

REPORT ON
TARGET MARKET CONDUCT EXAMINATION
OF
CMFG LIFE INSURANCE COMPANY
AS OF JUNE 30, 2012

Conducted from February 20, 2013

Through

August 28, 2013

By

Market Conduct Section

Life and Health Division

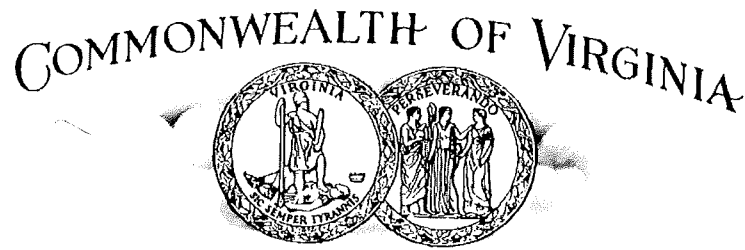
BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 39-0230590
NAIC: 62626

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**STATE CORPORATION COMMISSION
BUREAU OF INSURANCE**

I, Laura Klanian, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of CMFG Life Insurance Company as of June 30, 2012, conducted at the Company's office in Madison, Wisconsin is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2014-00197 finalizing the Report.

IN WITNESS WHEREOF, I have
hereunto set my hand and affixed
the official seal of this the Bureau
at the City of Richmond, Virginia,
this 8th day of October, 2014.

Laura Klanian

Laura Klanian
Examiner in Charge

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of CMFG Life Insurance Company, (hereinafter referred to as “CMFG”), formerly known as CUNA Mutual Insurance Society, was conducted under the authority of various sections of the Code of Virginia, (hereinafter referred to as “the Code”), and regulations found in the Virginia Administrative Code, (hereinafter referred to as “VAC”), including but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1317.1 and 38.2-1809 of the Code, as well as 14 VAC 5-41-150 C and 14 VAC 5-90-170 A.

A previous target market conduct examination covering the period of January 1, 2006, through March 31, 2006, was concluded on March 28, 2007. As a result of that examination, CMFG made a monetary settlement offer that was accepted by the State Corporation Commission on August 30, 2007, in Case No. INS-2007-00207.

A previous target market conduct examination covering the period of January 1, 2002, through December 31, 2002, was concluded on October 21, 2004. As a result of that examination, CMFG agreed to a consent order issued by the State Corporation Commission on November 19, 2004 in Case No. INS-2004-00312. The consent order required that on or before November 29, 2004, CMFG would cease issuing credit life or credit accident and sickness insurance in the Commonwealth of Virginia on loans with a set duration of more than ten years (120 months) in accordance with subsection 1 of § 38.2-3717 of the Code. At the close of the prior examination, CMFG made a settlement offer which was accepted by the State Corporation Commission on April 5, 2005 in Case No. INS-2005-00041.

The current examination revealed violations that were noted in the previous Report. Although CMFG had agreed after the previous Report to change its practices to comply with the Code and regulations, the current examination revealed certain instances where CMFG failed to do so. Therefore, in the examiners' opinion, CMFG has knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The period of time covered for the current examination was April 1, 2012, through June 30, 2012. Based on information provided by the company and as discussed on pages 18 and 20 of this Report, our examination included a review of coverage both issued and in force during this timeframe.

The on-site examination was conducted from April 15, 2013, through April 25, 2013, at CFMG's home office in Madison, Wisconsin and completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia on August 28, 2013. The violations cited and the comments included in this Report are the opinion of the examiners. The examiners may not have discovered every unacceptable or non-compliant activity in which the company is engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

The purpose of the examination was to determine whether CMFG was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code. Compliance with the following regulations was considered in this examination process:

14 VAC 5-30-10 et seq. Rules Governing Life Insurance and Annuity Replacements;

14 VAC 5-41-10 et seq.	Rules Governing Advertisement of Life Insurance and Annuities;
14 VAC 5-43-10 et seq.	Rules Governing Use of Senior-Specific Certifications and Professional Designations in Sale of Life or Accident and Sickness Insurance or Annuities;
14 VAC 5-45-10 et seq.	Rules Governing Suitability in Annuity Transactions;
14 VAC 5-70-10 et seq.	Rules Governing Accelerated Benefits Provisions;
14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;
14 VAC 5-140-10 et seq.	Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act;
14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS); and
14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices.

The examination included the following areas:

- Advertising
- Policy and Other Forms
- Agents
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act/Insurance Replacements
- Premium Notices/Reinstatements/Policy Loans and Loan Interest
- Cancellations/Nonrenewals
- Complaints
- Claim Practices

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to CMFG during the course of the examination.

II. COMPANY HISTORY

CMFG Life Insurance Company, an Iowa domiciled stock life and health insurer, was initially organized under the laws of the State of Wisconsin as CUNA Mutual Insurance Society (CUNA) in 1935. CUNA was established by credit union interests for the purpose of providing for the insurance needs of credit unions, credit union organizations, and credit union members. Ownership and control of the Company was vested in the Company's policyholders, which are comprised primarily of credit union institutions and individual members of credit unions. CUNA was licensed in the Commonwealth of Virginia on December 5, 1952.

Effective July 1, 1990, CUNA entered into an agreement of permanent affiliation with CUNA Mutual Life Insurance Company (CMLIC), an Iowa domiciled life insurer formerly known as Century Life of America. CMLIC serves as the primary direct writer of individual life insurance and individual annuities that are marketed to credit union members through CUNA's policyholder credit unions.

With the approval by the Boards of Directors, policyholders, and the Iowa Division of Insurance, CUNA and CMLIC merged on December 31, 2007, and retained the name CUNA Mutual Insurance Society. On June 2, 2011, CUNA adopted a reorganization plan to form a new mutual insurance holding company known as CUNA Mutual Holding Company. Policyholders approved the plan on September 7, 2011, and on October 7, 2011, the Iowa Division of Insurance issued an order approving the plan. On January 31, 2012, the new structure became effective and CUNA changed its name to CMFG Life Insurance Company. Under the new structure, ownership and control of CUNA shifted to become members and owners of CUNA Mutual Holding Company

(CMHC), the ultimate parent. The reorganization plan also formed a new intermediary legal entity, CUNA Mutual Financial Group, Inc. This new structure places CMFG Life Insurance Company and its subsidiaries under CUNA Mutual Financial Group, Inc.

The company maintains insurance authorization in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Canada. Most of the company's insurance business is written in the United States.

The major products marketed by the company include credit life, credit accident and sickness, group term life, individual life, pension products, and group accidental death and dismemberment (AD&D). Credit life and credit accident and sickness insurance coverage is purchased by individual credit union members to cover outstanding loan balances, or by credit union institutions as a free benefit provided to members. Group term life and individual term life coverage is purchased by individual credit union members. Home Mortgage Protection (HMP) is group term life insurance that is purchased by credit union members to reduce or pay off the member's mortgage in case of death. Group and individual AD&D coverage is purchased by credit unions who offer the coverage to its individual members. AD&D may be offered as a free benefit to credit union members with the opportunity for members to purchase additional coverage. Long-term care is no longer offered; however, current in-force policies are administered by CHS Services, Inc.

As of December 31, 2011, direct premiums in Virginia for CMFG's group and individual credit life and credit accident and sickness insurance lines of business totaled \$10,638,752 and direct premium earned in Virginia for CMFG's accident and health business totaled \$12,273,869.

III. ADVERTISING

A review was conducted of CMFG's advertisements to determine compliance with the Unfair Trade Practices Act, specifically §§ 38.2-502, 38.2-503, and 38.2-504 of the Code, as well as 14 VAC 5-41-10 et seq., Rules Governing Advertisement of Life Insurance and Annuities and 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. (14 VAC 5-41-30 B and 14 VAC 5-90-50)

14 VAC 5-41-150 C and 14 VAC 5-90-170 A require each insurer to maintain at its home or principal office a complete file of all advertising with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement. The review revealed that CMFG was in substantial compliance.

The examiners reviewed a sample of 25 from a total population of 116 advertisements used in the Commonwealth of Virginia during the examination timeframe. In the aggregate, there were 2 violations involving 1 of the advertisements reviewed.

14 VAC 5-90-50 A states that the content of an advertisement shall be sufficiently complete and clear to avoid the capacity or tendency to mislead. 14 VAC 5-90-50 B states that an advertisement shall be truthful and not misleading in fact or in implication. The review revealed 1 violation of each of these sections. As discussed in Review Sheet AD04, the advertisement included a testimonial in Spanish that implied that medical bills, such as surgery, will be paid through the Joint Credit Disability Insurance policy. CMFG disagreed with the examiners' observations stating,

“Upon reviewing the piece in its entirety, the Company does not agree that the citations referenced above are warranted because the piece, when viewed in its entirety, accurately states that credit disability insurance may pay for a consumer's loan obligation in the event of a covered disability. There are numerous references in the text stating that the insurance may help to make loan payments. With the exception of the single statement in the testimonial that the Examiner has questioned, there are no other references to paying medical bills; all coverage references direct the reader to loan payments. Additionally, further clarification is provided with “asterisk” references to review the terms and conditions of the coverage as provided in the insured's certificate. For these reasons, the Company believes the overall impression of the piece does not have the capacity or tendency to mislead or deceive the consumer which is the substantive consumer protection referenced in 14 VAC 5-90-50, 14 VAC 5-90-50B, subsection 1 of §38.2-502 and §38.2-503.

The Company does acknowledge that there was an inadvertent translation error in the testimonial statement referenced by the Examiner. The error does not rise to change the overall impression of the piece that credit insurance pays medical bills since all of the other descriptions refer to the financial consequences that may occur if one is disabled and all other disclosures explicitly reference possible benefits as loan payments. We appreciate that the Examiner has brought the error to our attention and although we do not agree with the Examiner's conclusion, we do believe the statement could have been worded to be more consistent with the overall content of the piece. Accordingly, we have pulled this piece from circulation effective immediately.”

Pursuant to 14 VAC 5-90-80 A, testimonials and endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer, in using

a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all the provisions of this chapter. The examiners consider that although the advertisement indicates that having insurance may help with loan payments, the testimonial itself indicates that Joint Credit Disability Insurance would pay for surgery. Therefore, the testimonial was not clear and had the tendency to mislead by the implication that medical bills would be paid for as a policy benefit.

SUMMARY

CMFG violated 14 VAC 5-90-50 A and 14 VAC 5-90-50 B, placing it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

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IV. POLICY AND OTHER FORMS

A review was made to determine if CMFG complied with various statutory, regulatory and administrative requirements governing the filing and approval of forms. Section 38.2-316 of the Code sets forth the filing and approval requirements for forms and rates that are to be issued or issued for delivery in Virginia.

Section 38.2-3725 of the Code sets forth the requirements for filing and approval of credit life and credit accident and sickness insurance forms that are issued for delivery in this Commonwealth. Section 38.2-3737 of the Code sets the standards for the use of application or enrollment forms for credit insurance contracts.

The examiners reviewed the policy forms issued in connection with the following policies and certificates:

Line of Business	Issued or In Force During the Exam Timeframe	Population	Sample Size
Group Life	Issued	1,724	25
Group Life EE Term	Issued	47	20
Group HMP Life	Issued	2	2
Group AD&D	Issued	11,572	32
Individual Life	Issued	79	20
Individual Annuities	Issued	1	1
Single Premium Credit Life	In Force	950	47
Single Premium Credit Accident and Sickness	In Force	1071	44
Monthly Premium Credit Life and Credit Accident and Sickness	In Force-Insured loans reported for April, May and June of 2012 (aggregate)	24,360	150

POLICIES/CERTIFICATES

Sections 38.2-316 B and 38.2-316 C 1 of the Code state that no individual certificate shall be used in connection with any group life insurance policy unless the certificate has been filed with and approved by the Commission.

