



STATE OF NEW YORK INSURANCE DEPARTMENT
REPORT ON MARKET CONDUCT EXAMINATION
OF THE
AXA EQUITABLE LIFE INSURANCE COMPANY

CONDITION:

DECEMBER 31, 2005

DATE OF REPORT:

MARCH 8, 2007

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OF THE
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AS OF
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EXAMINER:

ANTHONY MAURO
EDEN SUNDERMAN

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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

September 17, 2009

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

Sir:

In accordance with instructions contained in Appointment No. 30200, dated September 24, 2008 and annexed hereto, an examination has been made into the market conduct activities of AXA Equitable Life Insurance Company, hereinafter referred to as “the Company” or “AXA Equitable,” at its home office located at 1290 Avenue of the Americas, New York, New York, 10104.

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 findings and violations contained in this report are summarized below.

- The Company violated Section 4226(b) of the New York Insurance Law and certain sections of Department Regulation No. 60. The Company failed to: use comparisons that conform to all the requirements established by the Superintendent by Regulation, reduce the surrender values and death benefit values for the hypothetical rates of return on the Appendix 10B Disclosure Statements by investment fund level charges during the examination period and examine the Appendix 10B Disclosure Statements for variable annuity replacements and ascertain that they were accurate and met the requirements of the New York Insurance Law and Department Regulation No. 60; uniformly provide revised Appendix 10A Disclosure Statements where the insurance policy issued differed from the policy applied for; uniformly provide composite Appendix 10A Disclosure Statements where more than one existing policy was being replaced; and uniformly correct deficiencies involving Appendix 10A Disclosure Statements or reject the application within the 10 day time frame allowed by Department Regulation No. 60. (See item 4A of this report)
- The Company violated Section 3201(b)(1) of the New York Insurance Law by using an unapproved policy form in connection with its group variable annuity business (Equi-Vest product). (See item 4B of this report)
- The Company violated Section 2611(a) of the New York Insurance Law by failing to obtain written informed consent prior to subjecting applicants to HIV-related testing. (See item 4B of this report)
- The Company violated Department Regulation No. 64 by failing to maintain certain documents in the annuity claim, surrender and accelerated death benefit claim files and to maintain information necessary to reconstruct claims. (See item 4C of this report)
- The Company violated Section 3230 of the New York Insurance Law and Department Regulation No. 64 with regards to the claim processing for accelerated benefits. (See item 4C of this report)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2001 through December 31, 2005. As necessary, the examiner reviewed transactions occurring subsequent to December 31, 2005 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 Conduct Examiners 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 contained in the prior report on examination. The results of the examiner's review are contained in item 7 of this report.

This report on examination is confined to comments on those 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 on July 26, 1859, under the laws of the State of New York as a stock life insurance company and commenced business on July 28, 1859 under the name Equitable Life Assurance Society of the United States. In 1917, the Company commenced the process to become a mutual life insurance company. The Company completed its conversion to a mutual company in 1925.

On July 22, 1992, the Company demutualized and converted back to a stock life insurance company and became a wholly-owned subsidiary of The Equitable Companies Incorporated (hereinafter referred to as “EQ”). In connection with the demutualization, the Company’s eligible policyholders received cash, policy credits or common stock of EQ. At demutualization on July 22, 1992, AXA, a French holding company for an international group of insurance and related financial services companies, became the owner of 49% of EQ’s common shares outstanding as well as the owner of convertible preferred stock in exchange for a \$1 billion investment. On December 19, 1994, EQ exchanged all its outstanding redeemable preferred stock and substantially all of its convertible preferred stock for common stock, a new series of convertible preferred stock and convertible debentures. As a result, AXA’s ownership percentage of EQ as of December 31, 1995 increased to 60.6%.

On September 3, 1999, EQ changed its name to AXA Financial, Inc. (“AXA Financial”).

