

REPORT OF MARKET CONDUCT EXAMINATION

CENTRAL RESERVE LIFE INSURANCE CO.

17800 ROYALTON RD

STRONGSVILLE, OH 44136

AS OF MARCH 31,2003

BY

KANSAS INSURANCE DEPARTMENT

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Honorable Sandy Praeger
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612

January 9, 2004

Dear Commissioner Praeger:

In accordance with your respective authorization, and pursuant to K.S.A. 40-222, a market conduct examination has been conducted on the business affairs of:

Central Reserve Life Insurance Co

17800 Royalton Rd

Strongsville, OH 44136

hereafter referred to as “CRL” or “the Company”, and the following report as such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM
Market Conduct Supervisor
Examiner in Charge

EXECUTIVE SUMMARY

The Kansas Insurance Department performed a market conduct examination of the Central Reserve Life Insurance Co. (CRL). The examiners reviewed the company underwriting, claims, and rating manuals. The exam team reviewed claim, and complaint files in company's Administrative office in Strongsville, OH. A series of meetings were held with the CRL staff that focused on their current operations. To supplement and verify the understanding of how the company does business, a series of samples were selected for review to verify their procedures and practices in complaint and claim handling.

The company passed most tests; and in terms of delivering good service to its insured customers, the examiners were impressed with the overall positive and very professional performance by the CRL staff and management to their policyholders. The exam team has made recommendations on several issues.

LIST OF RECOMMENDATIONS

Complaint Handling

1. While the response times were within KID's tolerances, the exam team feels that the company should review their complaint handling procedures so everyone is aware of the response times required for the different levels of complaints.

General

1. The new business rejection letter listed the former third party administrator as the contact for anyone interested in obtaining health insurance through the Kansas Health Insurance Assoc. When advised of this error, the company corrected the form per K.S.A 40-2122 (f).

Claims

1. CRL needs to review their claim procedures to insure that claims are being processed in a timely fashion per K.S.A. 40-2442 (a)(1) and (a)(2).
2. CRL needs to review their claim procedures to insure that claims that are not processed within the time lines specified in the Prompt Pay Act, K.S.A. 40-2442, have interest paid according to K.S.A. 40-2442 (b).

SCOPE OF REVIEW

A targeted market conduct examination of CRL's, claims and complaints was completed to determine compliance with applicable statutes, regulations and bulletins of the state of Kansas. The examination was conducted according to the guidelines and procedures recommended in the NAIC Market Conduct Examiners Handbook.

The examination included, but was **not limited to the following:**

COMPANY OVERVIEW

Certificates of Authority

COMPLAINT HANDLING

Record Keeping

Timely Response

CLAIMS

Claim Processing

Use of Outside Pricing Entities

Timeliness and Accuracy of Claim Payment

Proper Maintenance of Claim Files

SUMMARY OF REVIEW

The market conduct examination focused on CRL. The testing and file review consisted of sampling from the Company's complaints and settled claim files in Strongsville, Oh.

The examination included a review of the Company's complaints and settled claim files from January 1, 2001 to March 31, 2003.

General topics were covered in Interrogatories submitted to the Companies for their written response. Subjects covered were Complaints, and Claims. The response received adequately addressed the issues presented.

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

History & Organization

CRL was originally incorporated in 1963 under the name American Central Reserve Life Insurance Company. In 1967 the name was changed to Central Reserve Life of North America Insurance Company. In 1967 the company was reorganized as Central Reserve Life Insurance Corporation (CRLC), with CRL as its principal operating subsidiary. In December of 1998 CRLC changed its name to Ceres Group, Inc. (Ceres). Ceres is a public company that has traded on NASDAQ since 1980.

CRL is an Ohio domiciled corporation that is authorized to transact business in 35 states. CRL offers small group, large group, association group and individual major medical insurance. Association group business is issued through Eagle Consumer Association, the situs of which is Illinois. Employer group business is issued through the International Professional Trust, this situs of which is Ohio.

CRL's products are marketed through a network of Managing General Agents and General Agents who work with more than 14,000 independent insurance agents.

Table 1 shows the organization of the Ceres group and its subsidiary Companies.

Table 2 shows the organization of the different departments within CRL

Tests for Company Operations/Management

Standard 7

Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. K.S.A. 40-222 (a), (b), (c) and (g).

The company provided the exam team with the necessary records and documents in a timely fashion.

Standard 8

The company is licensed for the lines of business that are being written. K.S.A. 40-216.

The Certificate of Authority was reviewed and found to be in order, and the company was complying with it.

