered the period from July 1, 2013, through June 30, 2014, for the lines of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. The standards applied during the examination are stated in this Report at page 17.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent compliance with Arizona law. The PF forms were submitted for review and comment to the

Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

The Examiners used both examination-by-test and examination-by-sample. Examination-by-test involves the review of all records within the population, while examination-by-sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, the Examiners completed examinations-by-test and examinations-by-sample as to those populations without the need to use computer software.

The Examiners based their file sampling on a review of Appeal, New Business, and Claims data provided by the Company. Samples were randomly or systematically selected by using ACL (formerly "Audit Command Language") software and computer data files provided by the Company's Representative, Mary Ellen Keim, Vice President, Corporate Regulatory Compliance. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data resulted in an exception ratio, which determined whether or not a standard was met. If the exception ratio found in the sample was, generally, less than 5%, the standard was considered as "met". A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXECUTIVE SUMMARY

The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report beginning at page 17, and the examination findings are reported beginning on page 5.

1. The Company failed Standard No. 1 by failing to maintain information relating to statistics used in one advertisement, as well as cited reference data, for a period of three years from the date of first dissemination, in apparent violation of A.R.S. § 20-157(A) and A.A.C. R20-6-201.01(B)(3) and (C).
2. The Company failed Standard 2 by:
    a. Failing to file 199 social media advertising and 30 video and/or television advertising items with the Department prior to their use, in apparent violation of A.R.S. § 20-1110(E).
    b. Disseminating advertising in various formats that include a description of benefits but do not include the relevant exclusions, reductions or limitations, in apparent violation of A.R.S. § 20-444(A) and A.A.C R20-6-201(C)(7).
    c. Disseminating advertising in various formats that tend to mislead or deceive the prospective insured by making unsupported and undocumented assertions regarding claims handling, and/or regarding the Company's relative position in the insurance industry, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(2) and (O).
    d. Using "testimonial" advertising without disclosing that the individuals were directly or indirectly compensated for the testimonial or endorsement, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(E)(2).
2. The Company failed Standard No. 10, in apparent violation of A.R.S. § 20-2106(8)(a), by using two Claim Authorization Forms that failed to limit the length of time the authorization remains valid to the term of coverage if the claim is for a health insurance benefit.
3. The Company failed Standard 14 by failing to pay benefits in accordance with policy provisions, and thereby misstating pertinent policy provisions, in apparent violation of A.R.S. § 20-461(A)(1) and A.A.C. R20-6-801(D)(1) regarding:
    a. Eight (15%) of 54 HIP "Not Covered" denied claims;

b. Eight (15%) of 55 HIP "Maximum Benefits Previously Paid" denied claims.

4. The Company passed Standard 14 with comment by:

   a. Underpaying the wellness benefit on one (1%) of 106 Cancer Paid claims reviewed. The Company has made restitution in the amount of $164.22.

   b. Incorrectly denying one (9%) of 11 Hospital Indemnity Policy ("HIP") claims denied under the category "Other." The Company has made restitution in the amount of $107.12.

5. The Company failed Standard 16 by using an Explanation of Benefits ("EOB") form when denying dental claims that instructed the member to file appeals with the Department, in apparent violation of A.R.S. § 20-2533(D).

6. The Company failed Standard 22 by:

   a. Failing to incorporate into the insurer's relevant insurance producer training manuals and failing to have a system to provide each insurance producer with a written statement of the insurer's position on the acceptability of replacements to guide the insurance producer as to the appropriateness of a replacement transaction, in apparent violation of A.R.S. § 20-1241.04(B)(1) and (2).

   b. Failing to establish and maintain procedures for the review of each agent's new business for the appropriateness of each replacement transaction and compliance with the insurer's replacement policy, to confirm that the requirements of statute have been met, and/or to detect replacement transactions that have not been reported as such by the applicant or insurance producer, in apparent violation of A.R.S. § 20-1241.04(B)(3), (4), and (5).

   c. Failing to provide a life insurance policy summary that meets the standards prescribed by A.R.S. § 20-1241.02(B).