In 1999, AXA Client Solutions, LLC (“Client Solutions”) was formed as a wholly-owned direct subsidiary of AXA Financial. At the same time, AXA Financial contributed to Client Solutions all of the Company’s common stock, making Client Solutions the direct parent of the Company.

On August 30, 2000, AXA Financial received a proposal from AXA for the acquisition of all of the outstanding common shares of AXA Financial not owned by AXA. On January 2, 2001, AXA completed its acquisition of the remaining minority interest in AXA Financial.

On January 1, 2002, Client Solutions distributed all of the Company’s common stock to AXA Financial, thereby making AXA Financial the direct parent of the Company. On April 22, 2002, Client Solutions changed its name to AXA Financial Services, LLC. Effective June 1,

2002, AXA Financial transferred ownership of the Company back to AXA Financial Services, LLC thereby making it once again the direct parent of the Company.

Effective September 7, 2004 the Company, formerly known as The Equitable Life Assurance Society of the United States, changed its name to AXA Equitable Life Insurance Company.

Effective November 7, 2007 AXA Financial Services, LLC changed its name to AXA Equitable Financial Services, LLC.

B. Territory and Plan of Operations

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 50 states, the District of Columbia, Puerto Rico, Canada, and the United States Virgin Islands. Policies are written on both a participating and non-participating basis.

The Company offers a portfolio of insurance products, including individual variable and interest sensitive life insurance products and individual and group variable annuity products. The Company also sells traditional whole life insurance, universal life insurance, term insurance products, and annuities with guaranteed death benefits. Variable annuity products and variable life insurance products in separate accounts accounted for 77.6% and for 45.8% of the total direct premiums and deposits respectively, for the year ending 2005.

The following tables show the percentage of direct premiums received, by state, and by major lines of business as reported in Schedule T of the annual statement for the year 2005:

<u>Life Insurance Premiums</u>		<u>Annuity Considerations</u>	
New York	13.8%	New York	11.0%
California	10.2	Florida	8.5
Florida	6.7	California	7.2
New Jersey	6.4	New Jersey	6.7
Pennsylvania	<u>5.5</u>	Texas	<u>6.4</u>
Subtotal	42.6%	Subtotal	39.8%
All others	<u>57.4</u>	All others	<u>60.2</u>
Total	<u>100.0%</u>	Total	<u>100.0%</u>

<u>Accident and Health Insurance Premiums</u>		<u>Other Considerations</u>	
New York	23.7%	New York	21.0%
New Jersey	9.2	Pennsylvania	16.4
California	8.8	District of Columbia	6.1
Pennsylvania	8.4	Illinois	<u>5.2</u>
Florida	<u>6.8</u>		
Subtotal	56.9%	Subtotal	48.7%
All others	<u>43.1</u>	All others	<u>51.3</u>
Total	<u>100.0%</u>	Total	<u>100.0%</u>

The Company's retail operations are conducted through an affiliated general agency and an affiliated wholesale broker/dealer. Annuity and life insurance products are issued directly to the public through financial professionals associated with AXA Network and AXA Advisors. As of December 31, 2005, approximately 5,980 financial professionals were associated with AXA Advisors and AXA Network. AXA Equitable has entered into agreements pursuant to which it compensates AXA Advisors and AXA Network for distributing and servicing AXA Equitable's products.

The Company's wholesale operations of its annuity and life insurance products are conducted through AXA Distributors, LLC ("ADL"). Annuity products are distributed through third-party national and regional securities firms, independent financial planning and other broker-dealers and banks. Sales of annuities through ADL accounted for 52.3% of the total premiums and deposits in 2005. Life insurance products are distributed through third-party brokerage general agencies.

The Company exited the accident and health line of business in the mid 1990s.

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.

A. Advertising and Sales Activities

Advertising

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

Section 219.4(p) of Department Regulation No. 34-A states, in part:

“An advertisement shall not use a trade name, an insurance group designation, name of the parent company or affiliate of the insurer . . . or reference if such use would have the tendency to mislead or deceive as to the true identity of the insurer, or create the impression that someone other than the insurer would have any responsibility for the financial obligation under a policy.”

