REPORT OF EXAMINATION

OF THE

MARKET CONDUCT AFFAIRS

OF

UNION NATIONAL LIFE INSURANCE COMPANY

ST. LOUIS, MISSOURI

AS OF

December 31, 2011

NAIC CODE 69779

NAIC ETS EXAM NO. LA071-M91

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LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

November 9, 2012

Honorable James J. Donelon
Commissioner of Insurance
P O Box 94214
Baton Rouge, Louisiana 70804-9214

Sir:

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

UNION NATIONAL LIFE INSURANCE COMPANY

12115 LACKLAND ROAD

ST. LOUIS, MISSOURI 63146

as of December 31, 2011, and the report of examination is herewith submitted.

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FOREWORD

A full scope market conduct examination was performed of the activities of Union National Life Insurance Company from January 1, 2008 through December 31, 2011. The examination was performed by test and all tests applied during the examination are included in this report.

PURPOSE AND SCOPE OF MARKET CONDUCT EXAMINATION

In accordance with **La. R.S. 22:1981 et. seq.**, the market conduct examination of Union National Life Insurance Company hereinafter referred to as ("Company"), was a full scope market conduct examination authorized by the Louisiana Department of Insurance ("LDI").

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

The ACL Program, a data manipulation program, provided by the LDI was utilized in this examination. Samplings were utilized to test the Company's records and procedures. The ACL Program was used to automatically generate a random sampling of claims records. "Random" is a theoretical concept meaning that all items in a population or file (before selection) have an equal chance of appearing in the sample. In instances in which ACL was not used, a systematic (sequential) sampling of certain Company record listings was performed.

Generally, a random or systematic sampling size of 60 records was selected for review. A minimum confidence level of 95% with a maximum error rate of 5% was used for all samples.

Failure to identify or criticize improper or non-compliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

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

- Company Operations,
- Complaint Handling,
- Marketing and Sales,
- Producer Licensing,
- Claims, and
- Underwriting

Company History

Union National Life Insurance Company was organized under the laws of the State of Louisiana as an industrial life insurer on June 29, 1928. Through its captive agents, it began its Home Service business on July 30, 1930. On December 30, 1954, its charter was amended to include the writing of ordinary life insurance. The Home Office for Union National Life was located on Goodwood Boulevard in Baton Rouge, Louisiana. On August 10, 2006, the Home Office of Union National Life was moved to South Sherwood Forest Boulevard in Baton Rouge, Louisiana and its Administrative Offices were moved to St. Louis, Missouri.

On October 31, 1989, the Company became a part of an insurance holding company system when United Insurance Company of America (United), an Illinois Corporation and a part of the Unitrin, Inc. Holding Company System, acquired all of the shares of the Company. On December 28, 2005, United paid a dividend to Unitrin, Inc. consisting of all the issued and outstanding stock of Union National Life thereby making Union National Life a direct wholly-owned subsidiary of Unitrin, Inc.

On December 31, 2009, Unitrin contributed all of the issued and outstanding common stock it owned of Union National Life to United. As a result of the contribution, Union National Life ceased being a direct, wholly-owned subsidiary of Unitrin and became a direct, wholly-owned subsidiary of United and an indirect subsidiary of Unitrin.

On August 25, 2011, Unitrin changed its name to Kemper Corporation (a Delaware corporation).

COMPANY OPERATIONS REVIEW

NAIC Standard 7 (Chapter 16) – (Company Records) - *Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.*

Company claims and underwriting records were available for examination on-line through the Company's imaging system and were adequate. All other records were accessible and adequate for the examination.

NAIC Standard 8 (Chapter 16) – (Certificate of Authority) - *The regulated entity is licensed for the lines of business that are being written.*

The Company's Certificate of Authority was reviewed during the examination and was issued with an effective date of January 1, 2010. It authorized the Company to transact the business of health and accident and life insurance in the State of Louisiana.