7. The Company passed Standards 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 15, 17, 18, 19, 20, and 21.

EXAMINATION FINDINGS – FAILED STANDARD 1

Based on the Examiners' review of 273 advertising, marketing and sales material samples, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
1	Company maintains and produces records in a timely manner as required by the Examiners for the completion of the market conduct examination.	A.R.S. § 20-157(A) and A.A.C. R20-6-801(C).

Records Retention -- Advertising

The Examiners reviewed the advertising materials that were provided by the Company on the CD-ROM entitled Disk #8 as well as the Company's response to REQ099-ADV. The Examiners reviewed one advertisement located in the Marketing Folder on Disk #8 under the Subfolder Competitive Intelligence, which contained information comparing the Company's claims processing speed to that of four of its competitors. The ad is silent regarding the lines of business being compared.

When asked to provide the source of the statistics used in the ads, the Company was able to produce the source for one of the four companies mentioned in the ad.

The Company did not meet Standard No. 1 in apparent violation of A.R.S. § 20-157(A) and A.A.C. R20-6-201.01(B)(3) and (C) by failing to maintain information relating to statistics used in the advertisement as well as cited reference data for a period of three years from the date of first dissemination. See PF # 020.

A standard in the areas of procedures, forms and/or the use of policy forms was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of 273 advertising, marketing and sales material samples, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
2	All advertising and sales materials are in compliance with applicable statutes and rules.	A.R.S. §§ 20-442, 20-443, 20-444, 20-1110, and A.A.C. R20-6-201, R20-6-201.01, and R20-6-202

Failure to File Advertising Prior to Use

The Examiners reviewed the Company's response to REQ097-ADV, which identified 1,044 Social Media Ads that were circulated during the examination period. The Examiners also reviewed the Company's response to REQ112-ADV, in which the Company stated that it was not the Company's practice to file social media advertising with the Department.

The Examiners determined that 76 of the ads were either not "advertisements" as defined by A.A.C. R20-6-201(A)(1)(b), or else were exempted from the filing requirement by the 2003 Order, Docket No. 03A-143-INS. The remaining 199 social media ads were not filed with the Department prior to use.

The Company did not meet Standard No. 2 in apparent violation of A.R.S. § 20-1110(E) with regard to 199 social media advertisements because the Company failed to file the advertisements with the Department as required by the statute. See PF # 032.

The Examiners reviewed the advertising provided on Disk #8 as well as the Disks entitled "Aflac Commercials" and "30-Second TV Spots" as well as the Company's response to REQ028-ADV that identified advertising circulated during the examination period.

The Examiners identified 30 video and/or television ads that had not been filed with the Department prior to use.

The Company has not met Standard No. 2 and appears to be in violation of A.R.S. § 20-1110(E) with regard to the 30 video and/or television advertisements because the Company failed to file the advertisements with the Department as required by the statute. See PF # 034.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified; therefore recommendations are warranted.

Advertising That References Specific Benefits

The Examiners reviewed the advertising materials that were provided by the Company on the CD-ROM entitled Disk #8. This review included a review of the advertising provided in the Folder entitled "Product" and the Subfolder entitled "Accident Direct Mail". The Examiners identified three advertisements, which advertised accident insurance and that identified specific benefits contained in the policy.

The Company did not meet Standard 2, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(7) by using ads that identify specific policy benefits but failing to disclose related policy exclusions, limitations and reductions with regard to three advertisements reviewed. See PF # 005.

The Examiners reviewed the website http://azdoimedsup.aflac.com/ that was identified in the Company's response to REQ107 as a reproduction of the website in use during the examination period. The Examiners identified one advertisement on the website that listed the services and the benefits paid by Medicare and the benefits paid by Medicare Supplement. These advertisements identified specific policy benefits payable under Medicare Supplement Insurance.