Standard 9

The company cooperates on a timely basis with examiners performing the examinations. K.S.A. 40-222 (c) and (g).

The company was very cooperative and provided the exam team with the items requested within the time frames established for this exam.

COMPLAINTS

Company Complaint/Grievance Procedures

CRL's complaint/grievance procedures are explained in their "Kansas Appeal Procedure Coverage Rider" which is described below:

Regular Appeal

1st Level Appeal Process

2nd Level Appeal Process

Utilization Review (UR) Appeal – Adverse decision

If expedited follow 1st Level Appeal Process

If Standard Follow 2nd Level Appeal Process

External Review

ADVERSE DECISION APPEAL PROCESS

Levels of Review

The Insured Person may ask CRL to review its decisions involving his requests for service or request to have *his* claims paid within sixty (60) days of CRL's response to *the Insured Person*. In general, the following three levels of review will be available to the *Insured Person*:

Level 1 - Expedited Appeal Level

2 - Standard Appeal Level

3 - External Review

(1) Expedited Appeal (Level 1)

(a) Eligibility:

i. *The Insured Person* may request Expedited Appeal only when a denial of Certification is made before or during an ongoing service, and the attending health care provider or other ordering provider believes that the determination warrants immediate Appeal. The attending health care provider or other ordering provider may request Expedited Appeal by telephone [1-800-321-3997] or via facsimile [1-440-572-8858].

ii. *The Insured Person* may not request Expedited Appeal of a denied request for a service that has already been provided. Instead, *he* may start the review process by seeking Standard Appeal.

(b) Decision:

i. CRL shall review the supporting documentation and provide immediate access to a Peer Clinical Reviewer, including the documentation used in the original determination. After reviewing the supporting documentation, CRL shall notify the Insured Person and the treating or ordering physician immediately by telephone of its decision. Written notification shall be sent within one (1) working day.

ii. If the Expedited Appeal does not resolve a difference of opinion, the Insured Person or the provider acting on behalf of the Insured Person may request further review through the Standard Appeal process.

(2) Standard Appeal (Level 2)

(a) Eligibility:

i. *The Insured Person* may request Standard Appeal as a formal request to reconsider a denial of the Certification of an admission, extension of stay, or other health care service. *He* may also request Standard Appeal for further review of your Expedited Appeal. *The Insured Person* may request Standard Appeal either in writing or by telephone to the following:

Standard Appeal
Central Reserve Life Insurance Company
17800 Royalton Road
Cleveland, Ohio 44136
1-800-321-3997

(b) Decision

i. CRL or its authorized Utilization Review Organization shall request copies of part or all of the clinical records or a written statement from the attending health care provider or other ordering provider as deemed necessary in order to review the Appeal. Prior to upholding any denial, the Appeal will be referred to a Peer Clinical Reviewer who was not involved in the original denial for review.

ii. In the absence of any contractual agreement, CRL shall notify the Insured Person, attending health care provider or other ordering provider, in writing, of its determination on the Appeal as soon as practical, but in no event later than thirty (30) days, after receiving all required documentation.

iii. If the Standard Appeal does not resolve a difference of opinion, the Insured Person or the provider acting on behalf of the Insured Person may request further review through the External Review process.

iv. CRL shall notify the Insured Person, attending health care provider or other ordering provider of their right to file External Review.

(3) External Review (Level 3)

(a) Eligibility:

If dissatisfied with the Standard Appeal, the Insured Person, treating physician, health care provider acting on behalf of the Insured Person (with written authorization), or a legally authorized designee of the Insured Person, may request External Review within ninety (90) days after the date of receipt of notice of the Standard Appeal Adverse Decision. *The Insured Person* may also request External Review if CRL agrees to waive the Standard Appeal process or if CRL has failed to respond to *his* Standard Appeal within sixty (60) days (except to the extent that the delay was requested by the Insured Person). In the case of an Emergency Medical Condition, your External Review shall be considered on an expedited basis. Requests for External Review should be sent to:

Kansas Department of Insurance Commissioner of Insurance
420 S.W. 9th Street
Topeka, Kansas 66612-1678
1-800-432-2484

(b) Decision

i. The External Review shall be assigned by the Commissioner to an approved External Review Organization to conduct the External Review.

ii. The Insured Person is required to provide the Commissioner of Insurance with an Appeal form and a fully executed release for the Commissioner and the External Review Organization authorizing them to obtain any medical records deemed necessary for the determination of benefits.

