ALERT
APRIL 28, 2011

GLOBAL INSURANCE GROUP
News Concerning
Recent Insurance Coverage and Regulatory Law

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John Hancock Financial's Settlement With California Highlights The Tension Between Compliance With The Law And Evolving Best Practice Standards

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On April 22, 2011 California's State Controller John Chiang announced a landmark settlement with John Hancock Financial (Hancock), a subsidiary of Manulife Financial Corporation. The settlement was the outcome of an investigation, commenced in July 2008, of 21 insurance companies relating to allegations that, under a decades-old, industry-wide practice, companies have failed to pay death benefits to the beneficiaries of life insurance policies. The settlement highlights that changing consumer expectations as well as advances in technology have created a very different atmosphere in which life and annuity insurers must now operate.

The controller's investigation of the insurers began under its authority to collect unclaimed property. The doctrine of escheat, at common law, prevented unclaimed property from being left in limbo by destroying, through operation of law, (unclaimed) ownership, which would then "escheat" to the state. Today, most U.S. jurisdictions have escheat statutes that require companies, typically financial institutions that hold money or property, to report and turn over to the state unclaimed property, such as bank accounts, payroll checks, insurance benefits, or company stock. Depending on the jurisdiction, companies may hold the unclaimed property during a "dormancy period," varying from three to ten years, or more.

California's investigation of Hancock, however, was not based on the carrier's failure to report or turn over unclaimed property. Rather, during a routine audit, the controller raised concerns as to whether Hancock was engaged in unacceptable business practices because, after an insured ceased making premium payments, the company did not affirmatively take steps to ascertain whether the insured was deceased before it applied the cash value of the policy to continue the stream of premium payments. In an example cited by the controller, Hancock issued a life policy incepting in 1963. The policyholder died 37 years later and no claim was made for benefits under the policy. After the first missed premium payment, Hancock began deducting premium from the policy's cash reserve to keep the insurance in force. Those cash reserves were depleted in 2009 and the policy terminated. No benefits were ever paid and no unclaimed benefits ever reported to the controller.

The process, cited by the controller as an example of abuse, is a common feature of life insurance policies. Life insurance policies are typically of long term or even indefinite duration. Many life products, such as whole or universal life, may necessitate little or no contact with a policyholder after inception. In order to protect policyholders from unintended lapse, many contracts require premiums be paid from the accumulated values of a policy. Termination of a whole or universal life policy may deprive a policyholder of accumulated value *i.e.,* value equal to more than simply the coverage provided. As a consequence, such policies often pay premium from the policy value to prevent termination through neglect or oversight. By contrast, term life policies paid by installment cease upon the policyholder's failure to pay premium and at termination the policyholder has received all the coverage (and value) for which he has paid.

Hancock argued that its activities did not violate California law. Following common industry practice, Hancock took the position its potential obligation to pay a death claim was triggered only after the beneficiaries or estate made a claim for benefits under the policy and it had no legal or contractual duty to affirmatively take steps to investigate whether a non-paying insured was, or was not, deceased. However, in challenging the historic practice, the controller cited Hancock's routine practice of verifying the death of persons receiving disability benefits (where the death would

cause the cessation of benefit payments), but taking no steps to employ those same means for life policies (where a death would trigger a benefit payment).

In the settlement Hancock agreed to (i) restore the full value of more than 6,400 accounts where the insurer could show little or no effort to contact beneficiaries; (ii) create (as yet unspecified) methods for identifying deceased policyholders and their beneficiaries; (iii) cooperate with the controller's efforts to reunite more than $20 million in death benefits with their owners or heirs; and (iv) pay California 3 percent compounded interest on the value of the amounts held since 1995. In addition to the California settlement, Hancock also settled with 21 other states and the District of Columbia.

The settlement demonstrates that life and annuity insurers should follow best practices that exceed the minimum requirements established under the letter of the law. Given technological advances that reduce or eliminate the historical burden of identifying whether a lapsed policy is indicative of the death of the insured, there is an evolving expectation by government agencies, regulators, and consumers that insurers make all reasonable efforts to unite benefit payments and their recipients.

To discuss any questions you may have regarding the issues discussed in this alert, or how they may apply to your particular circumstances, please contact Robert Tomilson at 215.665.5587 or rtomilson@cozen.com, or Linda Kaiser Conley at 215.665.2099 or lconley@cozen.com.