The Company did not meet Standard 2, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(C)(7) by using ads that identify specific policy benefits but failing to disclose related policy exclusions, limitations and reductions with regard to one website advertisement reviewed. See PF # 022.

A standard in the areas of procedures, forms and/or the use of policy forms was not met if any exception was identified.

Misstatements Regarding Claims Processing

During the examination period, the Company used five television ads that incorporated the statement that Aflac pays claims in four days. These ads are not product-specific, thereby implying that the four-day time for processing claims applies to all lines of business sold by the Company.

The Examiners reviewed the following samples of Hospital Indemnity Policy ("HIP") claims:

1. 110 HIP Paid Claim files in response to AFLAC-REQ032.
2. 60 HIP Pre-Existing Denied Claim files in response to AFLAC-REQ038.
3. 55 HIP Not Covered Denied Claim files in response to AFLAC-REQ039.
4. 55 HIP Ineligible Benefit Denied Claim files in response to AFLAC-REQ045.
5. 11 HIP Other Remarks Denied Claim files in response to AFLAC-REQ046.
6. 55 HIP Maximum Benefit Paid Previously Denied Claim files in response to AFLAC-REQ055.

During their review of the six samples of HIP claims, the Examiners noted that many of the claims were not entered into the claim system until several days after the date stamp appearing on the claim form. The calculation of the number of days to adjudicate the claim used the later of the two dates, rather than the actual date the Company received the claim. The use of the "posted" date rather than the "received" date tended to skew the calculation to give the appearance that more claims were adjudicated within the advertised four days than actually had occurred.

For purposes of calculating the number of days to pay or deny the claims, the Examiners used the actual received date as it appeared on the claim form. The Examiners used a "business days" formula, rather than "calendar days." The following table demonstrates the number and percentages of claims in each sample that were not processed within the four days suggested by the Company's advertising:

REQ #	Type of Claim	Claim Files Reviewed	Number Paid > 4 Working Days	Percent Paid > 4 Working Days
032	HIP Paid	110	44	40%
038	HIP Pre-ex Denied	60	50	83%
039	HIP "Not Covered" Denied	55	15	27%
045	HIP "Ineligible" Denied	55	1	2%
046	HIP "Other" Denied	11	5	45%
055	HIP Max. Benefit Exceeded Denied	55	3	5%
	Totals =	**346**	**118**	**34%**

The Company did not meet Standard 2 in apparent violation of A.A.C. R20-6-201(O) with regard to 118 (34%) of the 346 HIP Paid and Denied Claim Files reviewed, as listed on the foregoing table, because the Company used advertising that contained false statements about the time within which an insured may be led to expect claims to be adjudicated. See PF # 036.

A standard in the areas of procedures, forms and/or the use of policy forms was not met if any exception was identified.

Compensated Endorsers or Spokespersons

The Examiners reviewed the Company's response to REQ112-ADV, including all of the YouTube videos, other videos and radio advertising that were provided with the Company's response. The Examiners also reviewed the 30 Second TV Spots that were provided on two CD-ROMs entitled "30 Second TV Spots" and "30 Second TV Spots Transcripts." Scott McGillivray and Holly Sonders each participated in numerous advertisements reviewed. Both individuals acted

as spokespersons or endorsers for the Company's Supplemental Insurance Products. The Company indicated that both Holly and Scott were compensated as celebrity endorsers or celebrity spokespersons for providing testimonials about Aflac Supplement Insurance products based on a package compensation arrangement with the Company.

The Company did not meet Standard No. 2, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(E)(2) with regard to advertisements involving Holly Sonders and Scott McGillivray who were paid celebrity spokespersons for the Company because the ads failed to disclose that Holly Sonders and Scott McGillivray were directly or indirectly compensated for their testimonials or endorsements in those advertisements. See PF # 027.