The review revealed 2 violations of §§ 38.2-316 B and 38.2-316 C 1 of the Code. As discussed in Review Sheet PF04, the review revealed that CMFG issued a group life certificate for its HMP life product that was not filed with and approved by the Commission, as required. CMFG agreed with the examiners' observation, indicating that it discontinued use of the form in Virginia, and notified the credit union involved.

APPLICATIONS/ENDORSEMENTS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application and enrollment forms.

The review revealed 34 violations of §§ 38.2-316 B and 38.2-316 C 1 of the Code. An example is discussed in Review Sheet PF01 where CMFG failed to file an AD&D enrollment application prior to use. CMFG disagreed stating:

“The underlying accidental death and dismemberment policy was filed for approval under § 38.2-316 and we failed to include this enrollment form in that filing because we believed it was an administrative form not subject to filing.”

Sections 38.2-316 B and 38.2-316 C 1 of the Code require that all enrollment applications be filed and approved prior to use. Although CMFG disagreed with the examiners' observations, it also indicated that steps have been taken to file the AD&D enrollment form.

RATE FILING

Section 38.2-316 A of the Code sets forth the requirements for the filing of rates and rate changes for accident and sickness insurance. Section 38.2-316 C 2 of the Code requires that premium rate changes for individual accident and sickness policies be approved in writing by the Commission. Section 38.2-3728 A of the Code sets forth the requirements for the filing of rates and the use of rates that are not in excess of the prima facie rates as required by §§ 38.2-3726 and 38.2-3727 of the Code.

The review revealed that CMFG was in substantial compliance.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy shall file its EOB forms for approval by the Commission.

The review revealed 20 violations of this section. As discussed in Review Sheets PF08 and PF09, the EOBs that CMFG sent in connection with the sample long-term care claim files were not filed with and approved by the Commission. CMFG agreed with the examiners' observations.

V. AGENTS

The purpose of this review was to determine compliance with various Sections of Title 38.2, Chapter 18 of the Code.

A sample of 20 from a population of 689 agent and agency appointments was selected for review. In addition, the writing agents or agencies designated in the 100 new business files were also reviewed.

LICENSED AGENT REVIEW

Sections 38.2-1822 A and 38.2-3734 of the Code prohibit a person from acting as an agent prior to obtaining a license to transact the business of insurance in the Commonwealth. The review revealed that CMFG was in substantial compliance with this section.

APPOINTED AGENT REVIEW

Section 38.2-1833 A of the Code requires that an insurer, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent. The review revealed that CMFG was in substantial compliance with this section.

Administrative Letters

Administrative Letter 2002-2 was sent to all insurers conducting business in Virginia with the request that insurers insert a separate document in each new agent's packet directing the new agent to be aware of certain administrative letters specifically applicable to licensed agents in Virginia, and advising that a complete listing of these administrative letters is available on the Bureau of Insurance website.

Administrative Letter 2002-9 was sent to all insurers conducting business in Virginia with the request that insurers instruct each newly appointed Virginia agent to review this Administrative Letter at the BOI website.

CMFG indicated its procedures do not include instructions to provide newly-appointed agents with Administrative Letters 2002-2 and 2002-9. CMFG further indicated that it has initiated a revision to its procedures to notify and refer agents accordingly. Therefore, the review revealed that CMFG was not in compliance with the Commissioner's request.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commission or other valuable consideration to an agent or agency which was not appointed or that was not licensed at the time of the transaction. The review revealed that CMFG was in substantial compliance with this section.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an insurer notify the agent within 5 calendar days, and the Commission within 30 calendar days, upon termination of the agent's appointment.

A sample of 5 from a population of 25 agent and agency terminations processed during the examination time frame was selected for review. The review revealed 5 violations of this section. An example is discussed in Review Sheet AGTRM01 where CMFG failed to notify the agent within 5 calendar days of the appointment termination. CMFG agreed with the examiners' observation and indicated that it will request that its vendor review licensing requirements and make necessary corrections.

VI. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT/INSURANCE REPLACEMENT

The examination included a review of CMFG's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514; the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620; the Credit Life Insurance and Credit Accident and Sickness Insurance Act §§ 38.2-3717 through 38.2-3738; 14 VAC 5-30-10 et seq., Rules Governing Life Insurance and Annuity Replacements; 14 VAC 5-45-10 et seq., Rules Governing Suitability in Annuity Transactions; 14 VAC 5-70-10 et seq., Rules Governing Accelerated Benefit Provisions; and 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS).

UNDERWRITING/UNFAIR DISCRIMINATION

The review was made to determine whether CMFG's underwriting guidelines were unfairly discriminatory and whether applications were underwritten in accordance with CMFG's procedures, and correct premiums were being charged.

UNDERWRITING REVIEW

The examiners reviewed a sample of 100 from a total population of 13,425 policies and certificates issued during the examination timeframe.

Line of Business	Status	Population	Sample Size
Group Life	Issued	1,724	25
Group Life EE Term	Issued	47	20
Group HMP Life	Issued	2	2
Group AD&D	Issued	11,572	32
Individual Life	Issued	79	20
Individual Annuities	Issued	1	1
TOTALS		13,425	100

The review revealed that the policies and certificates were issued in accordance with CMFG's established procedures. There was no evidence of unfair discrimination.

Single Premium Credit Insurance

The examiners reviewed a sample of 91 from a population of 2,021 single premium credit life and credit accident and sickness certificates in force during the examination timeframe that were issued on or after January 1, 2008.

Section 38.2-3735 C 2 of the Code requires the clear disclosure of the difference in premiums charged for a contract with credit insurance and a contract without credit insurance. The disclosure shall include the difference between the amount financed, monthly payment, and premium for each kind of credit insurance. The review revealed 54 violations of this section. An example is discussed in Review Sheet UN03 where, in 24 instances, the disclosure form provided to the applicant was not properly completed by the creditor representative and failed to provide the required disclosures. CMFG disagreed with the examiners' observations stating,

“After reviewing the records listed above, the Company cannot agree with the Examiner's observations as stated. Section 38.2-3735 C 2 of the Code of Virginia requires the delivery of a disclosure form disclosing the difference in premiums charged for a contract with and without credit insurance. This disclosure is required when the consumer is given a single premium credit insurance contract. Thus, the disclosure obligation in Section 38.2-3735 C 2 occurs at the time of the consumer's purchase of the insurance contract.

The Company's review of the records referenced above indicate that all but one of the transactions (which is SPCD00011), when the consumer is given a single premium credit insurance contract, occurred prior to the effective date of the exam period. The exam period began on April 1, 2012.

Therefore, with all due respect, the Company believes that the observations as relying upon the stated records, cannot be agreed upon because all but one record is outside the scope of the exam. Accordingly, the Company respectfully requests that the Examiner's observations be withdrawn."

The examiners do not concur that any error occurring outside of the examination time frame cannot be cited as a violation because it is not within the scope of the examination. As previously discussed on page 2, the examination included a review of coverage both issued and in force between April 1, 2012 and June 30, 2012, based on information provided by the company. Although the examiners requested a population of single premium credit life and credit accident and sickness certificates issued during the examination timeframe, CMFG provided a population of single premium credit life and credit accident and sickness certificates in force during the examination timeframe and a sample was selected from that population. CMFG provided copies of the requested files and each sample file was reviewed in its entirety to verify compliance with Virginia's laws and regulations and CMFG's underwriting procedures. In addition, and as previously discussed with the company, page 4 of the Coordinator's Handbook specifically states that the examination timeframe does not limit the examiners' right to examine material falling outside of the timeframe. Violations of Virginia's statute were observed, and duly noted in the Report.

Due to the fact that violations of § 38.2-3735 C 2 were discussed in the prior Report and Settlement Order, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties for knowing violations.

Monthly Premium Credit Insurance

The examiners reviewed a sample of 150 from a population of 24,360 loans insured by CMFG in April, May and June of 2012. The review revealed that the certificates were issued in accordance with CMFG's established procedures. There was no evidence of unfair discrimination.

UNDERWRITING PRACTICES - AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS. The review revealed that CMFG was in substantial compliance.

MECHANICAL RATING REVIEW

Sections 38.2-3727, 38.2-3730, and 38.2-3732 of the Code set forth various requirements for rates charged and calculations of premium for contracts of credit life and/or credit accident and sickness insurance.

In most instances, premium for credit life and or credit accident and sickness insurance is calculated by the credit union where the policy is sold. CMFG verifies these premium calculations upon receipt of the application to ensure that the premium was calculated in accordance with the filed and approved rates and premium calculation formulas. Administrative Letter 2004-2 states that it is an insurer's responsibility to ensure that all duties delegated to a creditor are discharged in accordance with applicable laws and regulations. The Bureau of Insurance will hold the insurer responsible and accountable for any failure, oversights, omissions or violations committed by the creditor conducting business on behalf of the insurer.

Subsection 1 of § 38.2-3732 of the Code requires that any insurer that delegates to a creditor any of its duties under the laws of this Commonwealth or the regulations of this Commission shall be responsible to see that such creditor discharge such duties in accordance with said laws and regulations. Such responsibilities shall include but not be limited to a determination that proper insurance rates are being charged by the creditor.

The review revealed 1 violation of this section. As discussed in Review Sheet UN01, credit accident and sickness premium rates changed on March 1, 2012, and the insured applied for coverage on March 19, 2012. However, the credit union calculated the premium based on rates in effect prior to March 1, 2012. CMFG disagreed with the examiners' observations, stating that:

“The Company’s review reveals that the single premium credit life insurance enrollment occurred on March 19, 2012. Single premium credit insurance is calculated to be paid at the time of enrollment (as opposed to monthly-outstanding-balance credit insurance where premium is paid on a month-to-month basis). The scope of this exam is for the period April 1, 2012 through June 30, 2012. Therefore, any possible error that may have occurred prior to the beginning date of the exam is outside its scope and cannot be cited as a finding. Thus, CMFG ID#: SPCL0701 can factually be said to have occurred prior to the beginning of the exam and is technically out of scope.

Additionally, after reviewing CMFG ID#: SPCL0701, the Company believes that this is an isolated case arising from human error. The Company’s single premium verification process typically occurs shortly after the consumer purchases coverage and if calculation errors are identified, home office staff administers premium adjustments. As to this case, the Company has initiated the refund process to address the error despite the fact that it occurred before the exam period.”

The examiners do not concur that any error occurring outside of the examination time frame cannot be cited as a violation because it is not within the scope of the examination. As previously discussed on pages 2 and 18, the examination included a

review of coverage both issued and in force between April 1, 2012 and June 30, 2012, based on information provided by the company. In addition, page 4 of the Coordinator's Handbook specifically states that the examination timeframe does not limit the examiners' right to examine material falling outside of the timeframe. A violation of Virginia's statute was observed, and duly noted in the Report. Further, CMFG's response discussed a verification process. The examiners would point out that neither the creditor nor the verification process caught this "isolated case" of "human error".

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use, and disclosure of personal/privileged information gathered in connection with insurance transactions.

NOTICE OF INSURANCE INFORMATION PRACTICES (NIP)

Section 38.2-604 of the Code sets forth the requirements for a NIP, either full or abbreviated, to be provided to all individual applicants and to applicants for group insurance that are individually underwritten.

CMFG provided a full and abbreviated NIP form that complied with the requirements of this section.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The review revealed that CMFG's disclosure authorization forms used in the underwriting of new business and the processing of claims were in substantial compliance.

ACCELERATED BENEFITS

14 VAC 5-70-80 requires that a written disclosure, including a brief description of the provisions of an Accelerated Benefit Rider be given to each applicant and an acknowledgement of the disclosure shall be signed by the applicant and agent.

The review revealed that CMFG was in substantial compliance.

ACCESS TO RECORDED PERSONAL INFORMATION

Section 38.2-608 of the Code sets forth the requirements of providing access to personal information and the correction or amendment of such information. The review revealed that CMFG did not receive any requests for access to personal information during the examination time frame.

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 A of the Code requires that in the event of an adverse underwriting decision on an applicant that is individually underwritten, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission that provides the applicant with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 of the Code.