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

YEAR	PREMIUM VOLUME*
2008	$58,436,066
2009	$57,223,595
2010	$56,745,597
2011	$57,085,634

* From Annual Statements - Schedule T

NAIC Standard 9 (Chapter 16) – (Examinations) - *The regulated entity cooperates on a timely basis with examiners performing the examinations.*

The Company personnel were very cooperative during the examination and provided responses to examination requests in a timely manner.

Unclaimed Property

Effective July 10, 1997, Act 809 of the 1997 Regular Legislative Session requires all companies to file a report by November 1st each year of unclaimed property in its possession. The Company provided its procedures for handling unclaimed property. The unclaimed property reports for 2008 through 2011 were reviewed. All reports were filed on time.

COMPLAINT REVIEW

NAIC Standard 1 (Chapter 16) – (Complaint Register) - *All complaints are recorded in the required format on the regulated entity's complaint register.*

The Company provided a complaint register of complaints received from the LDI for the period of January 1, 2009 through December 31, 2011. The complaint register contained all elements required by the statute.

The Company's initial complaint register did not contain the LDI's complaint number. This made it difficult to compare the Company's register to the LDI's register. A request was made to get a revised register and the Company provided a revised register that contained the LDI's complaint number.

The Company's complaint register was compared to the LDI's complaint register. The Company's register did not contain six of the complaints that are on the LDI's register. The Company provided the following response:

Complaint 244910 - Complaint listed with servicing state as Alabama.

Complaint 253311 -	Complaint listed with servicing state as Texas.
Complaint 265577 -	Complaint is for a fire policy and should not be on the LDI's register for the Life Company.
Complaint 266070 -	Servicing state field was left blank in the system.
Complaint 269519 -	Complaint is listed as a Union National Fire policy and should be listed as a life policy.
Complaint 277668 -	Servicing state field was left blank in the system.

With the exception of complaint 265577, the remaining five complaints listed above should have been on the Company's original register. Therefore, the Company is not in compliance with **La. R.S. 22:1964 (17)** which states:

> **"The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance: ...**
>
> **(17) Failure to maintain adequate complaint handling procedures. Failure of any insurer to maintain a complete record of all the complaints that it received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this Paragraph, "complaint" shall mean any written communication primarily expressing a grievance received by the insurer from the Department of Insurance."**

It is recommended that the Company correct its complaint register where appropriate in order to be in compliance with the above statute.

The Company provided a response that it has corrected its complaint system so that the complaint register contains all complaints filed within a particular state not just those serviced by agents in a particular state.

NAIC Standard 2 (Chapter 16) – (Company Procedures) - *The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.*

The Company presented two complaint procedures, one from the 2012 Compliance Manual and the other which is a bulletin to all home office department managers for Procedures for Complaint Handling. These procedures were reviewed and were found to be adequate for investigating complaints submitted by the LDI and for providing responses to the LDI.

NAIC Standard 3 (Chapter 16) – (Complaint Disposition) - *The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language.*

There were 152 complaints received by the LDI during the period of January 1, 2009 through December 31, 2011. The reasons for the complaints are summarized in the following table:

Reason for Complaint	No. of Complaints
Policyholder Service/Other	41
Claim Delay	25
Cash Surrender Value	17
Delays/No Response	9
Refunds	8
Denial of Claim	7
Unsatisfactory Settlement	7
Premium Notice/Billing	7
Claims Handling/Other	6
Agent Handling	4
Fraud/Forgery	4
Assignment of Benefit	3
Misappropriation of Funds	3
Post Claim Underwriting	2
Cancel/Non-Renewal	2
Underwriting/Other	2
Marketing/Other	1
Policy Delivery	1
Premium Misquote	1
Rate Adjustment	1
Underwriting Delays	1
Total	152

The dispositions of the complaints are summarized in the following table:

Disposition	No. of Complaints
Company Position Upheld	37
Information Furnished	31
Claim Settled	28
Other	11
Insufficient Information	9
Compromise Resolution	7
Claim Denied	5
Refund	5
Duplicate Record	3
Invalid Complaint	3
No Jurisdiction	3
Policy Issued/Restored	3

Premium Problem Resolved	2
Record Flagged	1
Question of Fact/Law	1
Refer to Market Conduct	1
No Action Required	1
Refer to Proper Agency	1
Total	152

A random sample of 60 complaints was selected using ACL from the LDI's complaint register for complaints received during the examination period. The sample was reviewed to determine if the complaints were handled properly and to determine if the Company's response time was within the LDI's specified time frame.