The Examiners reviewed the Company's response to REQ114-ADV including six videos that featured interviews with various couples and/or individuals concerning their experience with Aflac Supplemental Insurance Products. In each of the six videos, the individuals or couples who participated in the videos acted as spokespersons or endorsers for Aflac Supplement Insurance Products. The Company response indicated that the Company paid for airfare, hotel and a daily meal stipend for the participants to travel to New York to shoot theestimonial ads. Therefore, each of the individuals or couples who participated in these six videos was directly or indirectly compensated for making the testimonial or endorsement.

The Company did not meet Standard No. 2 in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(E)(2) with regard to six video advertisements because the individuals or couples who participated in the videos were paid endorsers or spokespersons for the Company but the ads failed to disclose that they were directly or indirectly compensated for their testimonials or endorsements in those advertisements. See PF # 028.

A standard in the areas of procedures, forms and/or the use of policy forms was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 10

Based on the Examiners' review of the Company's underwriting guidelines and policy forms and notification documents, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
10	The Company complies with all notice of insurance information and privacy requirements.	A.R.S. §§ 20-2101, *et seq.*

Claims Authorization Forms

The Examiners reviewed the Release of Information Forms provided by the Company in response to Attachment A Critical Disease and Cancer Application Forms provided by the Company in Response to Attachment A UNDERWRITING/PORTABILIY/GUARANTEED ISSUE Request F. This Request asked for a copy of all authorizations for the release of information used in connection with underwriting and claims investigations as required by A.R.S. § 20-2106.

The Company did not meet Standard 10 in apparent violation of A.R.S. § 20-2106(8)(a) by using two Claims Authorization Forms that failed to limit the length of time the authorization remains valid to the term of coverage if the claim is for a health insurance benefit. See PF # 001.

EXAMINATION FINDINGS – FAILED STANDARD 14

Based on the Examiners' review of claims policies and procedures, as well as 44 claim samples totaling 2,482 claim files selected from a total population of 108,206 claims for all lines of business, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
14	The Company provides accurate benefits information to claimants and does not misstate pertinent provisions of the policy or Arizona law.	A.R.S. § 20-461, A.A.C. R20-6-801

Misstating Pertinent Policy Provisions

The Examiners reviewed 54 HIP "Not Covered" denied claim files provided by the Company in response to Request 039. The Examiners found eight (15%) of the 54 files reviewed where claims for Physician Visit Benefits were denied as "Not Covered," despite a policy provision indicating coverage from $15.00 to $20.00 per occurrence for this service.

The Examiners issued REQ117 asking the Company to explain the reason for these denials. The Company agreed that the claims were denied incorrectly due to a systems error.

Company has not met Standard No. 14 and appears to be in violation of A.R.S. § 20-461(A)(1) and A.A.C R20-6-801(D)(1) since it failed to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented. See PF # 037.

Subsequent Events: In response to the Examiners' inquiry about the appropriateness of these denials, the Company reprocessed and paid six of the eight claims that had been denied incorrectly. No additional benefits were owed on two claims that exceeded the maximum yearly benefit for Physician Visits Benefit already paid to those insureds. The Company paid additional benefits of $110.00, plus interest in the amount of $16.74, for total restitution of $126.74. No additional corrective action is necessary with regard to these eight claims. The Company did not indicate whether it conducted an audit of other claims denied under this benefit code to determine whether additional restitution might be owed to other policyholders.

The Examiners reviewed 55 HIP "Maximum Benefits Paid" denied claim files provided by the Company in response to Request 045. The Examiners found eight (15%) of the 55 files reviewed where claims for the Physician Visit Benefit were denied as "Maximum allowable Continuing Care Benefit has already been paid." The policies in question did not appear to have a Continuing Care Benefit provision.

The Examiners issued REQ125 asking the Company to explain the reason for these denials. The Company agreed that the claims were denied incorrectly due to a systems error.