iii. Within seven (7) business days CRL or its authorized Utilization Review Organization shall provide the Commissioner of Insurance with documents and information they wish the External Review Organization to consider in making its decision. The Commissioner will conduct a preliminary review and, if the case qualifies for External Review, it will be assigned to an External Review Organization. In addition to such documents, the External Review Organization shall consider the following documents in making its determination:

- [a] The Insured Person's pertinent medical records;
- [b] The attending health care professional's recommendation;
- [c] Consulting reports from appropriate health care professionals;
- [d] The terms of coverage under the insurance plan;
- [e] The most appropriate practice guidelines, including generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government and national or professional medical societies, boards, and associations; and
- [f] Any applicable clinical review criteria developed and used by CRL or its authorized Utilization Review Organization.

iv. Within thirty (30) business days of receipt of the request for External Review, the External Review Organization shall provide notice to the Insured Person or their authorized representative, CRL, and the Commissioner of its decision to uphold or reverse the Adverse Decision. Notification shall include:

- [a] A general description of the reason for the request for External Review;
- [b] The date the External Review was conducted;
- [c] The date of the External Review Organization's decision;
- [d] The rationale for the External Review Organization's decision; and
- [e] References, as needed, to the evidence or documentation, including the practice guidelines that the External Review Organization considered in reaching its decision.

v. In the case of an expedited External Review, the External Review Organization shall within seven (7) business days after the date of receipt of the request for External Review, make a decision to uphold or reverse the Adverse Decision. Notification of the decision shall be sent to the Insured Person, their authorized representative, CRL and the Commissioner. If the initial notification is not in writing, within two (2) days of its decision the External Review Organization shall provide written confirmation of its decision.

vi. CRL must provide benefits as determined by the External Review Organization, subject to the terms, limitations, and conditions of the certificate.

Tests for Complaint/Grievance Handling

Standard 1

All complaints are recorded in the required format on the company complaint register. K.S.A. 40-2404 (10).

The complaint register was up to date and complete with the required columns from the Kansas statutes and CRL complaint/grievance procedures.

Standard 2

The company has adequate complaint handling procedures in place and communicates such procedures to policyholders. K.A.R. 40-1-34 (5)(a) & (6).

The procedures written into company policy are adequate and provide control of the complaint/grievance timelines by one department and one assigned person. Generally, these procedures work quite well.

Standard 3

The company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. K.A.R. 40-1-34 (6).

The company met this standard. See Standard 4.

Standard 4

The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations. KAR 40- 1-34 (6) & (8a&c).

2001 Complaints/Grievance

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
DOI complaints	23	1	96.7%
1 st Level complaints	25	0	100.0%
2 nd Level complaints	8	1	87.5%

2002 Complaints/Grievance

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
DOI complaints	25	0	100.0%
1 st Level complaints	25	0	100.0%
2 nd Level complaints	10	2	80.0%
Total Complaints Reviewed	117	4	97%

117 complaints were reviewed at CRL’s headquarters. Timelines required by Kansas Regulations were met for the most part. One response to the Kansas Insurance Department took 23 working days instead of the required 15 working days. This is in violation of KAR 40-1-34 Sec 6.

There were 3 complaints where the company exceeded 30 days at 2nd level of complaint. “CRL shall notify the Insured Person, attending health care provider or other ordering provider, in writing, of its determination on the Appeal as soon as practical, but in no

event later than thirty (30) days, after receiving all required documentation.” This is in violation of the company’s insurance policy and K.A.R. 40-1-34, Sec 7, Sec 8(a) & 8(c).

Recommendations:

1. While the response times were within KID’s tolerances, the exam team feels that the company should review their complaint handling procedures so everyone is aware of the response times required for the different levels of complaints.

CLAIMS

Company claim processing procedures:

Tests for Claims (See Appendix I for the wording of the appropriate statute or regulation)

Standard 1

The initial contact by the company with the claimant is within the required time frame. K.A.R. 40-1-34, Sec 6(a) & (d); K.S.A. 40-2442 (a)(1), (a)(2) and (b).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Un-Paid	100	0	100%
Paid	99	0	100%

The Company passed Standard 1.

Standard 2

Investigations are conducted in a timely manner. K.A.R. 40-1-34, Sec. 7 & Sec. 8(c); K.S.A. 40-2442 (a)(1), (a)(2) and (b).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Un-Paid	100	11	89%
Paid	99	12	88%

The Company failed Standard 2.

