



STATE OF NEW YORK INSURANCE DEPARTMENT
REPORT ON THE MARKET CONDUCT EXAMINATION
OF THE
AMERICAN INTERNATIONAL LIFE ASSURANCE COMPANY
OF NEW YORK

CONDITION:

DECEMBER 31, 2007

DATE OF REPORT:

JANUARY 30, 2009

STATE OF NEW YORK INSURANCE DEPARTMENT
REPORT ON MARKET CONDUCT EXAMINATION
OF THE
AMERICAN INTERNATIONAL LIFE ASSURANCE COMPANY OF NEW YORK
AS OF
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EXAMINER:

MARC A. TSE

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

David A. Paterson
Governor

James J. Wrynn
Superintendent

May 27, 2010

Honorable James J. Wrynn
Superintendent of Insurance
Albany, New York 12257

Sir:

In accordance with instructions contained in Appointment No. 30297, dated January 15th 2008, and annexed hereto, an examination has been made into the market conduct activities of American International Life Assurance Company of New York hereinafter referred to as "the Company," or "AIL," at its office located at 3600 Route 66, Neptune, NJ 07753.

Wherever "Department" appears in this report, it refers to the State of New York Insurance Department.

The report indicating the results of this examination is respectfully submitted.

1. EXECUTIVE SUMMARY

The material violations contained in this report are summarized below.

- The Company violated Section 403(d) of the New York Insurance Law and Section 86.4 of Department Regulation No. 95 by utilizing claim forms without the required frauds warning statement. (See Item 4 of this report)
- The Company violated Section 3224-a(a) of the New York Insurance Law by failing to pay all claims in a prompt manner (See Item 4 of this report)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2003 through December 31, 2007. As necessary, the examiner reviewed transactions occurring subsequent to December 31, 2007 but prior to the date of this report (i.e., the completion date of the examination).

The examination comprised a review of: market conduct activities and utilized the National Association of Insurance Commissioners' Market Regulation Handbook or such other examination procedures, as deemed appropriate, in such review.

The examiner reviewed the corrective actions taken by the Company with respect to the market conduct violations, recommendations and/or comments contained in the prior report on examination. The results of the examiner's review are contained in item 5 of this report.

This report on examination is confined to comments on matters which involve departure from laws, regulations or rules, or which require explanation or description.

3. DESCRIPTION OF COMPANY

A. History

The Company was incorporated as a stock life insurance company under the laws of New York on March 16, 1962, was licensed on November 28, 1962 and commenced business on November 28, 1962. Initial resources of \$2,000,000, consisting of common capital stock of \$1,000,000 and paid in and contributed surplus of \$1,000,000, were provided through the sale of 10,000 shares of common stock (with a par value of \$100 each) for \$200 per share.

As of December 31, 2007 AIL had 16,125 shares of issued and outstanding common stock with a par value of \$200 per share. Capital and paid in and contributed surplus were \$3,225,000 and \$244,198,007, respectively, as of December 31, 2007. The Company paid cash dividends to its shareholders of \$50,000,000, \$62,000,000 and \$100,000,000 in 2005, 2006 and 2007 respectively.

Prior to December 18, 2007, American International Group, Inc, ("AIG"), held 78% of the outstanding stock of AIL and the remaining 22% was held by AIG's New York subsidiary, American Home Assurance Company ("AHAC"). On December 31, 2007 AHAC sold its 22% share to AIG effective December 18, 2007. AIG then contributed 100% of the shares to AIG Life Holdings, which in turn contributed all the shares to AGC Life Insurance Company, ("AGC Life"), a Missouri company, making AGC Life the sole shareholder of AIL as of December 31, 2007.

B. Territory and Plan of Operation

The Company is authorized to write life insurance, annuities and accident and health insurance as defined in paragraphs 1, 2 and 3 of Section 1113(a) of the New York Insurance Law.

The Company is licensed to transact business in all states, except Arizona, Connecticut, Maryland and the District of Columbia.

In 2007, 53.6% of life premiums, 25.0% of accident and health premiums, and 65.1% of annuity considerations were received from New York. Policies are written on a non-participating basis.

The Company's major product is a single premium immediate annuity, which it markets as a structured settlement and terminal funding vehicle.

The Company's agency operations are conducted on a general agency basis.

4. MARKET CONDUCT ACTIVITIES

The examiner reviewed various elements of the Company's market conduct activities affecting policyholders, claimants, and beneficiaries to determine compliance with applicable statutes and regulations and the operating rules of the Company.

Based upon the sample reviewed, no significant findings were noted.

A. Advertising and Sales Activities

The examiner reviewed a sample of the Company's advertising files and the sales activities of the agency force including trade practices, solicitation and the replacement of insurance policies.

B. Underwriting and Policy Forms

The examiner reviewed a sample of new underwriting files, both issued and declined, and the applicable policy forms.

Based upon the sample reviewed, no significant findings were noted.

C. Treatment of Policyholders

The examiner reviewed a sample of various types of claims, surrenders, changes and lapses. The examiner also reviewed the various controls involved, checked the accuracy of the computations and traced the accounting data to the books of account.