Company has not met Standard No. 14 and appears to be in violation of A.R.S. § 20-461(A)(1) and A.A.C R20-6-801(D)(1) since it failed to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented. See PF # 038.

Subsequent Events: In response to the Examiners' inquiry about the appropriateness of these denials, the Company reprocessed and paid the eight claims that had been denied incorrectly and should have been paid under the Physician Visit Benefit. The Company paid additional benefits of $145.00, plus interest in the amount of $9.72, for total restitution of $154.72. No additional corrective action is necessary with regard to these eight claims. The Company did not indicate whether it conducted an audit of other claims denied using this reason code to determine whether additional restitution might be owed to other policyholders.

Samples That Passed Standard 14 With Comment

The Department has established a benchmark of 5% for compliance with the review standards for market conduct examinations, except in the area of policies and procedures and/or forms review. A single violation, regardless of the percentage, does not represent a "general business practice." Although the following samples met the established benchmark, they are included in this Report because of unpaid or underpaid benefits and/or interest of more than five dollars per each claim noted, and for which restitution may be required:

The following samples passed Standard 14, but are included because the Company failed to pay or underpaid benefits under the terms of the policies:

1. The Company failed to pay the correct Wellness Benefit in the amount of $50.00 on one (1%) paid claim from a sample of 106 Cancer Paid claims provided by the Company in response to REQ035. The Company had paid $25.00. The Examiners issued REQ127 requesting clarification for the smaller benefit payment amount than the policy appeared to provide.

   Subsequent Events: In response to the Examiners' inquiries about this claim, the Company determined that this was one of six claims that had been underpaid for this same insured. On August 5, 2015, the Company paid additional benefits of $150.00 plus $12.98 in accrued interest. On August 12, the Company issued a

second check for an additional $1.24 in accrued interest, for total restitution paid of $164.22.

2. The Company failed to pay the correct benefit in the amount of $100.00 on one (9%) paid claim from a sample of 11 HIP claims denied under the category "Other" provided by the Company in response to REQ046. The Examiners issued REQ126 requesting clarification regarding the denial, despite a policy provision that appeared to provide benefits for the service involved.

   Subsequent Events: In response to the Examiners' inquiries about this claim, the Company determined that this claim had been denied incorrectly. On August 5, 2015, the Company paid additional benefits of $100.00 plus $7.12 in accrued interest for total restitution paid of $107.12.

EXAMINATION FINDINGS – FAILED STANDARD 16

Based on the Examiners' review of claims policies and procedures, as well as 44 claim samples totaling 2,482 claim files selected from a total population of 108,206 claims for all lines of business, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
16	The Company provides timely appeals from denied health insurance claims and/or denied services and provides appropriate and timely acknowledgments, responses, and notices throughout the appeal process.	A.R.S. §§ 20-2530, *et seq.*

Failing to Provide Accurate Notification of Appeal Rights

The Examiners identified the use of Form # DENEOB in the denial of dental claims that instructed the claimant to submit any appeals directly to the Department. The Form # DENEOB was used in 105 of 105 (100%) of the denied dental claims reviewed in REQ040, and in 53 of 53 (100%) of the denied dental claims reviewed in REQ047. See PF # 021.

The Company did not meet Standard 16 in apparent violation of A.R.S. § 20-2533(D) by using an EOB form that provided inaccurate instructions regarding the appeals procedure.

A standard in the areas of procedures, forms and/or the use of policy forms was not met if any exception was identified.

Subsequent Events: The Company submitted revised appeal language to the Department, and the Department approved the changes on June 26, 2015. The Company indicated the revised language would go live in October 2015.