The examiner's review of a sample of advertisements revealed that eleven advertisements disseminated in New York make reference and call attention to the assets under management of the AXA Group and an affiliate without also containing a statement of the assets under management of the Company. The use of these advertisements is potentially misleading by showing the assets under management of the parent or affiliate without showing the Company's separate assets under management.

The examiner recommends, and the Company agreed to, either add a statement to these advertisements showing the assets under management of the Company or cease use of these advertisements.

Section 219.5(a) of Department Regulation No. 34-A states:

“Each insurer shall maintain at its home office a complete file containing a specimen copy of every printed, published or prepared advertisement hereafter disseminated in this state, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. In order to be complete, the file must contain all advertisements whether used by the company, its agents or solicitors or other persons. That portion of the advertising file which has been covered by a filed report on examination may be eliminated.”

The examiner’s review of a sample of advertising files revealed that information relating to the manner and extent of distribution for each advertisement was not maintained in the advertising files. Additionally, the Company was unable to produce information relating to the manner and extent of distribution upon request.

The Company violated Section 219.5(a) of Department Regulation No. 34-A by failing to maintain a notation relating to the manner and extent of distribution of certain advertisements.

Department Regulation No. 60

The examiner selected 74 life insurance replacements issued during the examination period for review of which 45 (61%) were external replacements. The examiner selected a sample of 45 annuity replacements for review of which 40 (90%) were external replacements. Due to the high error rate regarding date stamping on the Equi-Vest annuities, an additional sample of 12 annuity replacements was selected for review of date stamping only. This additional sample was not reviewed for compliance with other sections of Department Regulation No. 60.

The replacements were reviewed for compliance with Department Regulation No. 60 as well as the Company’s own written replacement procedures on file with the Department. The examiner noted inconsistencies in the Company’s processing of the selected replacements as well as deviations from Department Regulation No. 60. These inconsistencies and deviations are noted below.

1. Section 4226(b) of the New York Insurance Law states:

“Any comparison of the policies or contracts of any such insurer or insurers shall be deemed to be an incomplete comparison if it does not conform to all the requirements for comparisons established by the superintendent by regulation.”

Section 51.6(b) of Department Regulation No. 60 states, in part:

“Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall . . .

(3) Examine any proposal used, including the sales material used in the sale of the proposed life insurance policy or annuity contract, and the ‘Disclosure Statement,’ and ascertain that they are accurate and meet the requirements of the Insurance Law and this Part . . .”

With respect to annuity replacements, the Appendix 10B Disclosure Statement (annuity to annuity replacements) requires that the surrender values and death benefit values for the hypothetical rates of return on annuity contracts be reduced by investment fund level charges.

For variable annuity replacements during the examination period, the Company failed to reduce the surrender values and death benefit values for the hypothetical rates of return on the Appendix 10B Disclosure Statements by investment fund level charges as required by Department Regulation No. 60.

The Company violated Section 4226(b) of the New York Insurance Law and Section 51.6(b)(3) of Department Regulation No. 60 by failing to use comparisons that conform to all the requirements established by the Superintendent by regulation, reduce the surrender values and death benefit values for the hypothetical rates of return on the Appendix 10B Disclosure Statements by investment fund level charges and examine the Appendix 10B Disclosure Statements for the variable annuity replacements and ascertain that they were accurate and met the requirements of the New York Insurance Law and Department Regulation No. 60.

2. With respect to life replacements, the Appendix 10A Disclosure Statement (all replacements other than annuity to annuity) requires that a “composite comparison shall be completed for all existing life insurance policies or annuity contracts to all proposed life insurance policies or annuity contracts” where more than one policy is being replaced.