The examiners reviewed a sample of 50 from a population of 345 applications for AD&D insurance, a sample of 25 from a population of 732 applications for group life insurance, and a sample of 10 from a population of 47 applications for individual life insurance that were declined during the examination time frame. In total a sample of 85 from a population of 1,124 declined applications was reviewed.

The review revealed that CMFG was in substantial compliance with this section.

INSURANCE REPLACEMENT

A review was conducted to determine if CMFG was in compliance with the requirements of 14 VAC 5-30-10 et seq., Rules Governing Life Insurance Replacements.

The review revealed CMFG was in substantial compliance with its established procedures and the requirements of this section.

SUITABILITY

A review was conducted to determine if CMFG was in compliance with the requirements of 14 VAC 5-45-10 et seq., Rules Governing Suitability in Annuity Transactions.

ANNUITIES

The examiners reviewed the total population of 1 annuity contract issued during the examination time frame.

14 VAC 5-45-40 B requires that prior to the purchase of an annuity, an insurer shall make reasonable efforts to obtain information concerning the consumer's financial status, tax status, investment objectives and other information considered to be reasonable by the insurer, in making recommendations to the consumer.

The review revealed that CMFG was in substantial compliance.

ADMINISTRATIVE LETTER 2010-12

The purpose of this Administrative Letter is to inform life and accident and sickness insurers of the disclaimer required to be attached to policies in order to comply with § 38.2-1715 B of the Code, which states that an insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the

policy or contract owner at the time of delivery of the policy or contract. The summary document, *Notice of Protection Provided by the Virginia Life, Accident and Sickness Insurance Guaranty Association*, was approved effective November 1, 2010.

The review revealed CMFG was in substantial compliance.

COPY

VII. PREMIUM NOTICES/REINSTATEMENTS/POLICY LOANS AND LOAN INTEREST

The examiners reviewed CMFG's procedures and practices for processing premium notices, reinstatements and premium loans.

PREMIUM NOTICES

Upon application for insurance, the applicant generally has two options related to premium notice or billing. Such options include direct bill or automatic withdrawal (ACH) from the member's credit union checking or savings account. Some participating credit unions may offer premium payment by credit card. Billing frequency, (monthly, quarterly, semiannually, or annually), is also determined by the insured. For ACH, policy owners may choose a draft date of 1 to 28 or the deduction will be determined by the policy effective date. Policy owners may make changes to the billing method by phone or by completing a form indicating the change; the form is available online. Long-term care policy owners receive a billing notice, a premium reminder notice, and a lapse notice.

The review revealed that CMFG was in substantial compliance with its established procedures and policy provisions.

REINSTATEMENTS

Reinstatement provisions may vary by policy. For most policies, in order to be considered for reinstatement, CMFG requires a completed reinstatement form, satisfactory evidence of insurability, payment of past due premiums, and payment of interest on past due premiums. In the event a loan balance existed prior to lapse, CMFG may require payment or reinstatement of the loan balance. For AD&D, coverage will be reinstated upon acceptance of the premium payment by CMFG. CMFG indicates

it reserves the right to require a reinstatement form and evidence of insurability. Coverage will be reinstated on the earlier of the date CMFG approves the reinstatement or the 45th day after the date of application for reinstatement. If reinstatement is not approved, the insured will receive written notice. For CMFG's HMP group life insurance, after the 31-day reinstatement period has expired and insurance is once again desired, CMFG requires a new insurance application and will be treated as such.

The examiners reviewed a sample of 25 from a population of 166 reinstatement requests received during the examination time frame. The review revealed that CMFG was in substantial compliance with its reinstatement procedures and policy provisions.

POLICY LOANS AND LOAN INTEREST

CMFG's policy loan procedure states that a loan may be requested in writing or by phone. In general, loan requests are processed within 3 days, although variable universal life loans are processed the day the request is received in the home office. The Automatic Premium Loan option borrows money from the policy's cash value to pay the premium provided the premium is not paid within 60 days of the anniversary. A policy owner also has the option to pay the premium using the loan value. This option may be exercised in writing or by phone.

The examiners reviewed a sample of 50 from a population of 2,026 policy loan transactions that took place during the examination time frame. The review revealed that policy loans and loan interest were calculated and processed in accordance with established procedures and policy provisions.

CASH WITHDRAWALS

The examiners reviewed the total population of 2 life insurance policies with cash withdrawals. The review revealed that cash withdrawals were calculated in accordance with established procedures and the policy provisions.

COPY

VIII. CANCELLATIONS/NONRENEWALS

The examination included a review of CMFG's cancellation practices and procedures to determine compliance with its contract provisions; the requirements of § 38.2-508 of the Code covering unfair discrimination; and § 38.2-3729 C of the Code, concerning credit insurance premium refunds.

LIFE INSURANCE

Cash Surrenders

CMFG's procedures state that a cash surrender request may be received by means of a surrender form, a written request to cancel the policy, 1035 paperwork from an external company, or as a phone call only during the Free Look Period. The examiners reviewed a sample of 14 from a population of 54 policies surrendered for cash during the examination time frame. Policy values and calculations for each cash surrender were reviewed.

The review revealed that CMFG calculated the cash surrender amounts in accordance with established procedures and policy provisions.

Extended Term Insurance

The examiners reviewed a sample of 11 from a population of 42 policies converted to extended term insurance during the examination time frame.

The review revealed that CMFG was in substantial compliance with its established procedures and policy provisions.

Cancellations

The examiners reviewed a sample of 7 from a population of 25 individual annuity cancellations, a sample of 25 from a population of 968 group life cancellations, and a

sample of 15 from a population of 72 individual life cancellations. In total, a sample of 47 from a population of 1,065 policies that were cancelled during the examination time frame was reviewed.

The review revealed that CMFG was in substantial compliance with its established procedures and policy provisions.

ACCIDENT AND HEALTH

CMFG's long-term care policy cancellation procedures permit the insured to request the termination of the policy either by submitting a written request or by phone. The examiners reviewed a sample of 4 selected from a population of 8 long-term care policies that were cancelled during the examination time frame.

The review revealed that CMFG was in substantial compliance with its established procedures and policy provisions.

CREDIT INSURANCE

Cancellations involve those policies no longer in force but which have premium refunds payable due to death, early payoff, renewal or refinancing of the loan, or receipt of the insured's request for cancellation. The examiners reviewed a sample of 10 from a population of 46 single premium credit life insurance cancellations and a sample of 10 from a population of 54 single premium credit accident and sickness insurance cancellations during the examination time frame. The examiners also reviewed the cancellations of credit accident and sickness insurance associated with the sample credit life claims.

Section 38.2-3729 H 1 of the Code states that if an indebtedness is prepaid by the proceeds of a credit life insurance policy covering the debtor, then it shall be the responsibility of the insurer to see that an appropriate refund of the credit accident and

sickness insurance premium is paid to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate. Subsection 2 of § 38.2-3732 of the Code requires, in part, that any insurer that delegates the duty of providing proper refunds shall be responsible for ensuring that the creditor discharges such duty in accordance with Virginia statute.

The review revealed 9 violations of each section. As discussed in Review Sheet CL09G, CMFG failed to promptly refund the credit accident and sickness insurance premium. CMFG agreed with the examiners' observations.

COPY

IX. COMPLAINTS

CMFG's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

The total population of 5 written complaints received during the examination time frame was reviewed. The review revealed that CMFG was in substantial compliance with its established procedures and the requirements of this section.

X. CLAIM PRACTICES

The examination included a review of CMFG's claim practices for compliance with §§ 38.2-510, 38.2-3115, and 38.2-3731 of the Code as well as 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of group and individual life, individual annuities, HMP group life, AD&D, long-term care, and closed credit life and credit accident and sickness claims. All claims are processed by CMFG, except long-term care claims. Although CMFG no longer offers long-term care insurance, claims for in-force long-term care policies are processed by CHCS Services, Inc. The examiners were provided copies of all claims manuals.

PAID CLAIM REVIEW

Life and Annuity

A sample of 25 was selected from a total population of 119 life, annuity and HMP group life insurance claims paid during the examination time frame.

The review revealed that the claims were processed in accordance with CMFG's established procedures and the terms of the policy.

Accident and Sickness

A sample of 14 was selected from a total population of 41 AD&D and long-term care claims paid during the examination time frame.

The review revealed that the claims were processed in accordance with CMFG's established procedures and the terms of the policy.

Credit Life

A sample of 23 was selected from a total population of 50 credit life claims paid during the examination time frame.

The violations observed during the review of the sample claim files were previously discussed in the Cancellations section of the Report.

Credit Accident and Sickness

A sample of 90 was selected from a total population of 1,514 credit accident and sickness claims paid during the examination time frame. The review revealed that the claims were processed in accordance with CMFG's established procedures and the terms of the policy.

INTEREST ON CLAIM PROCEEDS

Section 38.2-3115 B of the Code states that interest upon the principal sum shall be paid at an annual rate of 2.5% or the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater.

The review revealed 5 violations of this section. An example is discussed in Review Sheet CL03G, where the policy was issued in Virginia and the policy owner was a resident of Oklahoma at the time of death, and CMFG failed to pay interest. CMFG disagreed with the examiners' observation and stated that it was CMFG's "...practice to administer claims according to the state of residence". However, when an individual or group life insurance policy is issued in Virginia, the insurer is subject to the requirements of § 38.2-3115 B of the Code, regardless of where the insured resided on the date of death.

TIME PAYMENT STUDY

The time payment study was computed by measuring the time it took CMFG, after receiving the properly executed proof of loss, to issue a check for payment. The term “working days” does not include Saturdays, Sundays, or holidays. The study was conducted on the total sample of 152 paid claims.

PAID CLAIMS		
<u>Working Days To Settle</u>	<u>Number of Claims</u>	<u>Percentage</u>
0 – 15	151	99.34%
16 – 20	1	0.06%
Over 20	0	0.0%

Of the 152 claims reviewed for the time study, 1 claim (0.06%) was not settled within 15 working days.

DENIED CLAIM REVIEW

Life and Annuity

The total population of 2 life insurance claims denied during the examination time frame was reviewed. CMFG informed the examiners that no annuity or HMP group life claims were denied during the examination time frame. The review revealed that the 2 life insurance claims were processed in accordance with CMFG’s established procedures and the terms of the policy.

Accident and Health

A sample of 11 from a total population of 25 AD&D and long-term care claims denied during the examination time frame was reviewed. The review revealed that the

claims were processed in accordance with CMFG's established procedures and the terms of the policy.

Credit Life

The total population of 2 credit life claims denied during the examination timeframe was reviewed. The review revealed that the claims were processed in accordance with CMFG's established procedures and the terms of the policy.

Credit Accident and Sickness

A sample of 10 was selected from a total population of 29 credit accident and sickness claims denied during the examination time frame. The review revealed that the claims were processed in accordance with CMFG's established procedures and the terms of the policy.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

A total sample of 177 paid and denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time.

14 VAC 5-400-60 A states that within 15 working days after receipt of a properly executed proof of loss, a first party claimant shall be advised of the acceptance or denial of a claim by the insurer.

The review was conducted using the date the letter or check was mailed as the settlement date. The areas of non-compliance are discussed in the following paragraphs.

14 VAC 5-400-50 A – In 3 instances, claims were not acknowledged within 10 working days upon receipt of notification. An example is discussed in Review Sheet

CL01G, where CMFG took 18 working days to acknowledge the claim. CMFG agreed with the examiners' observations.

14 VAC 5-400-60 A – In 1 instance, the claimant was not advised of acceptance or denial of a claim within 15 working days after proof of loss was received. CMFG agreed with the examiners' observation.

CMFG's failure to comply with 14 VAC 5-400-50 A and 14 VAC 5-400-60 A did not occur with such frequency as to indicate a general business practice.

THREATENED LITIGATION

The examiners were informed by CMFG that it received no claims involving threatened litigation during the examination time frame.