EXAMINATION FINDINGS – FAILED STANDARD 22

Based on the Examiners' review of life insurance policies and procedures for replacement of policies, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
22	Company internal policies and procedure, forms and materials regarding replacement of existing coverage comply with applicable statutes, rules and regulations.	A.R.S. §§ 20-1241, *et seq.*

Producer Training Policies and Procedures

The Examiners reviewed the Company's responses to Attachment A of the Coordinator's Handbook, as well as the response to REQ101 and REQ110. The Company's responses indicate that "The Company does not have any specific training materials to provide as the specific replacement training occurs one-on-one *verbally* between the producer and their RSC or DSC." (Emphasis added).

The Company has not met Standard No. 22 and appears to be in violation of A.R.S. § 20-1241.04(B)(1) and (2) by failing to incorporate life insurance replacement requirements into the insurer's relevant insurance producer training manuals and failing to have a system to provide each insurance producer with a written statement of the insurer's position on the acceptability of replacements to guide the insurance producer as to the appropriateness of a replacement transaction. See PF # 024.

A standard in the areas of procedures, forms and/or the use of policy forms was not met if any exception was identified.

Oversight of Producer Replacements of Life Insurance

The Examiners reviewed the Company's responses to requests for policies and procedures for the monitoring of producers' replacements of life insurance policies requested in Attachment A of the Coordinator's Handbook and REQ110, the Company provided a "Replacement Chart" and "Replacement Manual." Neither of these materials contained any procedures for reviewing a producer's new business for the appropriateness of each replacement transaction for compliance with the insurer's replacement policy, to confirm that the requirements of statute have been met, and/or to detect replacement transactions that have not been reported as such by the applicant or insurance producer.

The Company has not met Standard No. 22 in apparent violation of A.R.S. § 20-1241.04(B)(3), (4) and (5) by failing to have suitable policies and procedures in place for reviewing agent's new business for the appropriateness of each replacement transaction for compliance with the insurer's replacement policy, to confirm that the requirements of statute have been met and to detect replacement transactions that have not been reported as such by the applicant or insurance producer. See PF # 025.

A standard in the areas of procedures, forms and/or the use of policy forms was not met if any exception was identified.

Policy Summaries

The Examiners reviewed the Company's responses to Attachment A of the Coordinator's Handbook, as well as the response to REQ101 and PF # 026 [later withdrawn] requesting "Copies of all policy summaries provided to applicants during the examination period as required by A.R.S. § 20-1241.02."

The policy summaries provided by AFLAC do not contain:

- Current death benefit.
- Current cash surrender value.
- Current dividend, if applicable.
- Application of current dividend, if applicable.
- Amount of outstanding loan, if any.

The Company has not met Standard No. 22 in apparent violation of A.R.S. § 20-1241.02(B), by failing to include all of the notification requirements for an adequate policy summary as prescribed by the statute. See PF # 031.

A standard in the areas of procedures, forms and/or the use of policy forms was not met if any exception was identified.

ADDENDUM I – STANDARDS FOR REVIEW

A. Operations and Management

#	STANDARD	PASS	FAIL
1	Company maintains and produces records in a timely manner as required by the Examiners for the completion of the market conduct examination. A.R.S. § 20-157(A) and A.A.C. R20-6-801(C)		X

B. Advertising, Marketing, and Sales

#	STANDARD	PASS	FAIL
2	All advertising and sales materials comply with applicable statutes and rules. (A.R.S. §§ 20-442, 20-443, 20-444, 20-1137, and A.A.C. R20-6-201, R20-6-201.01, and R20-6-202)		X
3	The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups. (A.R.S. §§ 20-448, 20-1378, 20-1379, 20-2304, 20-2307, 20-2313, 20-2324)	X	
4	The Company discloses information concerning the provisions of coverage, the benefits and the premiums available to small group employers as part of sales materials for its small group employers. (A.R.S. § 20-2304)	X	