In 20 of 74 (27%) of the life replacements reviewed where more than one policy was being replaced; the Company failed to uniformly provide the required composite presentation

section of the Disclosure Statement, whereby the values of multiple existing policies or contracts are summed up and compared to the new policy or contract of the Company.

The Company violated Section 51.6(b)(3) of Department Regulation No. 60 in all cases where it failed to examine and ascertain that a composite Appendix 10A Disclosure Statement was required and to provide such in situations where more than one existing policy was being replaced.

3. Section 51.6(b) of Department Regulation No. 60 states, in part:

“Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall . . .

(7) Where the required forms are not received with the application, or if the forms do not meet the requirements of this Part or are not accurate, within ten days from the date of receipt of the application either have any deficiencies corrected or reject the application and so notify the applicant of such rejection and the reason therefore. In such cases, the insurer shall maintain any material used in the proposed sale, in accordance with the guidelines of Section 51.6(b)(6) herein . . .”

In 38 out of 74 (51%) life replacements reviewed the Disclosure Statement was incomplete or contained inaccuracies for either the proposed policy and/or the existing policy(ies). The deficiencies were neither identified by the Company nor corrected within ten days of receipt of the application and the Company did not reject the application.

In two additional life replacements reviewed, the required Disclosure Statement was provided to the applicant after the application was signed. In an additional life replacement, the agent failed to provide the applicant with the required Disclosure Statement.

The Company violated Section 51.6(b)(7) of Department Regulation No. 60 in all cases where it failed to correct deficiencies involving Appendix 10A Disclosure Statements or reject the application within ten days from date of receipt of the application.

4. Section 51.6(b) of Department Regulation No. 60 states, in part:

“Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall . . .

(9) In the event the life insurance policy or annuity contract issued differs from the life insurance policy or annuity contract applied for, ensure that the requirements of this Part are met with respect to the information relating to the life insurance policy or annuity contract as issued, including but not limited to the revised ‘Disclosure Statement,’ any revised or additional sales material used and acknowledgement by the applicant of receipt of such revised material.”

In 10 out of 74 (14%) life replacements reviewed the applicant should have received a revised Disclosure Statement where the insurance policy issued differed from the policy applied for.

The Company violated Section 51.6(b)(9) of Department Regulation No. 60 in all cases where it failed to provide a revised Appendix A Disclosure Statement when the insurance policy issued differed from the policy applied for.

5. Sections 243.2(b)(1) and (8) of Department Regulation No. 152 state, in part:

“(b) Except as otherwise required by law or regulation, an insurer shall maintain . . .

(1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this Part A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to Section 243.3(a) of this Part. A policy record shall include:

(i) The policy term, basis for rating, and return premium amounts, if any;
(ii) The application, including any application form or enrollment form for coverage under any insurance contract or policy;
(iii) The contract or policy forms issued including the declaration pages, endorsements, riders, and termination notices of the contract or policy. Binders shall be retained if a contract or policy was not issued; and
(iv) Other information necessary for reconstructing the solicitation, rating, and underwriting of the contract or policy . . .

(8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review.”

In 13 out of 74 (18%) life insurance replacements reviewed (nine internal and four external replacements), information to support the surrender and death benefit values used in the Appendix 10A Disclosure Statement for the existing life insurance was not maintained in the policy record.

The Company violated Section 51.6(b)(3) of Department Regulation No. 60 in the cases where it failed to examine the Appendix 10A Disclosure Statements to ascertain that they were accurate and met the requirements of the New York Insurance Law and the Regulation. The Company also violated Sections 243.2(b)(1) and (8) of Department Regulation No. 152 in the cases where it failed to maintain the information used to complete the Disclosure Statement that was received from the company being replaced.

6. Section 51.6(b) of Department Regulation No. 60 states, in part:

“Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall . . .

(4) Within ten days of receipt of the application furnish to the insurer whose coverage is being replaced a copy of any proposal, including the sales material used in the sale of the proposed life insurance policy or annuity contract, and the completed ‘Disclosure Statement’ . . .”