COPY

XI. CORRECTIVE ACTION PLAN

Based on the findings in this Report, CMFG shall:

1. Review and revise its procedures to ensure that its advertisements comply with 14 VAC 5-90-10 et seq., as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;
2. Review all advertisements available for use and take the necessary actions to bring each into compliance with 14 VAC 5-90-10 et seq., as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;
3. Establish and maintain procedures to ensure that all certificates and applications are filed with and approved by the Commission prior to use, as required by §§ 38.2-316 B, 38.2-316 C 1, of the Code;
4. Immediately file its AD&D enrollment form as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;
5. Immediately file its EOB forms as required by § 38.2-3407.4 A of the Code;
6. Establish and implement procedures to ensure compliance with Administrative Letters 2002-2 and 2002-9;
7. Establish and maintain procedures for compliance with § 38.2-1834 D of the Code concerning the notification to agents of appointment termination;
8. As recommended in the prior Report, establish procedures to ensure that insured debtors are provided the disclosures required by § 38.2-3735 C 2 of the Code;
9. Establish and maintain procedures to ensure that upon payment of the indebtedness by the proceeds of a credit life insurance policy covering the debtor, an appropriate refund of the credit accident and sickness insurance

- premium is paid or credited promptly to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate as required by § 38.2-3729 H 1 of the Code;
10. Establish and maintain procedures to ensure that the creditors to whom it delegates the duty of making proper premium refunds discharge such duties in accordance with Virginia statute, as required by subsection 2 of § 38.2-3732 of the Code;
 11. Review all single premium credit life insurance claims processed in 2009, 2010, 2011, 2012, 2013 and the current year where the indebtedness was prepaid by the proceeds of a credit life insurance policy covering the debtor, and identify each instance where the appropriate refund of the credit accident and sickness insurance premium was not paid or credited promptly to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate as required by §§ 38.2-3729 H 1 and 38.2-3732 of the Code. Send checks for the required refunds to the insured debtor or beneficiary along with a letter of explanation stating that as a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, an error was found. Then, within 180 days after this Report is finalized, furnish the examiners with documentation that the required amounts have been paid;
 12. Establish and implement procedures to ensure that for Virginia consumers, the payment of interest is based on the state the policy or certificate is issued to ensure compliance with § 38.2-3115 B of the Code;

13. Review and reopen all individual life insurance claims where interest was due for the years 2009, 2010, 2011, 2012, 2013 and the current year and make interest payments where necessary as required by § 38.2-3115 B of the Code. Send checks for the required interest along with letters of explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was either underpaid or had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized;
14. Establish and maintain procedures to ensure that it acknowledges receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A; and
15. Within 180 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XII. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by CMFG's officers and employees during the course of this examination is gratefully acknowledged.

Melissa Gerachis, FLMI, AIRC, MCM, Bill Benson, FLMI, AIE, ACS, MCM, and Laura Klanian, MCM, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,



Julie Fairbanks, FLMI, AIE, AIRC, MCM
Supervisor, Market Conduct Section
Life and Health Division
Bureau of Insurance

XIII. REVIEW SHEET SUMMARY BY AREA

ADVERTISING

14 VAC 5-90-50 A, 1 violation, AD04

14 VAC 5-90-50 B, 1 violation, AD04

POLICY FORMS

§§ 38.2-316 B and 38.2-316 C 1, 36 violations, PF01 (32), PF02, PF04 (2), PF10

§ 38.2-3407.4 A, 20 violations, PF08 (10), PF09 (10)

AGENTS

§ 38.2-1834 D, 5 violations, AGTRM01, AGTRM02, AGTRM03, AGTRM04, AGTRM05

UNDERWRITING

Subsection 1 of § 38.2-3732, 1 violation, UN01

§ 38.2-3735 C 2, 54 violations, UN03 (24), UN04 (10), UN05 (15), UN06 (5)

CANCELLATIONS

§ 38.2-3729 H 1, 9 violations, CL09G

Subsection 2 of § 38.2-3732, 9 violations, CL09G

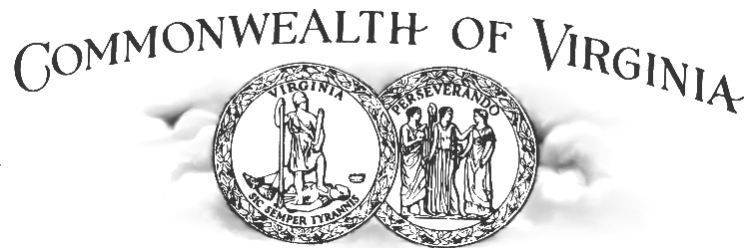
CLAIMS PRACTICES

§ 38.2-3115 B, 5 violations, CL01G, CL02G, CL03G, CL04G, CL05G

14 VAC 5-400-50 A, 3 violations, CL01G, CL06G, CL07G

14 VAC 5-400-60 A, 1 violation, CL01G

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE



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February 7, 2014

CERTIFIED MAIL 7012 2210 0000 4815 3211
RETURN RECEIPT REQUESTED

Ms. Kathy Graham
Compliance Leader
Market Conduct Examinations
Cuna Mutual Group
Mail Stop: 5910 4 A2
5910 Mineral Point Road
Madison, Wisconsin 53705

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Graham:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of CMFG Life Insurance Company (CMFG) for the period of April 1, 2012, through June 30, 2012. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of CMFG, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. CMFG's response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie Fairbanks, FLMI, AIE, AIRC, MCM
Supervisor
Market Conduct Section
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia Battle

Kathy Graham
Compliance Leader, Market Conduct Examinations
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Fax: 608.236.7008



March 27, 2014

Ms. Julie R. Fairbanks
Supervisor, Market Conduct Section
Commonwealth of Virginia
Bureau of Insurance
P.O. Box 1157
Richmond VA 23218

Dear Ms. Fairbanks:

Thank you for the opportunity to review the Exposure Draft of the Market Conduct Examination Report dated, February 7, 2014. We would like to thank you and your team for the professionalism displayed during the course of this examination including the opportunity to confer on matters throughout the examination process.

CMFG Life Insurance Company (hereafter, "Company") views the market conduct examination process as an opportunity to enhance our business practices. We also believe our comments to the Exposure Draft Report allow you and your staff an opportunity to understand our business so that any Examiner's findings are justified by fact and a reasoned application of Virginia insurance law.

The scope of this exam was broad and covered multiple products. We appreciate the Examiner's attention to the diversity of business practices the exam addressed. In many areas, the Company's practices complied with Virginia's requirements. In others, the Examiner found areas where procedures deserve to be revised. In many cases, the Company has already initiated corrective action.

The Company agrees with the Examiner's findings with respect to the following:¹

1. Review and revise its procedures to ensure that its advertisements comply with 14 VAC 5-90-10 et seq., as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;

Company Response: The Company has reviewed procedures to ensure that advertisements comply with 14 VAC 5-90-10 et seq. and subsection 1 of sections 38.2-502 and 38.2-503 of the Code. Attached please find the General Advertising Review Guidelines and the additional guidelines that apply to non-English advertisements labeled Exhibit A. Advertisements must be submitted for review and approval prior to use. In addition, to help ensure compliance with the Code, a certified translation must be submitted with the advertisement.

¹ These comments follow the sequence found in the Examiner's Exposure Draft Report beginning on page 39.

2. *Review all advertisements available for use and take the necessary actions to bring each into compliance with 14 VAC 5-90-10 et seq., as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;*

Company Response: All non-English advertisements available for use in Virginia have been reviewed for compliance with the above referenced sections of the Code. As stated in the Company's response to AD04, the mistakenly translated piece was pulled from use immediately. Four additional pieces that had been available for use in Virginia were also pulled from use.

3. *Establish and maintain procedures to ensure that all certificates and applications are filed with and approved by the Commission prior to use, as required by §§ 38.2-316 B, 38.2-316 C 1, of the Code;*

Company Response: The Company has revised the filing instructions for Virginia to reflect this change in practice. The new procedure is attached labeled Exhibit B. The long-term care explanation of benefits and the accidental death and dismemberment enrollment forms have been added. The Rate & Form Filing Team refers to these and state specific documents, as well as SERFF instructions to determine what items require filing and approval.

With regards to the Home Mortgage Protection form #B3d-NAVY-0211, as previously addressed in the Company's response to PF04, the Company took corrective action by discontinuing the availability of the form in Virginia. The Company sent notice to that effect on March 11, 2013, to the credit union involved in the issuance. Please refer to the referenced notice labeled Exhibit C.

4. *Immediately file its AD&D enrollment form as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;*

Company Response: The SERFF approval for the AD&D enrollment forms is attached labeled Exhibit D.

5. *Immediately file its EOB forms as required by § 38.2-3407.4 A of the Code;*

Company Response: The Company will work with its third party administrator to file the appropriate EOB forms for the long term care product and report to the Bureau upon approval of the filing.

6. *Establish and implement procedures to ensure compliance with Administrative Letters 2002-2 and 2002-9;*

Company Response: While the Company believes that administrative letters are guidance that the Bureau suggests insurance companies disseminate to all newly appointed agents, we are currently in the process of creating a systematic notification to all newly appointed agents that will direct them to the Bureau's webpage where all relevant administrative letters are available for viewing. This new process will be implemented upon completion of the automation.

7. *Establish and maintain procedures for compliance with § 38.2-1834 D of the Code concerning the notification to agents of appointment termination;*

Company Response: As indicated in the response to the producer review sheets, the Company's procedures were based on the guidance of the vendor who did not indicate a difference between a voluntary appointment terminations and an appointment termination for cause and therefore were not processing voluntary terminations in the appropriate 5 day window. The vendor has performed an extensive review and has updated the licensing system accordingly. All future appointment terminations will be handled in the appropriate timeframe.

12. Establish and maintain procedures to ensure that upon payment of the indebtedness by the proceeds of a credit life insurance policy covering the debtor, appropriate refunds of the credit accident and sickness insurance premium and any amount of benefits in excess of the amount required to repay the indebtedness after crediting any unearned interest or finance charges are paid or credited promptly to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate as required by §§ 38.2-3729 H 1 and 38.2-3729 H 2 of the Code;

Company Response: During the corrective action period, the Company will be revising procedures regarding appropriate refunds of credit accident and sickness insurance premium and any amount of benefits in excess of the amount required to repay the indebtedness after crediting any unearned interest or finance charges are paid or credited promptly to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate pursuant to §§ 38.2-3729 H 1 and 38.2-3729 H 2 of the Code.

13. Establish and maintain procedures to ensure that the creditors to whom it delegates the duty of making proper premium refunds discharge such duties in accordance with Virginia statute, as required by subsection 2 and subsection 4 of § 38.2-3732 of the Code;

Company Response: During the corrective action period, the Company will be revising procedures regarding policyholder administration of premium refunds pursuant to subsection 2 and subsection 4 of § 38.2-3732 of the Code.

18. Establish and maintain procedures to ensure that it acknowledges receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A;

Company Response: During the corrective action period, the Company will be revising procedures to ensure it acknowledges receipt of notification of a claim within 10 working days.

20. Within 180 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

Company Response: The Company will provide documentation regarding the outstanding action items within 180 days of this Report being finalized.

As noted, the Company has already completed corrective action to many of the items noted above and the remaining will be addressed within the corrective action period after the final report is issued.

Technical Corrections

Upon review of the Exposure Draft, the Company identified content it believes are technical errors which we would like to point out so that the final report correctly references these items.

Again, for your convenience, our comments follow the same sequence as presented in the Exposure Draft Report.

Company History

Accident and health direct premium (referenced in the exposure draft beginning on p. 5):

In the last paragraph the direct premium amount listed is overstated. It should read \$10,638,752. Please find the attached a copy of the financial annual statement state page as support for this number labeled Exhibit E.