C. Forms

#	STANDARD	PASS	FAIL
5	Policy forms, including but not limited to contracts, certificates, applications, riders, and endorsements, comply with pertinent Arizona laws and/or the laws of the state where the policy was issued. (A.R.S. §§ 20-1205, 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01)	X	
6	Individual insurance policy forms, except those for which no renewal is provided, contain a 10-day free look provision, which is prominently displayed on the first page of the policy. (A.A.C. R20-6-501	X	

D. Underwriting/Portability/Guaranteed Issue

#	STANDARD	PASS	FAIL
7	The Company issues coverage to all eligible groups and individuals. (A.R.S. §§ 20-1378, 20-1379, 20-2304, 20-2307, 20-2313, 20-2324)	X	
8	The Company provides approved disclosure of information forms to all group employers prior to executing a contract for coverage under a health care plan. (A.R.S. § 20-2323)	X	
9	The Company uses appropriate consent and/or release forms regarding the testing for or disclosure of HIV-related or genetic testing information. (A.R.S. §§ 20-448.01, 20-448.02, and A.A.C. R20-6-1201, *et seq.)*	X	
10	The Company complies with all notice of insurance information and privacy requirements. (A.R.S. §§ 20-2101, *et seq.*)		X

E. Claims Processing

#	STANDARD	PASS	FAIL
11	The Company handles claims timely and appropriately, and in accordance with policy provisions and applicable statutes and rules. (A.R.S. §§ 20-448, 20-461, 20-462, 20-1215 and 20-3102, and A.A.C. R20-6-801)	X	
12	The Company adequately documents claim files to contain all notes and work papers in such detail as necessary to reconstruct the claim. (A.R.S. § 20-461 and A.A.C. R20-6-801)	X	
13	All claim forms contain an appropriate fraud warning. (A.R.S. § 20-466.03)	X	
14	The Company provides accurate benefits information to claimants and does not misstate pertinent provisions of the policy or Arizona law. (A.R.S. § 20-461, A.A.C. R20-6-801)		X

F. Policyholder Services

#	STANDARD	PASS	FAIL
15	The Company takes adequate steps to finalize and dispose of the complaints in accordance with policy provisions and applicable statutes and rules. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
16	The Company provides timely appeals from denied health insurance claims and/or denied services and provides appropriate and timely acknowledgments, responses, and notices throughout the appeal process. (A.R.S. §§ 20-2530, *et seq.*)		X

G. Cancellation, Non-Renewals, and Rescissions

#	STANDARD	PASS	FAIL
17	The Company affords adequate grace periods without cancellation of coverage for the receipt of premiums as required by law. (A.R.S. §§ 20-191, 20-1203, and 20-1347)	X	
18	The Company does not cancel, non-renew, or rescind coverage except as allowed by law (A.R.S. §§ 20-448, 20-1204, 20-1213, 20-1342, 20-1346, 20-1347, 20-1378, 20-1380, 20-1402, 20-1404, 20-1411, 20-2110, 20-2309, 20-2321)	X	
19	**(Life Insurance)** The Company's contracts and applications contain appropriate notices concerning the right to return the policy/contract for a full refund of premiums. A.R.S. § 20-1233(A), (B), and (C).	X	
20	**(Life Insurance)** Company handling of requests for refunds using the "Free Look" option, or the 30 day option if the application involved replacement of existing coverage comply with applicable statutes, rules and regulations. A.R.S. §§ 20-1233(A) & (B), 20-1241.05(E) and 20-1241.07(B)	X	

H. Nonforfeiture, Dividends, Loans (Life and Annuity)

#	STANDARD	PASS	FAIL
21	The Company complies with pertinent Arizona law regarding nonforfeiture, dividends and/or policy loans. (A.R.S. §§ 20-1207 through 20-1212, and 20-1231)	X	

I. Replacements (Life and Annuity)

#	STANDARD	PASS	FAIL
22	Company internal policies and procedure, forms and materials regarding replacement of existing coverage comply with applicable statutes, rules and regulations. A.R.S. §§ 20-1241, *et seq.*		X