The complaints generally related to questions about policies, policy lapses, surrender values, and claim delays. In all cases, the Company adequately addressed the issues and either explained its position or resolved the complaint.

NAIC Standard 4 (Chapter 16) – (Timely Response) - *The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.*

The complaint sample was reviewed to evaluate the Company's response time to the complaints. All responses were either within the time limit specified or the Company requested an extension to the due date and the extension was granted by the LDI.

MARKETING AND SALES REVIEW

NAIC Standard 1 (Chapter 16) – (Advertising and Sales) - *All advertising and sales materials are in compliance with applicable statutes, rules and regulations.*

The Company does not do any advertising through any media outlets, but provides sales material on its products to potential customers. The Company provided the following narrative of its marketing and sales process:

"We are committed to serving the insurance needs of modest income families. As a home service company, we are dedicated to frequent personal contact with our customers. Day to day sales activities include regularly prospecting for sales opportunities from three main sources, policyholders, referred leads, and people we do not know yet (door to door prospecting).

- Selling on a needs basis, using only approved sales processes and materials.
- Following company underwriting practices and writing business only on prospects that have a need and the ability to pay.
- Adhering to company market conduct rules."

No exceptions were found in this review.

NAIC Standard 2 (Chapter 16) – (Training Materials) - *Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.*

The training of Company producers is accomplished through the Professional Agents Development (PAD) program which is the Company's basic development program for new producers. The entire PAD program spans a period of 26 weeks and is comprised of several different formats: self-study, one-on-one sessions with a trainer, role play, and field coaching.

No exceptions were found in this review.

NAIC Standard 3 (Chapter 16) – (Producer Communication) - *Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.*

The Company communicates with its producers through bulletins and memorandums. There is also a Company publication that goes to all employees that contains Company news. District offices conduct weekly meetings where the District Manager addresses the entire district staff. Furthermore, each region has a regional meeting each year, where the district managers and staff managers from each district in the region come together for meetings and presentations from home office senior management.

No exceptions were found in this review.

PRODUCER LICENSING REVIEW

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

The Company provided a narrative of its Louisiana license and appointment process:

"Once hired all unlicensed producers must get fingerprinted and then apply for the limited LA&H license. This license does not require an exam.

If the producer is licensed when they are hired, the Company makes sure that they have the proper license for the Company or they will need to apply for the proper license on-line.

Once the license is issued, the home office licensing department does the company appointments for the limited LA&H license and assigns the producer to an agency. The appointments are done through SIRCON so there is a 3-5 day waiting period for the license to show up on the producer data base and the appointment can be submitted. The Company appoints for the license issue date. The license dates, appointments, and renewal dates are added to the producer licensing screen (AG80)."

The Company provided a listing of producer's who were paid commissions during 2011. This list was compared to the LDI's records for these producers. It was found that one producer was not on the LDI's appointment list. The Company was asked to provide commission and appointment information for this producer. The producer was an advance recruit from 12/13/2010 to 2/14/2011. He was assigned to an agency on 2/14/2011 and his license was issued on 2/18/2011. On 2/18/2011, the Company keyed him to an agency with an effective date of 2/14/2011. The licensing department was going to proceed with his appointment on that date,

but found out he was terminated as of 2/18/2011. Because he was assigned to an agency from 2/14/2011 to 2/18/2011, he earned agent commission in the amount of $527.22.

This is not in compliance with **La. R.S. 22:1558 C** which states:

> **"Any insurance producer, unless otherwise prohibited by contact, licensed in this state, may solicit, negotiate, or effect applications for polices of insurance with any insurer lawfully doing business in this state, other than an insurer such producer is appointed to represent, if such producer is under contract with such insurer. However, no commissions shall be paid by such insurer to the producer until the appointment has been recorded by the commissioner."**

It is recommended that the Company implement procedures to ensure that it is in compliance with the above statute.