Policy and Other Forms

Chart detailing population and sample sizes (referenced in the exposure draft beginning on p. 9): The data presented does not agree to the Company's records.

- For the Single Premium Credit Life population the number of active policies 835, expired policies 118, cancelled policies 46 for a total of 999 line items. Combinations of these numbers do not result in the population in the chart.
- For the Single Premium Credit Life sample size the number the Company has is 50.
- For the Single Premium Credit Disability population the number of active policies 915, expired policies 155, cancelled policies 54 for a total of 1,124 line items. Combinations of these numbers do not result in the population in the chart.
- For the Single Premium Credit Disability sample size the number the Company has is 50.
- For the Monthly Premium Credit Life & Disability population the number should be 8,757. When the Company provided these data listing there was a tab for each month of the examination period. Because the data was in force items certificates may or may not have appeared on all three tabs. Therefore an overall unique number was applied to each certificate. The total of those unique numbers is 8,757. Based on the population in the chart the Examiner may have used the total number of line items in all three tabs.

Denied Claim Review

Accident and Health (referenced in the exposure draft beginning on p. 35): In the last paragraph the total population of AD&D and long term care claims denied should read 25.

Outstanding Concerns

After carefully reviewing the Exposure Draft, the Company found areas which deserve additional comment and clarification. In our view, the Examiner's preliminary findings raise questions on how cited provisions of the Code of Virginia (the Code) and the Virginia Administrative Code (VAC) were applied, the deference given to standard market conduct risk tolerances and prior examination findings. In some cases, we also raise concerns over the proposed corrective action in light of the factual findings obtained during the exam. With respect to these matters, the Company's comments follow the content of the Exposure Draft Report.

Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act/Insurance Replacement

Underwriting Review Group AD&D (referenced in the exposure draft beginning on p. 15):

The Examiners indicate that the Company failed to comply with Section 38.2-302 A by failing to obtain applications or consents for insurance. They also find violations of 38.2-514.1A by failing

to provide the required disclosures outlined in Section 38.2-3402 of the Code. The Company disagreed with the Examiners conclusions and the examiners did not concur with the Company's interpretation of the law.

The Company mails solicitations for Group Accidental Death and Dismemberment coverage to credit union members. The basic coverage is provided at no cost to credit union members as a benefit of membership and the premium for this coverage is paid for by the credit union. Members interested in obtaining the benefit complete an enrollment form or call a telephone number provided in the enrollment materials. The Examiner's position is that by failing to record the telephone conversations in a manner that could be reproduced and by failing to provide a script to its licensed sales representatives the Company has failed to document consent.

The Company verifies the identity of all callers in order to ensure privacy and confidentiality for our customers and those wishing to enroll for coverage. The written procedures for the sales area state that the agents must verify the applicant's full name, phone number, and address. Ensuring this validation occurs is included in our quality assurance audit process.

The Company supports enrollment in this non-contributory coverage by sending a certificate of coverage to customers who have enrolled via this process. The Company believes that the enrollment process for these "live applications" is sufficient to satisfy the requirements of 38.2-302 and see no public policy benefit or additional protection that would be provided to Virginia residents by making the enrollment process more cumbersome for those seeking to take advantage of this benefit or by imposing additional recordkeeping requirements on the Company. The Examiner's requirements to have a script and to reproduce the telephone calls are very specific requirements that do not appear within the statute.

The corrective action cited as No. 8 would require that the Company "establish and implement procedures to ensure that audio from insurance applications taken by telephone are recorded and retained as if it were a paper application" does not appear to be justified under the circumstances surrounding the enrollment for this coverage that is provided at no cost to the insured by the credit union.

Regarding the alleged violations of 38.2-514.1A by failing to provide the disclosures outlined in 38.2-3402 the Company agrees that that Section 38.2-3402 B of the Code states that subsection A applies to an application by an individual for coverage under a group policy where underwriting is done. However, this provision does not apply to the Company's AD&D coverage, because the coverage is not subject to underwriting.

The Examiners interpretation of 38.2-3402 with regard to providing the required disclosures appears to be that every policy or certificate for Accidental Death and Dismemberment Insurance in VA requires the disclosures mandated by this Section of the Code unless the certification is omitted or modified with the consent of the Commissioner.

The Company believes that the "guaranteed issue/non-underwritten" non-contributory basic coverage certificates issued under the Company's group policy to credit union members are not subject to Section 38.2-3402 of the Code. The reasons are as follows:

- 1) Section 3402 A. says: "Each application for an individual accident and sickness insurance policy shall obtain a certification..." The group certificates issued by the Company are not individual accident and sickness policies so they are not covered by this subsection of the law.

- 2) Section 3402 B. says: "Subsection A shall also apply to an application by an individual for coverage under a group policy where individual underwriting is done." The group certificates issued by the Company are not underwritten so they are not covered by this subsection of the law.
- 3) Section 3402 C. says: "If the certification is wholly or partially inapplicable to a particular form of policy, the insurer may modify or omit the certification with the approval of the Commissioner. The logical interpretation of Subsection C is that it is intended to apply to those policies subject to either 3402 A. or 3402 B. where the certification is wholly or partially inapplicable. The Company does not agree that it is necessary for certificates falling entirely outside the scope of either Section 3402A. or 3402B. to obtain the commissioner's approval to not obtain a certification when neither Section of the law applies to them.

Section 3402 of the Code is intended to provide information to applicants about the effect of false statements or misrepresentations in applications. Applying this section of the Code to guaranteed issue certificates where no underwriting is performed provides no benefit to customers and is likely to create more confusion than clarification.

The corrective action cited as No. 9 that the Company implement procedures to ensure that required disclosures (as described in 38.2-3402) are provided to ensure compliance with 38.2-514.1B of the Code is not justified under the circumstances described above. The Company sees no requirement under the statute that these notices be provided nor does the Company see any benefit to providing disclosures about underwriting issues in connection with non-underwritten policies.

Single Premium Credit Insurance (referenced in the exposure draft beginning on p. 17):

During the course of the exam, the Company raised concern over the relevance of the exam period with respect to matters that occurred before the exam began. In this case, the issue was whether a point of sale disclosure that occurred before the exam period is subject to the Examiner's review. With respect to the disclosure, all but one of the findings occurred before the April 1, 2012 start date of the exam period.

The Company believes that the findings the Examiner references should not be included in this exam because the incidents occurred before the exam period and therefore should be viewed as outside its scope. The Company understands that some policies may have been in effect during the exam period even though coverage may have been issued before the exam began. In meeting its record production responsibility, the Company provided such records because the administration of policies and certificates during the exam period is legitimately within the scope of how the exam was defined.² Matters relating to these records occurring before the exam period should be excluded.

Although the Company believes that the findings should be considered outside the scope of this exam, these matters have provided the Company the opportunity to review its single premium

² It is also worth noting that the Examiner described the Company's production of records as being submitted "without question" (see, p. 18) as if to suggest that if the Company had reservations regarding the content of these records, an objection should have been raised as the records were being produced. The Company requests that this reference be deleted from the exposure draft. The Company has responded to the record production process in good faith and has avoided challenges to Examiner record requests consistent with its obligation to cooperate in the examination process. The Company has elected to respond to specific Examiner inquiries to address whether the factual record is relevant given the stated scope of the exam. In this case, the Company has questioned the relevance of "pre-scope" incidents.

credit insurance offerings in the Commonwealth. It is now evaluating whether single premium credit insurance will continued to be made available to Virginia consumers. If it elects to discontinue the product, the Company will honor the single premium credit insurance certificates currently in place and administer the group policies in a “run off” status (meaning that no new certificates will be issued, thus addressing the disclosure issue referenced above). The Company will provide its decision in the final report due to the Bureau 180 days after the final examination report. Alternatively, if it elects to continue to offer single premium credit insurance, Company will provide a response on how it intends to administer the disclosures the Examiner references.

Mechanical Rating Review (referenced in the exposure draft on pp. 19-21): The Examiner references a single incident that occurred before the beginning date of the exam period as a potential violation of a Virginia statute. The Company believes that the single incident should not be considered within the scope of the exam. In addition, the Company reported that the single incident occurred as a result of human error and as soon as it was revealed, the Company took immediate corrective action. Based on this single incident, the Examiner recommends corrective action. The recommendation in essence represents a zero tolerance for incidents of human error; a standard the Company believes is unreasonable. A single incident is not indicative of a systemic error.

This single incident was taken from a sample of 100 single premium calculations (divided equally between credit life and credit disability) of which 99 were calculated correctly. The single incident represents 1% of the sample. The Company believes that a single incident is not statistically significant for market conduct reporting purposes. Certainly, standards in the NAIC Market Regulation Handbook do not justify corrective action as the Examiner now suggests. The Handbook refers to a 7% tolerance level for claims samples and 10% for other business practices.³ This market conduct industry standard is significantly higher than what the Examiner has applied here.

Given that 99% of the calculations the Examiner reviewed were correct, the results indicate that the Company’s practices substantially comply with Virginia’s requirements and the Company’s performance is well within accepted tolerance limits for the processes the Examiner reviewed. The Company respectfully requests that the Examiner withdraw the corresponding corrective action that is currently identified as No. 11 on page 40 of the Exposure Draft Report.

Cancellations/Nonrenewals

Credit Insurance (referenced in the exposure draft beginning on p. 28; the content is also cross referenced to provide the basis for citing claims violations on p.34): The Examiner concludes that (1) the Company failed to provide evidence that it or its creditor paid excess benefits to the beneficiary as required by § 38.2-3729 H 2 (involuntary prepayment of loan and payment of excess benefits), §38.2-3732 subsection 4 (insurer delegation of duties) and language in the Company’s certificate⁴; and (2) the Company’s claim files did not include all notes and work papers pertaining to a claim in such detail that pertinent events and the dates of such events can be reconstructed.

³ See, NAIC Market Regulation Handbook, 2012 Edition, Vol. I, Chapter 14 – Sampling, Section D – Standards, p. 180.

⁴ Although the Examiner does not cite the certificate language referenced in the report, the Company believes that language that the Examiner intends is: “Benefits are paid to your credit union to pay off or reduce your loan. If the benefits are more than the balance of your loan, the difference will be paid to the Secondary Beneficiary named by you, if any, or to the estate.”

In response to Review Sheet CL08G, which the Examiner references on pages 29-31 of the Exposure Draft Report, the Company explained that its home office claim files do not include account statement documentation showing how its policyholders apply excess benefits to the insured, beneficiary or estate's accounts. The Examiner contends that such documentation should be included in the claims file; the Company believes that historically, such records, which are maintained by its policyholders, have not been required to be part of the claims file.

The fundamental difference between the Company and the Examiner is whether the account statements provided by the creditor are sufficient to document the distribution of benefit proceeds. Aside from whether these records are part of the claims file, the Company believes that the account statements combined with the claims adjudication documentation demonstrate compliance with §38.2-3729 H 2 and §38.2-3732 subsection 4. Further, the Company believes the Examiner cannot base a conclusion on questions regarding claims file documentation as grounds for not meeting delegation of duty and payment of excess benefits obligations when the evidence clearly shows that benefit payments were made on a timely basis consistent with the terms of the certificate.

After reviewing the records involved, which includes account statement and disbursement documentation maintained by the credit union policyholder (which can vary from credit union to credit union) and records found in the Company's claims files, the Company believes that the Examiner's conclusion may have resulted from the lack of familiarity with credit union practices. For example, the Company's review indicates that over 40% (10) of the 23 records cited by the Examiner apply the benefit to the outstanding loan and do not appear to involve excess benefits at all. Remaining records also contain clear examples that excess benefits were distributed.

It is important to note that the Company's 2007 market conduct examination reviewed the Company's claims payment process and the reliance placed on the creditor policyholder. At that time, the issue of whether "benefit distribution documentation" in the claims file was not cited. The 2007 exam reviewed timeliness of benefit payment which would have considered the policy holder's distribution of benefit amounts to the insured, secondary beneficiary, or other credit union account (that would be part of the decedent's estate).