For un-paid claims. – There were 12 files that were not adjudicated and paid within 30 days per K.A.R. 40-11-34, Sec 7 and K.S.A. 40-2442(a). From the sample, 10 cases were from 2001, and 1 was from 2002.

For paid claims. – There were 11 files that were not adjudicated and paid with in 30 days per K.A.R. 40-11-34, Sec 7 and K.S.A. 40-2442 (a). Out of the sample of errors, 4 claims were from 2002 and the remainders were from prior years.

Standard 3

Claims are resolved in a timely manner. K.A.R. 401-34 Sec. 8(a) & 8(c); K.S.A. 40-2442(a)(1), (a)(2) and (b).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Un-Paid	100	11	89%
Paid	99	12	88%

The Company failed Standard 3. See the comments under Standard 2.

Standard 4

The company responds to claim correspondence in a timely manner. K.A.R. 40-1-34, Sec. 6(a) and 6(d); K.S.A. 40-2442(a)(1), (a)(2) and (b).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Un-Paid	100	11	89%
Paid	99	12	88%

The Company failed Standard 4. See the comments under Standard 2.

Standard 5

Claim files are adequately documented. K.A.R.40-1-34 Sec.4, Sec. 6(a) & Sec. 8(b).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Un-Paid	100	0	100%
Paid	99	0	100%

The Company passed Standard 5.

Standard 6

Claims are properly handled in accordance with policy provisions HIPAA and state law. K.A.R. 40-1-34, Sec. 5(a), Sec. 8, &K.S.A. 40-2442(a) (1), (a)(2) and (b).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Un-Paid	100	4	96%
Paid	99	3	97%

The Company passed Standard 6.

For un-paid claims - There were 2 coding errors per 40-1-34 5a. On a portion of 2 claims where there was a payment made late, the interest was not calculated per K.S.A. 40-2442 (b).

For paid claims - There were 3 claims where there was a payment made late, the interest was not calculated per K.S.A. 40-2442 (b).

Standard 7

Company claim forms are appropriate for the type of product.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
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Un-Paid	100	0	100%
Paid	99	0	100%

The Company passed Standard 9.

Standard 8

Claim files are reserved in accordance with the company's established procedures.

The exam team did not specifically test for this standard.

Standard 9

Denied and closed-without-payment claims are handled in accordance with policy provisions, HIPPA and state law. K.A.R. 40-1-34, Sec. 8(a) & 8(c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Un-Paid	100	0	100%

The Company passed Standard 9.

Standard 10

Canceled benefit checks and drafts reflect appropriate claim handling practices. KAR 40-1-34 5(f).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Un-Paid	99	0	100%

The Company passed Standard 10.

Standard 11

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. K.S.A. 40-2404 9(f) and (9)(g)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Un-Paid	100	0	100%
Paid	99	0	100%

The Company passed Standard 11.

Standard 12

The company complies with the requirements of The NewBorns' and Mothers' Health Protection Act of 1996. K.S.A. 40-2,102

This standard was not specifically tested for. In the normal review of the 100 un-paid and 99 paid claims, any maternity claims would have been reviewed and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 13

The group health plan complies with the requirements of the Mental Health Parity Act of 1996 (MHPA). K.S.A. 40-2,105(a)

Separate from the exam but observed by the exam team in several of the sample files, the company had additional language in their contracts that had been filed and approved and was interpreting it inconsistent with how KID viewed K.S.A. 40-2,105 (a) - Mental Health Parity Act. The company and KID came to an agreement on the policy language, and the company has re-filed their policies to correct the contracts on a going forward basis for claims incurred beginning 7/1/03.

Recommendations:

1. CRL needs to review their claim procedures to insure that claims are being processed in a timely fashion per K.S.A. 40-2442 (a)(1)and (a)(2).
2. CRL needs to review their claim procedures to insure that claims that are not processed with in the time lines specified in the Prompt Pay Act, K.S.A. 40-2442, have interest paid according to K.S.A. 40-2442 (b).

GENERAL COMMENTS

Complaint Handling

1. While the response times were within KID's tolerances, the exam team feels that the company should review their complaint handling procedures so everyone is aware of the response times required for the different levels of complaints.

General

1. The new business rejection letter listed the old third party administrator as the contact for anyone interested in obtaining health insurance through the Kansas Health Insurance Assoc. When advised of this error, the company corrected the form per K.S.A 40-2122 (f).

Claims

1. CRL needs to review their claim procedures to insure that claims are being processed in a timely fashion per K.S.A. 40-2442 (a)(1) and (a)(2).