NAIC Standard 2 (Chapter 16) – (Licensing) - *The producers are properly licensed and appointed and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken.*

During the Underwriting review, the producers who wrote the applications in the New Business sample were checked for proper licensing and appointments. All of the producers who wrote applications for life and accident and health policies in the sample were properly licensed and appointed.

NAIC Standard 3 (Chapter 16) – (Termination Notification) - *Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.*

The Company provided a list of 43 producers terminated for cause. A sequential sample of 12 producers was selected. The Company was asked to provide the producer files for these 12 producers for review. It was found that five producers in the sample were Mississippi producers, appointed in Mississippi, who worked out of a Louisiana district office but did not do any business in Louisiana. The review showed that, for the remaining producers, the Company timely advised the LDI of these terminations and the causes for termination in accordance with statute **La. R.S. 22:1559 B.**

NAIC Standard 5 (Chapter 16) – (Termination Documentation) - *Records of terminated producers adequately document reasons for terminations.*

The review showed that the records of the terminated producers contained the reasons for termination.

CLAIMS REVIEW

NAIC Standard 3 (Chapter 16) – (Timely Resolution) - *Claims are resolved in a timely manner.*

The following statute applies for the payment of life claims:

La. R.S. 22:1811:

> **"All death claims arising under policies of insurance issued or delivered within this state shall be settled by the insurer within sixty days after the date of receipt of due proof of death and if the insurer fails to do so without just cause, the amount due shall bear interest at the rate of eight percent per annum from date of receipt of due proof of death by the insurer until paid."**

The following statute applies for the payment of accident and health claims:

La. R.S. 22:1821 A:

> **A. All claims arising under the terms of health and accident contracts issued in this state, except as provided in Subsection B, shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. The insurer shall make payment at least every thirty days to the assured during that part of the period of his disability covered by the policy or contract of insurance during which the insured is entitled to such payments. Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be determined by the court. Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, shall have jurisdiction to try such cases.**

Paid Life Claims Sample Review

The Company provided a listing of paid life claims for the period of January 1, 2009 through December 31, 2011. A random sample of 60 claims was selected by ACL from the file

of paid claims provided by the Company. The files were reviewed to determine the time taken to pay the claims and to determine if the files contained adequate documentation. Also, the files were reviewed to determine if the claims were paid in accordance with the statutes.

It was found that one claim (1.7% of the sample) was not paid within the 60 days allowed by statute. This claim is detailed in the table below:

Claim Number	Proof of Death Date	Paid Date	Payment Time	Statute Allows
08041242	5/5/09	7/8/09	64 Days	60 days

This is not in compliance with **La. R.S. 22:1811** which is stated above.

It is recommended that the Company implement procedures to ensure that all claims are paid in accordance with the above statute.

The Company acknowledged that there was an error in processing the above claim.

The claims in the life claims sample were paid in an average of 15 days after the proof of death date.

Paid Accident & Health (A&H) Claims Sample Review

The Company provided a listing of paid accident and health (A&H) claims for the period of January 1, 2009 through December 31, 2011. A random sample of 60 claims was selected by ACL from the file of paid claims provided by the Company. The files were reviewed to determine the time taken to pay the claims and to determine if the files contained adequate documentation. Also, the files were reviewed to determine if the claims were paid in accordance with the statutes.

It was found that three claims (5% of the sample) were not paid within the 30 days allowed by statute. They are detailed in the table below:

Claim Number	Proof of Claim Date	Paid Date	Payment Time	Statute Allows
10137769	11/18/10	12/27/10	39 Days	30 Days
11031897	12/20/10	3/23/11	93 Days	30 Days

1929245	3/18/09	11/9/09	236 Days	30 Days

This is not in compliance with **La. R.S. 22:1821 A** which is stated above.

It is recommended that the Company implement procedures to ensure that all claims are paid in accordance with the above statute.