The same administrative processes were reviewed in 2007 as they were in this exam. In the Company's final communication with the Bureau it explicitly stated that it will continue to administer its claims according to the same processes as used at that time. The Company did not receive any comment or objection from the Bureau. Therefore, it is only reasonable for the Company to conclude that (1) its practices were acceptable to the Bureau and (2) continuing such would not create a risk of noncompliance triggering the type of corrective action the Examiner now recommends.

The Examiner has proposed two corrective actions with respect to these matters. First, the Examiner proposes that the Company take corrective action by revising its procedures for the policyholder's administration of excess benefits. Second, the Examiner proposed reviewing all benefit payments to determine whether all excess benefits have been distributed consistent with the terms of the certificate.

With respect to the second proposal, the Company believes that a review of the transactional activity is excessive because the factual findings of the exam do not support a conclusion that such payments are not being made. Further, the Company should not be required to take corrective action to the degree the Examiner suggests particularly for a practice which was subject to a recent examination where no finding was issued.

The Company agrees to revise its procedures so that future examinations have a defined standard for evaluating policyholder administration of excess benefits. The Company believes that the issuance of revised procedures is consistent with the findings of this report and reconciles the results of this and its previous exam. Accordingly, the Company respectfully requests the Exposure Draft Report be revised to align the corrective action with the Examiner's actual findings and thus withdraw the transactional review (i.e., No. 15) for the final report.

Claims Practices

Credit Insurance (referenced in the exposure draft on p. 34): The Examiner refers to asserted credit life insurance violations in the Cancellations section of the Exposure Draft Report which were based on the conclusion that claims files did not contain documentation regarding the payment of excess benefit payments. With respect to these findings, the Company restates its position as noted above regarding excess benefits and the content of its claims file.

Interest on Claim Proceeds (referenced in the exposure draft on p. 34): The Company has longstanding procedure to ensure that proper interest is paid on claims.

The examination identified questions about interest payment of 4 of the 18 individual life insurance policies audited.

- One was a human error interest calculation mistake using 2% instead of 2.5%
- Two were missed interest payments on claim settlement
- One was a Virginia issued policy where the decedent resided in Oklahoma

In support of the conclusion that there were 5 violations of the identified section the Examiner makes the statement: "However, when an individual or group policy is issued in Virginia, the insurer is subject to the requirements of Section 38.2-3115b of the Code, regardless of where the insured resided at the time of death". No explanation is provided for the basis of this conclusion. The Company does not believe that the law is so absolute or so clear on which states' rules apply when calculating interest on death claims.

When assessing the potential impact of the corrective action No. 17, the Company reviewed a larger sample of individual life insurance paid claims dating to 2008 for policies issued in Virginia and for Virginia residents.

- 2316 - Policies issued in Virginia where the claimant was a Virginia resident
- 175 - Policies issued in other states where the claimant was a Virginia resident
- 115 - Policies issued in Virginia where the claimant was not a Virginia resident

The Company recognized the need for improvement of the accuracy of interest payments for life claims and initiated an effort to automate the payment of interest for life claims before the initiation of this market conduct examination. When the Company established the automation rules, it adopted a state of residence standard. This affords a uniform process across states to improve the accuracy of the calculation. The Company implemented the automated system in August, 2013. After that date, the payment accuracy for interest improved to 100% based on state of residence.

The Company respectfully asks that Virginia permit us to use the state of residence for future administration. The Company has demonstrated a commitment to paying claims accurately and

delivering benefits to our customers in a prompt and efficient manner. Automation using different conflicting standards creates a much more complicated automation which the Company is not positioned to execute. Changing Virginia to a state of issue rule for interest payments would require us to discontinue using the automated interest calculations for all policies issued in Virginia even though more than 90% of those claims are for Virginia residents.

The Company's experience with other states is that some states look to the location where the contract is to be performed in determining what law applies to how the contract is to be performed. The basis for this conclusion appears to be a result of applying conflict of law rules to interpretation of individual insurance contracts. The Law of Life and health Insurance, Section 15.03 "Choice of law in individual insurance contracts" says: "Traditionally, courts have applied 'mechanical' rules to determine which jurisdiction's laws govern an individual insurance law contract. The primary traditional rules are that rights and obligations under an individual contract are governed by the law of the jurisdiction where the contract was made, and that matters of performance are governed by the law of the jurisdiction where the contract is to be performed." The treatise goes on to suggest that in recent years courts have begun adopting new approaches under which a number of factors or interests are considered in determining choice of law.

The Restatement of Law Second, Conflict of Laws 2d in a discussion of what law should be applied in interpreting contracts has two relevant comments:

1) "The place of contracting. As used in the Restatement of this Subject, the place of contracting is the place where occurred the last act necessary, under the forum's rules of offer and acceptance, to give the contract binding effect, assuming, hypothetically, that the local law of the state where the act occurred rendered the contract binding.

Standing alone, the place of contracting is a relatively insignificant contact. To be sure, in the absence of an effective choice of law by the parties, issues involving the validity of a contract will, in perhaps the majority of situations, be determined in accordance with the local law of the state of contracting. In such situations, however, this state will be the state of the applicable law for reasons additional to the fact that it happens to be the place where occurred the last act necessary to give the contract binding effect."

2) "The place of performance. The state where performance is to occur under a contract has an obvious interest in the nature of the performance and in the party who is to perform. So the state where performance is to occur has an obvious interest in the question whether this performance would be illegal (see s 202). When both parties are to perform in the state, this state will have so close a relationship to the transaction and the parties that it will often be the state of the applicable law even with respect to issues that do not relate strictly to performance. And this is even more likely to be so if, in addition, both parties are domiciled in the state."

Corrective action No. 16 requires that the Company implement procedures to ensure Virginia consumers receive interest based upon the state where the policy is issued. The Company believes that it is reasonable to pay interest based upon the state of residence of the insured at time of death for the reasons described above. The Company's position means that Virginia consumers residing in Virginia at the time of death receive benefits in accordance with Virginia requirements even if they purchased their policy in another state. There is no benefit to the Company to pay interest according to the laws of the state where the insured resided at time of death; it is a reasonable interpretation of the laws that has been accepted by other states.

Instituting the proposed corrective action would benefit some former Virginia residents while harming other current residents of Virginia and complicating the Company's claims processes.

Corrective action No. 17 requires that the Company reopen all individual claims for the years 2008, 2009, 2010, 2011, 2012 and the current year to make all interest payments where necessary as required by the Code. Data shows that the Company will be required to open 515 of 2316 claims for review. Some of this population received interest but there is no documentation indicating the interest rate used for the calculation. Some of this population does not include interest because the interest due was less than \$5. The effort required to determine the rates used in calculations, reconfirm those instances when no interest was due and analyze which states' rate was applied seems a substantial penalty for a situation where few people may ultimately derive substantial benefits and there is no risk of future violations. The Company believes that the procedures put into place by the Company during 2013 indicate that there is an automated process in place that will ensure Virginia residents are receiving the proper benefits. Under these circumstances the remediation required by corrective action No. 17 does not seem necessary.

Unfair Claims Settlement Practices Review (referenced in the exposure draft on pp. 37-38): The Examiner rejects the Company's position that the act of posting benefits to the claimants account is notification of acceptance of the claim. The Examiner cites the Company for not meeting its first party claimant notice obligations as stated in 14 VAC 5-400-60 even though all of the claims the Examiner referenced, with one exception, were paid and credited to the insured's account within the 15 day notice period cited in that regulation.

The Company has carefully reviewed its claims payment practices and prior responses to Examiner inquiries in light of the Exposure Draft Report. The operative language the Examiner relies upon is 14 VAC 5-400-60 A which provides "Unless otherwise specified in the policy, within 15 working days after receipt by the insurer of properly executed proofs of loss, a first party claimant shall be advised of the acceptance or denial of the claim by the insurer." The Company believes it has met this obligation because through the administration of the benefit payments, it communicates directly with the credit union policyholder on the status of the claim. With respect to the records the Examiner references, all payments were posted to the beneficiary's account within the 15 day period. By necessity, the policyholder credit union received a communication on the status of these claims in order to administer the distribution of benefits within the required 15 day period.

The Company contends that the credit union policyholder legally meets the definition of a first party claimant as defined in 14 VAC 5-400-20. This provision defines a first party claimant as "an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy...." Under the terms of the group credit insurance policy, the creditor policyholder possesses a right to payment as evidenced by the the policy language which states that "benefits under this Policy will be paid to you once we receive due written proof" (quoted language applies to life benefits, comparable language applies to credit disability benefits). The group policy further sets forth the required documentation the credit union policyholder must submit to substantiate proof of the claim. As a matter of Virginia law, these policy terms establish the group policy holder as the first party claimant who may assert a right of payment if these terms are met under the policy. Accordingly, the communication with the credit union as to the status of the claim satisfies 14 VAC 5-400-60.

The Company's timely claims payment process was reviewed in the recent 2007 exam where there was no finding that the Company's practices with respect to claimant notices were in

violation of Virginia code or regulations. In that exam, with the exception of one claim that was untimely in payment, none of the other claim files were found to be in violation of 14 VAC 5-400-60. The Company and its policyholders rely upon the same practices today as those reviewed in 2007.

The Company respectfully requests that the Examiner modify the findings in the Exposure Draft Report because the Company has met the legal standards on timely notice under the Virginia Administrative Code. More specifically, the Exposure Draft Report should be revised by withdrawing the asserted conclusion that the Company violated 14 VAC 5-400-60 A and §38.2-510 A 5 of the Code. Additionally, since the Company believes that as a matter of law, it has satisfied its obligations under 14 VAC 5-400-60 A and §38.2-510 A 5 of the Code, the Company respectfully requests that the Examiner withdraw the proposed corrective action that is currently identified as No. 19 on page 42 of the Exposure Draft Report.

Company Responses to the Proposed Corrective Action Plan

The Company now turns to providing the Bureau with comments regarding elements of the proposed corrective action plan contained in the Exposure Draft Report. Our comments are consistent with what we have presented above and follow the same sequence as found in the Exposure Draft Report, beginning on page 39.

8. Establish and implement procedures to ensure that audio from insurance applications taken by telephone are recorded and retained as if it were a paper application;

Company Response: The corrective action cited is not required by the statutes nor does it seem justified under the circumstances surrounding the enrollment for this coverage that is paid for by the credit union as described earlier in the Company response. The Company respectfully requests this corrective action plan requirement be withdrawn from the final report.

9. Establish and implement procedures to ensure that required disclosures are provided to ensure compliance with § 38.2-514.1 B of the Code;

Company Response: The corrective action cited is not justified under the circumstances described earlier in the Company response. The Company sees no requirement under the statute that these notices be provided nor does the Company see any benefit to providing disclosures about underwriting issues in connection with non-underwritten policies. The Company respectfully requests this corrective action plan requirement be withdrawn from the final report.

10. As recommended in the prior Report, establish procedures to ensure that insured debtors are provided the disclosures required by § 38.2-3735 C 2 of the Code;

Company Response: The Company will provide its decision in the final report due to the Bureau 180 days after the final examination report whether it will continue to offer single premium credit insurance in Virginia. Alternatively, if it elects to continue to offer single premium credit insurance, the Company will provide a response on how it intends to administer the disclosures the Examiner references.

11. Strengthen its procedures to ensure that credit accident and sickness premium rates are based on the rate in effect on the date of application for coverage;

Company Response: The Examiner has included a corrective action plan to address an isolated incident based on human error. While the Company has already reviewed its premium verification processes, it believes that requiring to “strengthen its procedures” based on a single finding is problematic for the reasons put forth earlier. The Company respectfully requests this corrective action plan requirement be withdrawn from the final report.