1. Section 403(d) of the New York Insurance Law states, in part:

"All applications for commercial insurance, individual, group or blanket accident and health insurance and all claim forms...shall contain a notice in a form approved by the superintendent that clearly states in substance the following:

'Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Pursuant to Section 403(d) of the New York Insurance Law, the Superintendent promulgated Section 86.4 of Department Regulation No. 95, which states in part:

“(a) . . . all claim forms for insurance, and all applications for commercial insurance and accident and health insurance, provided to any person residing or located in this State in connection with insurance policies for issuance or issuance for delivery in this State, shall contain the following statement:

‘Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.’ . . .

(e) . . . insurers may use substantially similar warning statements provided such warning statements are submitted to the Insurance Frauds Bureau for prior approval.”

A review of 20 paid death claim files revealed 12 instances where the frauds warning statement on the claim form was different from the language required under Section 403(d) of the New York Insurance Law and Section 86.4 of Department Regulation No. 95; the disparate language was not submitted to the Insurance Frauds Bureau for prior approval. The remaining death claim forms reviewed did not have any frauds statement required by Section 403(d).

The Company violated Section 403(d) of the New York Insurance Law and Section 86.4 of Department Regulation No. 95 by utilizing claim forms without the required frauds warning statement.

The examiner recommends that the Company utilize claim forms with the required frauds warning language and if the Company uses language which varies from the required frauds warning language, that the Company obtain prior approval from the Frauds Bureau before the use of such language.

2. Section 3224-a (a) of the New York Insurance Law states, in part:

In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to articles thirty-two, forty-two . . . and all bills for health care services rendered by health care providers pursuant to such contracts or agreements, any insurer or . . . shall adhere to the following standards:

(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information

available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered.."

The review of a sample of 20 health claim files revealed 3 (15%) cases whereby the Company failed to pay the claim within the required 45 days of receipt of the claim.

The Company violated Section 3224-a (a) of the New York Insurance Law by failing to pay all claims in a prompt manner.

5. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following are the market conduct violations and recommendations contained in the prior report on examination and the subsequent actions taken by the Company in response to each citation:

<u>Item</u>	<u>Description</u>
A	<p>The Company violated Section 3214(c) of the New York law by not paying interest from date of death to date of payment on certain death claims.</p> <p>The review of a sample of death claims indicated that the Company paid interest from the date of death to the date of payment.</p>
B	<p>The examiner recommends that the Company pay the correct amount of interest on all five death claims identified by the examiner during the examination, and review all death claims paid since January 1, 1999 to determine whether interest was paid correctly and to pay the correct interest to claimants in those instances where incorrect amounts were paid.</p> <p>The Company paid additional interest to correct the five death claims identified by the examiner, reviewed the claims paid during the prior examination period and made additional interest payments to correct the interest amounts.</p>
C	<p>The examiner recommends that the Company investigate all Life Benefit accounts that have been dormant a minimum of three years in order to determine if any account(s) should be reported as unclaimed funds and eventually remitted to the appropriate state(s).</p> <p>The Company reviewed the dormant accounts and identified accounts for the purpose of escheatment.</p>
D	<p>The examiner recommends that the Company include as part of its "Proof of Death – Claimant's Statement" form, or through some other method of disclosure, the option of a settlement check for the full death benefit amount when proceeds are \$10,000 or greater.</p> <p>The review of claim forms indicated that the Company properly disclosed the option of obtaining a lump sum benefit.</p>

6. SUMMARY AND CONCLUSIONS

Following are the violations and recommendation contained in this report:

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
A	The Company violated Section 403(d) of the New York Insurance Law and Section 86.4 of Department Regulation No. 95 by utilizing claim forms without the required frauds warning statement.	6
B	The examiner recommends that the Company utilize claim forms with the required frauds warning language and if the Company uses language which varies from the required frauds warning language, that the Company obtain prior approval from the Frauds Bureau before the use of such language.	6
C	The Company violated Section 3224-a (a) of the New York Insurance Law by failing to pay all claims in a prompt manner.	7

Respectfully submitted,

_____/s/_____
Marc A. Tse
Associate Insurance Examiner

STATE OF NEW YORK)
)SS:
COUNTY OF NEW YORK)

Marc A. Tse, being duly sworn, deposes and says that the foregoing report, subscribed by him, is true to the best of his knowledge and belief.

_____/s/_____
Marc A. Tse

Subscribed and sworn to before me

this _____ day of _____

APPOINTMENT NO. 30297

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, ERIC R. DINALLO, Superintendent of Insurance of the State of New York,
pursuant to the provisions of the Insurance Law, do hereby appoint:

MARC TSE

as a proper person to examine into the affairs of the

AMERICAN INTERNATIONAL LIFE ASSURANCE COMPANY OF NEW YORK

and to make a report to me in writing of the condition of the said

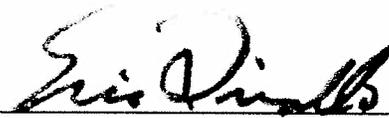
COMPANY

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by name
and affixed the official Seal of the Department
at the City of New York

this 4th day of February, 2009

ERIC R. DINALLO
Superintendent of Insurance


Superintendent