The Company provided a response to the exceptions and stated that adjuster errors led to the claims being paid beyond 30 days. They also stated:

"However the majority of what appears to be a 200+ day delay [on claim 1929245] was due to a system error. Though the adjuster released the claim to be paid, the check never issued and there is no indication that the system was closed. The claim system should have closed the case after issuing the check. A system error caused the claim to sit in a pay status in the claim system instead of a check being issued. This system error is very rare. Nevertheless, the Company has since put in place a procedure whereby the IT department periodically checks to make sure there are no claims lingering in a pay status without a check being issued."

Interest was paid on two of the three A&H claims listed above.

The claims in the A&H sample were paid in an average of 18 days after the proof of claim date.

NAIC Standard 4 (Chapter 16) – (Timely Response) - *The regulated entity responds to claims correspondence in a timely manner.*

The claims files were reviewed to determine if correspondence was answered or responded to within a timely manner. No exceptions were found in this area.

NAIC Standard 5 (Chapter 16) – (Adequate Documentation) - *Claim files are adequately documented.*

All claim files reviewed contained adequate documentation required for the review.

NAIC Standard 6 (Chapter 16) – (Claims Handling) - *Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.*

Claims Processing

The Company stated that it does not have written claims handling procedures or a claims handling manual. The claims department employees are provided with a desk reference which contains the claims handling requirements for each state. The Company provided a copy of this desk reference along with a flowchart of the claims handling process and a spreadsheet which details the "due proof of death" documents required for the payments of claims.

A claims walkthrough was performed on August 14, 2012 at the Company's offices in St. Louis, MO.

Most claims are received by mail with a small number received by fax. The mail is opened and all claims are scanned and indexed into the imaging system the same day that the mail is opened. The received date of the claim is the date the claim is scanned into the system. The support staff receives the scanned documents and opens a claim in the system. The claim is then put in a queue and is assigned to an adjuster. The adjuster then takes over the claims handling process. The adjuster reviews all documentation and requests any additional documentation that is required to process the claim. When all documentation is received and reviewed, the claim is either paid or denied. Checks are printed and mailed out daily.

A&H claims can be received from the insureds, producers, or providers. There must be an itemized bill and a diagnosis in order to establish the proof of claim date for an A&H claim.

The Company's claims handling process seemed adequate.

Paid Claims Review

The Company provided a listing of paid claims for the period of January 1, 2009 through December 31, 2011. The file was analyzed using ACL and various reports were generated. The

file contained 31,515 claim payments totaling $60,681,999. The following table shows the breakdown of all paid claims processed by type of claim:

Type	No. of Claim Payments	Percentage	Amount
A&H	6,477	21	$2,708,622
Life	25,038	79	57,973,377
Total	31,515	100	$60,681,999

NAIC Standard 9 (Chapter 16) – (Denied Claims) - *Denied and closed without payment claims are handled in accordance with policy provisions and state law.*

The Company provided a file of denied claims for the period of January 1, 2009 through December 31, 2011. The following table shows the breakdown by type of claim:

Type of Claim	Number of Claims	Percentage
A&H	10,410	98
Life	177	2
Total	10,587	100

The Company submitted an explanation for the large volume of denied claims in the file:

"When the Company receives a health claim document, it sets up a claim and processes it for all known health policies for that insured. This is done regardless of the type of the health claim being filed or types of policies covering the insured. An insured may have multiple policies with the Company."

The insured would receive payment under the one policy that would apply. A denial would be processed under the remaining policies.

"As a result of this process the number of denied claims appears to be elevated. When in fact many of the claims listed as denied claims are for health policies owned by the insured which are unrelated to the health claim document submitted and for which the insured may have received a payment under another policy."