2. CRL needs to review their claim procedures to insure that claims that are not processed with in the time lines specified in the prompt Pay Act, KSA 40-2442, have interested paid according to K.S.A. 40-2442 (b)

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by the Ms. Sandra Pogozelski and the staff of CERES Insurance Group.

The following examiners of the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

Market Conduct Division

Lyle Behrens
Supervisor

Michael Grover
Market Conduct Examiner

Mary Lou Maritt
Market Conduct Examiner

Respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM

CERES GROUP, INC.
EIN# 34-1017531

Central Reserve Life
EIN# 34-0970995
NAIC# 61727 OH

Continental General Corp.
EIN # 47-0717079

**Provident American
Life & Health Ins Co**
EIN# 23-1335885
NAIC# 67903 OH

**United Benefit
Life Ins Co**
EIN# 75-2305400
NAIC# 65269 OH

**Continental
General Ins. Co.**
EIN# 47-0463747
NAIC# 71404 NE

**Ceres Administrators
LLC**
EIN # 34-1880408

**Ceres Health
Care Inc.**
EIN # 34-1915295

**Ceres Sales
LLC**
EIN # 34-1947043

QQLink.com, Inc
EIN # 34-1937200

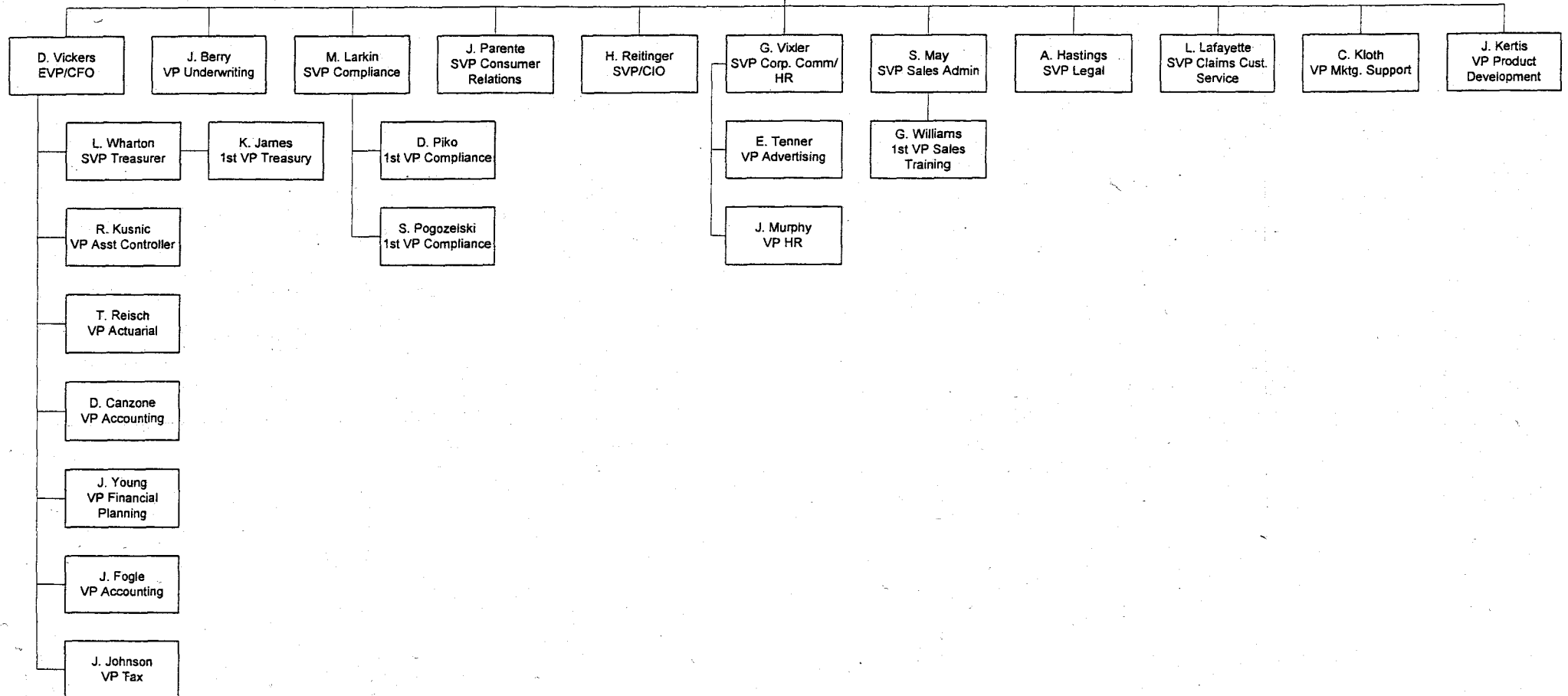
**The Pyramid Life
Insurance Co**
EIN # 48-0557726
NAIC # 68284 -KS