14. Review all cancellations and credit life insurance claims processed in 2009, 2010, 2011, 2012, 2013 and the current year where the indebtedness was prepaid by the proceeds of a credit life insurance policy covering the debtor, and identify each instance where the appropriate refund of the credit accident and sickness insurance premium was not paid or credited promptly to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate as required by §§ 38.2-3729 H 1 and 38.2-3732 of the Code. Send checks for the required refunds to the insured debtor or beneficiary along with a letter of explanation stating that as a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, an error was found. Then, within 180 days after this Report is finalized, furnish the examiners with documentation that the required amounts have been paid;

Company Response: The Company has reviewed the single premium credit life insurance claims processed since 2009 to present. There were eleven (11) instances of loans cancelled due to a credit life insurance benefit where the deceased also purchased single premium credit disability insurance. Of the eleven (11), eight (8) credit disability premium refunds were paid. The Company is now in the process of refunding premium with interest for the remainder and will include the results in its report to the Examiners 180 days after this Exposure Draft Report is finalized.

In the Exposure Draft Report, the Examiner's comments regarding the prepayment of indebtedness by the proceeds of credit life insurance was limited to single premium credit insurance yet the corrective action proposed appears to apply to “all” credit insurance claims. The proposal is more expansive than what was addressed in the Exposure Draft Report and it is at odds with how monthly outstanding balance (MOB) premium is paid by the policy holder. MOB coverage does not result in a refund because the group policy holder, per the terms of the group policy, pays premium in arrears. Accordingly, when a loan is prepaid due to a credit life benefit or by other means, there is no refund of premium that was originally paid for prospective coverage. For these reasons, the Company requests that the recommended corrective action be stated to apply to single premium credit life insurance.

The Company also notes that the proposed corrective action extends significantly longer than the scope of the exam period. The Company finds this to be problematic because the Examiner did not establish a factual basis to justify that such a remediation should extend beyond the scope of the exam.

15. Review all cancellations and credit life insurance claims processed in 2009, 2010, 2011, 2012, 2013 and the current year where the indebtedness was prepaid by the proceeds of a credit life insurance policy covering the debtor, and identify each instance where the amount of benefits exceeded the amount required to repay the indebtedness after crediting any unearned interest or finance charges. Verify that the excess amount was paid to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate as required by §§ 38.2-3729 H 2 and 38.2-3732 of the Code, and provide to the examiners evidence of each payment. If evidence cannot be provided, send checks for the

required amounts to the insured debtor or beneficiary along with a letter of explanation stating that as a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, an error was found. Then, within 180 days after this Report is finalized, furnish the examiners with documentation that the required amounts have been paid;

Company Response: With respect to excess benefits, the Company has agreed to adopt new procedures applicable to the distribution of excess benefits despite a difference of opinion as to whether the current process contains adequate documentation of how benefits are distributed by the policyholder. The Company also restates its concern that the Examiner's proposed recommendation is inconsistent with prior market conduct examination findings.

Based upon the results of this exam and as explained earlier, the Company believes the transactional review is excessive. In this exam, the findings are all in the context of whether sufficient documentation was included in the claims file which Company believes is substantially different than findings regarding posting of benefit errors. In the examples the Examiner references, factual inconsistencies appear showing that no excess benefits need to be distributed, or if excess benefits were involved, they were in fact properly handled. Further, the Company believes that the implementation of new procedures creates a standard that reconciles prior exam findings with the ones the Examiner reported here and allows the posting of excess benefits to be measured on a going forward basis. Accordingly, the Company requests that the final report limit the corrective action to the adoption of the new procedures and that the proposed transactional review cited in No. 15 be withdrawn.

16. Establish and implement procedures to ensure that for Virginia consumers, the payment of interest is based on the state the policy or certificate is issued to ensure compliance with § 38.2-3115 B of the Code;

Company Response: As described earlier in the response the Company believes that it is reasonable to pay interest based upon the state of residence of the insured at time of death. The Company's position means that Virginia consumers residing in Virginia at the time of death receive benefits in accordance with Virginia requirements even if they purchased their policy in another state. There is no benefit to the Company to pay interest according to the laws of the state where the insured resided at time of death; it is a reasonable interpretation of the laws that has been accepted by other states. Instituting the proposed corrective action would benefit some former Virginia residents while harming other current residents while complicating the Company's claims processes and making compliance more difficult. For these reasons the Company believes that the Examiner's recommendation No. 16 should be withdrawn from the report

17. Review and reopen all individual life insurance claims where interest was due for the years 2008, 2009, 2010, 2011, 2012 and the current year and make interest payments where necessary as required by § 38.2-3115 B of the Code. Send checks for the required interest along with letters of explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest was either underpaid or had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized;

Company Response: As described earlier in the response the Company believes that the procedures put into place by the Company during 2013 indicate that there is an automated

process in place that will eliminate many of the issues identified in the exam and ensure Virginia residents are receiving the proper benefits. Under these circumstances the remediation required by corrective action No. 17 does not seem necessary.

19. Establish and maintain procedures to ensure that the claimant is advised of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code; and

Company Response: The Company respectfully requests that the Examiner withdraw this corrective action item because the Company has met the legal standards on timely notice under 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code.

Conclusion

The Company appreciates the Examiners comments recognizing the cooperation and exemplary effort by our staff throughout the examination process. We also very much appreciate the opportunity to provide these comments. We look forward to working with the Bureau to bring the process to a conclusion. If there are any remaining questions, please do not hesitate to contact me.

Sincerely,



Kathy Graham
Compliance Leader, Market Conduct Examinations

KG

Enclosures

cc:

Reginald J. Jones, Esq.
Stephen W. Koslow, SVP, Chief Ethics & Compliance Officer
Claude J. Kazanski, Associate General Counsel
Ross D. Hansen, Associate General Counsel

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August 4, 2014

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RETURN RECEIPT REQUESTED

Kathy Graham
Compliance Leader, Market Conduct Examinations
CMFG Life Insurance Company
Mail Stop 5910 4 A2
5910 Mineral Point Road
Madison, WI 53705

Dear Ms. Graham:

The Bureau of Insurance (hereinafter referred to as "the Bureau") has completed its review of your March 27, 2014, response to the Target Market Conduct Examination Report of CMFG Life Insurance Company (hereinafter referred to as "CMFG" or "the Company") sent with my letter of February 7, 2014.

Your response indicates that the CMFG has concerns regarding the writing of the Report. This letter addresses those concerns in the same order as presented in your March 27th response. Since CMFG's response will be attached to the final Report, this response does not address those issues where the Company indicated agreement.

The Bureau acknowledges the corrective actions that CMFG has already taken as the result of this examination. As noted in Corrective Action Plan (CAP) Item 15 (formerly Item 20), within 180 days of finalization of the Report, CMFG will be required to document compliance with all of the corrective action items included in the Final Report. Upon receipt, the examiners will review the documentation provided and communicate with you and your staff if they have any questions or require additional documentation or further action.

Technical Corrections

Company History

Page 5 of the Report has been revised to reflect \$10,638,752 in direct premium in Virginia.

Policy and Other Forms

While the examiners are in agreement with the population sizes and sample selections quoted in your letter, during the course of the examination it was determined that

several of the files under review involved coverage that was issued prior to or within the period in which CMFG was allowed to comply with the corrective action plan included in the prior report. As such, these sample files, and any violations associated with those files, were removed. It is not the examiners intention to penalize CMFG for samples that may have been reviewed during or as the result of the prior examination. The Report appears correct as written.

The last bullet point in CMFG's response concerned the Monthly Premium Credit Life and Disability population and sample sizes included in the Report. Since CMFG provided the examiners with the number of loans that were insured for each of these months rather than a unique population of certificates in force during that three month period, a random sample of 50 insured loans was selected from each month for review. Therefore, the number of insured loans from which the sample was taken is reflected in the Report. In light of CMFG's concerns, the chart in the Policy Forms section of the Report and the Monthly Premium Credit Insurance section of the Report have been revised to provide clarification on what the population and samples sizes actually represent. The examiners did identify an error in the population, and the Report has been revised to reflect 24,360 insured loans instead of 24,457.

Denied Claim Review

This section of the Report has been revised to state, "A sample of 11 from a total population of 25 AD&D and long-term care claims denied during the examination time frame was reviewed."

Outstanding Concerns

Underwriting/Unfair Discrimination/ Insurance Information and Privacy Protection Act/ Insurance Replacement

Underwriting Review Group AD&D (referenced in the original exposure draft beginning on p. 15 and in the revised draft on p. 14):

Upon further review, the violations of §§ 38.2-302 and 38.2-514 of the Code have been removed from the Report. CAP Items 8 and 9 have also been removed and the remaining CAP items were re-numbered.

Single Premium Credit Insurance (reference in the original exposure draft beginning on p. 17 and in the revised draft on p. 15):

The examiners acknowledge CMFG's objection to the inclusion of violations for its failure to provide proper disclosures at the time of sale, which occurred prior to the examination timeframe. However, as noted in the Report, CMFG was notified on page 4 of the Coordinator's Handbook that the examination timeframe does not limit the examiners' right to examine material falling outside of the timeframe. CMFG was cited for violations of § 38.2-3735 C 2 of the Code in the prior Report, therefore any violations of this section identified during the current exam are considered knowing and must be noted. As mentioned in a previous section of this letter, sample sizes and violation counts were revised to remove files involving certificates that were issued during the period in which CMFG was provided to make corrective actions as the result of the prior

exam. Upon further consideration, “without question” has been removed from this section of the Report. There will be no further changes to the Single Premium Credit Insurance section of the Report.

Mechanical Rating Review (referenced in the original exposure draft on pp. 19-21 and in the revised draft on pp. 17-19):

The Market Regulation Handbook does mention a benchmark error rate of 7% for auditing claim practices and 10% for other trade practices. However, the Handbook goes on to state that “many other state laws are not dependent upon the frequency of commission of an act in order to constitute a violation of the law – each instance of commission of the act constitutes a separate and distinct violation.” A violation of subsection 1 of § 38.2-3732 of the Code was observed and must be duly noted in the Report. The violation will remain, however, CAP Item 11 will be removed and the remaining CAP items will be re-numbered.

Cancellations/Nonrenewals

Credit Insurance (referenced in the original exposure draft beginning on p. 28 and in the revised draft beginning on p. 27; the content is also cross referenced to provide the basis for citing claims violations on p. 34 and in the revised draft on p. 31):

Subsequent to a conference call with CMFG after receipt of its March 27th letter, additional documentation was provided to the examiners. The examiners reviewed the additional documentation submitted by CMFG, and determined that the documentation provided evidence of compliance with § 38.2-3729 H 2 and Subsection 4 of § 38.2-3732 of the Code. Following review of the additional documentation, the examiners have removed the 23 violations of each of these sections as well as CAP Item 15.

Claim Practices

Credit Insurance (referenced in the original exposure draft on p. 34 and in the revised draft on p. 31):

As stated above in the Cancellations/Nonrenewals section, the examiners agree to remove the violations regarding excess benefits but have maintained the violations for CMFG’s failure to refund credit accident and sickness insurance premiums when the indebtedness has been prepaid by the proceeds of a credit life insurance policy covering the debtor.

Interest on Claim Proceeds (referenced in the original exposure draft on p. 34 and in the revised draft on p. 31):

CMFG stated that, “*The Company does not believe that the law is so absolute or so clear on which states’ rules apply when calculating interest on death claims*” and that “*No explanation is provided for the basis*” that § 38.2-3115 B of the Code applies to group and individual policies issued in Virginia irrespective of where the insured resided at the time of death.

Section 38.2-300 of the Code clearly establishes the applicability of Virginia's statutes to life insurance policies and accident and sickness insurance policies that are delivered or issued for delivery in Virginia. This statute supports that life insurance interest proceeds shall be based on the state of issuance of the policy instead of the state of residence of the insured at the time of death.

In connection with the 5 violations cited in the Report, the group policy was issued in Virginia; therefore, the application of § 38.2-3115 B of the Code is clear. For these reasons, CAP Item 17 (currently CAP 13) will remain. However, this CAP item has been revised to reflect a review period of 2009 through 2013 and the current year, instead of 2008 through 2012.