ACL was used to summarize the life claims in the file by reason code. A summary is presented in the following table:

Reason for Denial	Number of Claims
Policy not in force - non-payment of premiums	49
Policy not in force - benefits expired before loss	42
Policy was not assumed by the Company	37
Policy not in force - benefits expired for extended term insurance	23
Policy not in force - cash surrendered	13
Policy value consumed	8
Miscellaneous	5
Total	177

A random sample of 60 denied life claims was selected using ACL from the file provided by the Company. The files were reviewed to determine the reason for the denial or closure and to review the documentation in the files. A summary of the reasons for denial or closure is presented in the following table:

Reason for Denial	Number of Claims
Policy not in force - non-payment of premiums	17
Policy was not assumed by the Company	14
Policy not in force - benefits expired before loss	9
Policy not in force - benefits expired for extended term insurance	8
Policy not in force - cash surrendered	5
Policy value consumed	5
Policy not in force - policy matured	1
Claim paid by legal department	1
Total	60

ACL was used to summarize the A&H claims in the file by reason code. A summary is presented in the following table:

Reason for Denial	Number of Claims
Accident only policy	3,665
Hospital indemnity policy	2,502
Surgical expense policy	1,582
Charges not covered	788
Cancer policy	652
Late filing of claim	256
Hospital confinement policy	173
Attending physician not covered	119
Condition not covered	77
Disability policy	72
Policy expired before service date	72

Life insurance policy	68
Maximum x-ray benefit paid	57
EOB's not covered; bill & diagnosis needed	49
Maximum miscellaneous benefit paid	47
Not this Company's policy	31
Maximum policy year benefit paid	23
Maximum accident benefit already paid	13
Miscellaneous	164
Total	10,410

A random sample of 60 denied A&H claims was selected using ACL from the file provided by the Company. The files were reviewed to determine the reason for the denial or closure and to review the documentation in the files. A summary of the reasons for denial or closure is presented in the following table:

Reason for Denial	Number of Claims
Accident only policy	23
Hospital indemnity policy	16
Surgical expense policy	9
Cancer policy	2
Hospital confinement policy	2
Policy expired before service date	2
EOB's not covered; bill & diagnosis needed	1
Maximum miscellaneous benefit paid	1
Maximum accident benefit already paid	1
Maximum x-ray benefit paid	1
Maximum policy year benefit paid	1
Claim previously paid	1
Total	60

No exceptions were found in this review.

NAIC Standard 11 (Chapter 16) – (Litigation) - *Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.*

There was no evidence found during the claims reviews that the Company's claims handling practices compelled the claimants to institute litigation.

UNDERWRITING REVIEW

NAIC Standard 4 (Chapter 16) – (Underwriting Practices) – *The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.*

During the Underwriting reviews, there was no evidence that the Company's Underwriting practices were unfairly discriminatory.

NAIC Standard 5 (Chapter 16) – (Form Filing) - *All forms, including contracts, riders, endorsement forms and certificates are filed with the insurance department, if applicable.*

The Company provided a listing of policy forms in use during the examination period. A sequential sample of ten policies was selected for review and approval documentation was requested from the Company. All forms had been properly approved by the LDI.

NAIC Standard 6 (Chapter 16) – (Policy Issuance) - *Policies, riders and endorsements are issued or renewed accurately, timely and completely.*

Both Life and A&H policies were issued in an average of 12 days after the date of the application.

NAIC Standard 7 (Chapter 16) – (Rejections/Declinations) - *Rejections and declinations are not unfairly discriminatory.*

The Company provided a file of declined applications for the period January 1, 2009 through December 31, 2011. The file contained 2,758 declined applications for life insurance and 331 declined applications for accident and health insurance. ACL was used to analyze the data and various reports were produced. A summary of the reasons for the declinations is presented below:

Life Declined Applications

Reason for Declination	**No. of Applications**
Medical history	575
Improper application	498
Improper signature on application	412
Height/weight	227
Medical history and height/weight	165
Medical findings	104

Medical history and medical findings	76
Declined due to confidential information	37
Postponed due to medical history and height/weight	29
Medical history, recommend GI policy	16
Medical findings and height/weight	8
Age exceeds maximum for plan	4
Amount exceeds maximum available	3
Unknown - must consult file to find declination reason	604
Total	2,758

Accident and Health Declined Applications

Reason for Declination	**No. of Applications**
Improper application	121
Medical history	60
Medical history and height/weight	49
Height/weight	47
Improper signature on application	30
Amount exceeds maximum available	6
Age exceeds maximum for plan	3
Miscellaneous	15
Total	331