SOLD
3/31/03

CRL Organizational Chart

May 1, 2003

George Gehring
President



APPENDIX I

A. K.A.R. 40-1-34 - Unfair claims practices provides for the following guidelines to be met in the processing and investigation and settlement/denial of a claim:

- Definitions, Sec. 3
- File and Record Documentation, Sec. 4
- Misrepresentation of Policy Provisions, Sec. 5
- Failure to Acknowledge to Pertinent communication, Sec. 6
- Standards for Prompt Investigation of Claims, Sec. 7
- Standards for Prompt, Fair and Equitable Settlements Applicable to all Insurers, Sec. 8
- Standards for Fair and Equitable Settlements Applicable To Auto Insurance, Sec. 9

- Kansas Automobile Injury Reparations Act (Payment of Benefits). K.S.A. 40-3110
- Unfair methods of competition or unfair and deceptive acts or practices. KSA 40-2404
- Interest Due On Insurance Settlements. KSA 40-2,126

1. K.A.R. 40-1-34 Sec. 3. Definitions

The definitions of "person" and of "insurance policy or insurance contract" contained in section 2 of the Unfair Trade Practice Act shall apply to this regulation and, in addition, where used in this regulation:

(a) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insure with respect to a claim;

(b) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

(c) "First party claimant" means an individual, corporation, association, or partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;

(d) "Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract in this State.

(e) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

(f) "Notification of claim" mean any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(g) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer; and

(h) "Worker's Compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.

2. K.A.R. 40-1-34 Sec. 4 - File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his/her duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

3. K.A.R. 40-1-34 Sec. 5. Misrepresentation of Policy Provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(c) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(d) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(e) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

4. K.A.R. 40-1-34 Sec. 6 - Failure to Acknowledge Pertinent Communications:

(a) Every insurer, upon receiving notification of a claim shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(b) Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within ten working days of notification of a claim shall constitute compliance with subsection (a) of this section.

5. K.A.R. 40-1-34 Sec. 7 - Failure to Acknowledge Pertinent Communications

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time.

6. K.A.R. 40-1-34 Sec. 8 - Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

(a) Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(b) If a claim is denied for reasons other than those described in paragraph (a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(c) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(d) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(e) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without

giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.

(f) No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

(g) An insurer shall not attempt to settle a loss with a first party claimant on the basis of a cash settlement which is less than the amount the insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

B. KSA 40-2404. Unfair methods of competition or unfair and deceptive acts or practices; disclosure of nonpublic personal information; rules and regulations. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

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

C. KSA 40-2442 Same; claims; procedures; rules and regulations.

(a) Within 30 days after receipt of any claim, and amendments thereto, any insurer issuing a policy of accident and sickness insurance shall pay a clean claim for reimbursement in accordance with this section or send a written or electronic notice acknowledging receipt of and the status of the claim. Such notice shall include the date such claim was received by the insurer and state that:

(1) The insurer refuses to reimburse all or part of the claim and specify each reason for denial; or

(2) additional information is necessary to determine if all or any part of the claim will be reimbursed and what specific additional information is necessary.

(b) If any insurer issuing a policy of accident and sickness insurance fails to comply with subsection (a), such insurer shall pay interest at the rate of 1% per month on the amount of the claim that remains unpaid 30 days after the receipt of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest

D. KSA 40-2,126. Interest Due On Insurance Settlements,

Except as otherwise provided by K.S.A. 40-447, 40-3110 and 44-512a, and amendments thereto, each insurance company, fraternal benefit society and any reciprocal or interinsurance exchange licensed to transact the business of insurance in this state which fails or refuses to pay any amount due under any contract of insurance within the time prescribed herein shall pay interest on the amount due. If payment is to be made to the claimant and the same is not paid within 30 calendar days after the amount of the payment is agreed to between the claimant and the insurer, interest at the rate of 18% per annum shall be payable from the date of such agreement. If payment is to be made to any other person for providing repair or other services to the claimant and the same is not paid within 30 calendar days following the date of completion of such services and receipt of the billing statement, interest at the rate of 18% per annum shall be payable on the amount agreed to between the claimant and the insurer from the date of receipt of the billing statement.