Unfair Claims Settlement Practices Review (referenced in the original exposure draft on pp. 37-38 and in the revised draft on pp. 33-34):

Related to 14 VAC 5-400-60 A, 25 violations have been removed, and the 1 violation that CMFG agreed with will remain. The Report has been revised to reflect these revisions, and CAP Item 19 has been removed.

Company Responses to the Proposed Corrective Action Plan

CAP 8: This corrective action has been removed and the remaining CAP items were re-numbered.

CAP 9: This corrective action has been removed and the remaining CAP items were re-numbered.

CAP 10, currently CAP 8: The examiners acknowledge that CMFG will provide its decision on whether to continue to offer single premium credit insurance in Virginia within 180 days of the Report being finalized. Should the Company decide to continue to offer single premium credit insurance in Virginia, the examiners will expect, at that time, to receive from CMFG its procedures for review.

CAP 11: As stated in the Mechanical Rating Review section on page 3 of this letter, CAP Item 11 will be removed and the remaining CAP items will be re-numbered.

CAP 14, currently CAP 11: The corrective action will be revised to require "*Review of all single premium credit life insurance claims processed in 2009....*" Based upon the review of single premium credit life insurance claims processed during the exam timeframe, CMFG failed to properly refund credit accident and sickness insurance premiums in 9 out of 10 instances where such refund was due. It appears that CMFG did not have procedures in place to ensure that proper premium refunds were made prior to or during the examination timeframe. As such, monies are owed to Virginia consumers and CMFG is obligated to ensure that proper refunds are made in accordance with Virginia statute. Section 38.2-218 of the Code permits the Commission to require a person to make restitution in the amount of the direct actual financial loss

CAP 15: As stated in the Cancellations/Nonrenewals section on page 3 of this letter, CAP Item 15 will be removed. The remaining CAP items will be re-numbered.

CAP 16, currently CAP 12: As previously stated, Virginia law applies to policies issued or issued for delivery in Virginia. All claims populations, in addition to other requested populations, only included policies that were issued or issued for delivery in Virginia. CAP 16 (currently CAP 12) will not be withdrawn.

CAP 17, currently CAP 13: Based on the reasons discussed in the section on Interest on Claims Proceeds on page 4 of this letter, as well as the summary above in CAP Item 16 (currently 12), CAP Item 17 (currently 13) will remain in the Report.

A copy of the revised Report is attached, and incorporates the only substantive revisions the examiners plan to make before it becomes final. CMFG will be required to complete the Corrective Action Plan within 180 days of this Report being finalized.

On the basis of our review of the entire file, it appears that CMFG has violated the Unfair Trade Practices Act, specifically Subsection 1 of § 38.2-502 and § 38.2-503 of the Code of Virginia.

In addition, there were violations of §§ 38.2-316 B; 38.2-316 C 1; 38.2-1834 D; 38.2-3115 B; 38.2-3407.4 A; 38.2-3729 H 1; subsection 1 of 38.2-3732; subsection 2 of 38.2-3732 and 38.2-3735 C 2 of the Code, as well as 14 VAC 5-90-50 A and 14 VAC 5-90-50 B, Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-400-50 A and 14 VAC 5-400-60 A, Rules Governing Unfair Claims Settlement Practices.

Violations of the above sections of the Code and Virginia Administrative Code can subject CMFG to monetary penalties of up to \$5,000 for each violation and the suspension or revocation of its license to transact business in Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter.

Very truly yours,

Julie R. Fairbanks, AIE, FLMI, AIRC
Supervisor
Market Conduct Section
Life and Health Division
Telephone (804) 371-9385

cc: Bob Grissom

Kathy Graham
Compliance Leader, Market Conduct Examinations
Telephone: 608.665.7008
E-mail: kathy.graham@cunamutual.com
Fax: 608.236.7008

August 20, 2014

Ms. Julie R. Fairbanks
Supervisor, Market Conduct Section
Commonwealth of Virginia
Bureau of Insurance
P.O. Box 1157
Richmond VA 23218

Dear Ms. Fairbanks:

CMFG Life Insurance Company (hereafter, "Company") has completed its review of your August 4, 2014 letter and the revised Target Market Conduct Examination Report. The Company appreciates the Bureau of Insurance's willingness to consider the additional information the Company has provided and the changes made to the Report.

At this time, the Company has only a minor technical correction to provide as well as an update regarding the single premium credit insurance business in Virginia. With these changes, the Company believes the process can proceed to finalization of the Report.

Technical Corrections

Claims Practices

Credit Insurance (referenced on the revised draft on page 31): As we discussed, please update the second sentence to remove the reference regarding the number of claims files (23) to simply indicate "sample claim files".

Company Response to Proposed Corrective Action

Corrective Action Item 8 (previously 10)

The Company has decided as a method of remediation to the issues identified in the Report to discontinue the sale of single premium credit insurance in Virginia.

Conclusion

The Company has completed many of the corrective action items and will submit within 180 days of the finalization of the Report, documentation supporting compliance with all of the corrective action items included in the final Report.

I greatly appreciate all the assistance The Bureau has provided the Company throughout the examination process. We look forward to working with the Bureau to bring the process to a conclusion. If there are any remaining questions, please do not hesitate to contact me.

Sincerely,



Kathy Graham
Compliance Leader, Market Conduct Examinations
KG

cc:

Reginald J. Jones, Esq.
Stephen W. Koslow, SVP, Chief Ethics & Compliance Officer
Claude J. Kazanski, Associate General Counsel
Ross D. Hansen, Associate General Counsel

COPY

COMMONWEALTH OF VIRGINIA

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE



P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

August 21, 2014

CERTIFIED MAIL 7013 2630 0001 8681 0679
RETURN RECEIPT REQUESTED

Kathy Graham
Compliance Leader, Market Conduct Examinations
CMFG Life Insurance Company
Mail Stop 5910 4 A2
5910 Mineral Point Road
Madison, WI 53705

Dear Ms. Graham:

The Bureau of Insurance (hereinafter referred to as "the Bureau") has reviewed the technical correction proposed in your letter dated August 20, 2014, and the revision has been made to the Target Market Conduct Examination Report of CMFG Life Insurance Company (CMFG). Two additional errors were identified, one in CAP Item 9 and the other on the cover page, and they have also been corrected. The revised pages are attached for your review.

The three revisions mentioned above are the only substantive revisions the examiners plan to make before it becomes final. The examiners acknowledge the corrective actions that CMFG has already taken, and look forward to receiving documentation supporting compliance with all of the corrective action items within 180 days of the finalization of the Report.

On the basis of our review of the entire file, it appears that CMFG has violated the Unfair Trade Practices Act, specifically Subsection 1 of § 38.2-502 and § 38.2-503 of the Code of Virginia.

In addition, there were violations of §§ 38.2-316 B; 38.2-316 C 1; 38.2-1834 D; 38.2-3115 B; 38.2-3407.4 A; 38.2-3729 H 1; subsection 1 of 38.2-3732; subsection 2 of 38.2-3732 and 38.2-3735 C 2 of the Code, as well as 14 VAC 5-90-50 A and 14 VAC 5-90-50 B, Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-400-50 A and 14 VAC 5-400-60 A, Rules Governing Unfair Claims Settlement Practices.

Violations of the above sections of the Code and Virginia Administrative Code can subject CMFG to monetary penalties of up to \$5,000 for each violation and the suspension or revocation of its license to transact business in Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter.

Very truly yours,

Julie R. Fairbanks, AIE, FLMI, AIRC
Supervisor
Market Conduct Section
Life and Health Division
Telephone (804) 371-9385

cc: Bob Grissom

COPY

Stephen W. Koslow
SVP, Chief Ethics & Compliance Officer
Telephone: (608) 665-7562
E-mail: steve.koslow@cunamutual.com
Fax: (608) 236-6746

STATE CORP. COMMISSION



CMFG Life Insurance Company

2014 SEP 10 AM 9:08

BUREAU OF INSURANCE

September 09, 2014

Ms. Althelia P. Battle, FLMI, HIA, AIE, MHP, AIRC, ACS
Deputy Commissioner
Bureau of Insurance
1300 East Main Street
Richmond, VA 23219

SEP 11 2014 *50002H

RE: Alleged Violations of violated the Unfair Trade Practices Act, specifically Subsection 1 of § 38.2-502 and § 38.2-503 of the Code of Virginia, as well as, violations of §§ 38.2-316 B; 38.2-316 C 1; 38.2-1834 D; 38.2-3115 B; 38.2-3407.4 A; 38.2-3729 H 1; subsection 1 of 38.2-3732; subsection 2 of 38.2-3732 and 38.2-3735 C 2 of the Code, as well as 14 VAC 5-90-50 A and 14 VAC 5-90-50 B, Rules Governing Advertisement of Accident and Sickness Insurance, and 14 VAC 5-400-50 A and 14 VAC 5-400-60 A, Rules Governing Unfair Claims Settlement Practices.

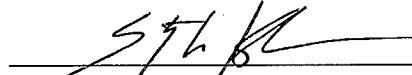
Dear Ms. Battle:

This will acknowledge receipt of your letter dated August 22, 2014, concerning the above-captioned matter.

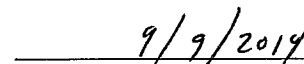
CMFG Life Insurance Company wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of \$21,000 payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement, it is entitled to a hearing in this matter and waives its right to such a hearing and agrees to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of June 30, 2012.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Yours very truly,



Company Representative



Date

Enclosure (check)
cc: Kathy Graham

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

140940072

AT RICHMOND, SEPTEMBER 26, 2014

SCC CLERK'S OFFICE
DOCUMENT CONTROL CENTER

2014 SEP 26 P 12: 21

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2014-00197

CMFG LIFE INSURANCE COMPANY,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that CMFG Life Insurance Company ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Commonwealth"), in certain instances, violated §§ 38.2-502 (1) and 38.2-503 of the Code of Virginia ("Code"), as well as 14 VAC 5-90-50 A and 14 VAC 5-90-50 B of the Commission's Rules Governing Advertisement of Accident and

Sickness Insurance, 14 VAC 5-90-10 *et seq.*, by failing to comply with advertising requirements; violated §§ 38.2-316 B and 38.2-316 C (1) of the Code by failing to comply with policy and form filing requirements; violated § 38.2-1834 D of the Code by failing to comply with agent licensing requirements; violated § 38.2-3115 B of the Code by failing to properly pay interest on life insurance proceeds; violated § 38.2-3407.4 A of the Code by failing to comply with explanation of benefits practices; violated § 38.2-3729 H (1) of the Code by failing to comply with the laws regarding appropriate refund of credit accident and sickness insurance premiums; violated §§ 38.2-3732 (1) and 38.2-3732 (2) of the Code by failing to comply with the laws regarding delegation of duties; violated § 38.2-3735 C (2) of the Code by failing to comply with the laws regarding disclosure and readability; and violated 14 VAC 5-400-50 A and

14 VAC 5-400-60 A of the Commission's Rules Governing Unfair Claims Settlement Practices, 14 VAC 5-400-10 *et seq.*, by failing to acknowledge pertinent communications, and by failing to properly investigate a claim prior to acceptance or denial.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of its right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to the Commonwealth the sum of Twenty-one Thousand Dollars (\$21,000), waived its right to a hearing, and agreed to comply with the corrective action plan contained in the Target Market Conduct Examination Report as of June 30, 2012.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

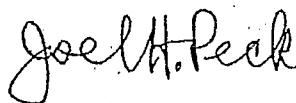
Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to:
Stephen W. Koslow, SVP, Chief Ethics & Compliance Officer, CMFG Life Insurance Company,
P.O. Box 391, 5910 Mineral Point Road, Madison, Wisconsin 53701-0391; and a copy shall be
delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of
Deputy Commissioner Althelia P. Battle.

A True Copy
Teste:



Clerk of the
State Corporation Commission

COPY