Random samples of 60 Life applications and 60 A&H applications were selected using ACL for review. The files were reviewed to determine the reasons for the declination and to determine if the files contained adequate documentation. The following tables show the reasons for declination of the applications in the samples:

Life Declined Applications

Reason for Declination	**No. of Applications**
Medical history and medical findings	17
Height and weight	12
Owner did not sign application	7
Insured did not sign application	6
Need parent's signature on application	4
Improper application, missing initials on medical questions	3
District request, confidential information received	3
Insured must be at least 15 days old at time of application	2
Spouse's signature needed on application	1
Improper application, back of application not scanned	1
Agent request	1

Postpone for medical history for 3 months	1
Application written prior to agent appointment	1
Maximum benefits available through grandparent's policy	1
Total	60

Accident and Health Declined Applications

Reason for Declination	**No. of Applications**
Medical history	13
Height and weight	12
Medical history and height and weight	5
Improper answers to medical questions	4
Amount applied for exceeds maximum policy limit	3
Insured did not sign application	3
Insured must initial medical questions	3
Must have plan 54 before purchasing plan 55	2
Agent cannot witness her own signature	2
Oldest insured needs to be listed first on application	2
Plan not available at current age	2
Spouse did not sign application	1
Insured can have only one accident policy	1
Printed signature must be witnessed	1
Insured lives in TX; agent licensed in LA	1
Client already has another policy in force	1
Parent must sign application	1
Application was altered	1
Medical findings and height and weight	1
Back of application was not completed	1
Total	60

There was no evidence found that the declinations were unfairly discriminatory. The insureds were notified in writing that the applications had been declined and they were given the reasons for the declinations.

NAIC Standard 8 (Chapter 16) – (Cancellations/Non-Renewals) - *Cancellation/non-renewal, discontinuance and declination notices comply with policy provisions, state laws and the regulated entity's guidelines.*

The Company stated that it does not cancel life policies and therefore does not issue cancellation notices. Life policies will lapse for non-payment of premium or policy overloan or

will terminate upon cash surrender or the death of the insured. No further review was deemed necessary for the purpose of this report.

NAIC Standard 1 (Chapter 19) – (Applications) – *Pertinent information on applications that form a part of the policy is complete and accurate.*

The Company provided a listing of new business policies issued during the period of January 1, 2009 through December 31, 2011. Random samples of 60 Life policies and 60 A&H policies were selected using ACL for review. The policy files were reviewed to determine if the applications were properly completed and signed. The producers who wrote the applications were checked to ensure that they were properly licensed and appointed. The application forms used were checked to determine if they had been properly approved.

All applications had been properly completed and signed by both the insured and the producer. All producers had been properly licensed and approved. All application forms used for the new business policies had been properly approved.

COMMENTS AND RECOMMENDATIONS

Various non-compliant practices were identified, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the State's insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

COMPLAINT REVIEW

The Company's register did not contain five of the complaints that are on the LDI's register. This is not in compliance with **La. R.S. 22:1964 (17).** It is recommended that the Company correct its complaint register where appropriate in order to be in compliance with the above statute.

PRODUCER REVIEW

It was found that one producer was not on the LDI's appointment list. This is not in compliance with **La. R.S. 22:1558 C.** It is recommended that the Company implement procedures to ensure that it is in compliance with the above statute.

CLAIMS REVIEW

It was found that one life claim (1.7% of the sample) was not paid within the 60 days required by statute. This is not in compliance with **La. R.S. 22:1811**. It is recommended that the Company implement procedures to ensure that all claims are paid in accordance with the above statute.

It was found that three accident and health claims (5% of the sample) were not paid within the 30 days allowed by statute. This is not in compliance with **La. R.S. 22:1821 A**. It is recommended that the Company implement procedures to ensure that all claims are paid in accordance with the above statute.

CONCLUSION

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

UNION NATIONAL LIFE INSURANCE COMPANY

ST. LOUIS, MISSOURI

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

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

Respectfully submitted,

Richard S. Robison

Richard S. Robison
Louisiana Department of Insurance