In 18 out of 40 (45%) variable annuity external replacements reviewed, the Company did not furnish the existing insurer a copy of the proposal, including sales material used in the sale and the completed Appendix 10B Disclosure Statement, within ten days of receipt of the application.

The Company violated Section 51.6(b)(4) of Department Regulation No. 60 in the cases where it failed to furnish the existing insurer a copy of the sales material used in the sale of the proposed variable annuity contract, and the completed Appendix 10B Disclosure Statement, within ten days of receipt of the application.

7. Section 51.6(e) of Department Regulation No. 60 states, in part:

“Both the insurer whose life insurance policy or annuity contract is being replaced and the insurer replacing the life insurance policy or annuity contract shall establish and implement procedures to ensure compliance with the requirements of this Part. These procedures shall include a requirement that all material be dated upon receipt. . . .”

In 15 out of 52 (29%) variable annuity replacements reviewed, replacement documents were not date stamped upon receipt by the Company. In addition, in 10 out of 74 (14%) life replacements reviewed, the Company did not date stamp materials including sales materials used at the point of sale, upon receipt by the Company.

The Company violated Section 51.6(e) of Department Regulation No. 60 in the cases where it failed to date stamp variable annuity and life insurance policy replacement documents upon receipt.

The Company has indicated that effective June 30, 2006, the Company's National Compliance Office implemented an audit plan designed to review, test and monitor compliance with Department Regulation No. 60. The results of this independent audit plan are provided to appropriate senior management for corrective action, where needed. In addition, the Company's Chief Compliance Officer reports periodically to the Audit Committee of the Board of Directors when appropriate. Furthermore, each service center conducts periodic quality assurance reviews and makes appropriate adjustments and corrections, as needed.

B. Underwriting and Policy Forms

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

Section 2611 of the New York Insurance Law states, in part:

“(a) No insurer or its designee shall request or require an individual proposed for insurance coverage to be the subject of an HIV related test without receiving the written informed consent of such individual prior to such testing and without providing general information about AIDS and the transmission of HIV infection.
(b) Written informed consent to an HIV related test shall consist of a written authorization that is dated . . .”

The examiner's review of new underwriting files standard issue, substandard issue, withdrawn and declined applications revealed that in 16 out of 165 (10%) files reviewed, the HIV consent form was signed by the applicant after the applicant's blood was drawn and tested for HIV. In an additional case, the underwriting file failed to contain evidence that the written informed consent was obtained at all.

The Company violated Section 2611(a) of the New York Insurance Law by failing to obtain written informed consent prior to subjecting the applicant to HIV-related testing.

Section 3201 of the New York Insurance Law states, in part:

“(a) In this article, ‘policy form’ means any policy, contract, certificate, or evidence of insurance and any application therefor, or rider or endorsement thereto, affording benefits of the kinds of insurance specified in paragraph one, two, three or twenty-four of subsection (a) of section one thousand one hundred thirteen of this chapter, a group annuity certificate to which subsection (a) of section three thousand two hundred nineteen of this article applies, and a funding agreement authorized by section three thousand two hundred twenty-two of this article . . .

(b)(1) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law. . . .”

The Company sells a group annuity contract that is used as a funding vehicle for an employer’s 401(k) plan, referred to as Momentum. As part of the participant application process for the Momentum group annuity plan, the employee is required to complete either a Full Service enrollment form or a Basic Service enrollment form, depending on the plan option adopted by the employer. During the review of policy forms it was noted that the Company changed the policy form number on the Full and Basic Service enrollment forms. However, the form language was not altered.

The examiner recommends, and the Company has agreed to, refraining from changing policy form numbers after the policy forms are approved by the Superintendent.

In addition, the Company sells a variable annuity in New York referred to as Equi-Vest. A review of policy forms used with Equi-Vest revealed that the Company used a group application, form #983-135B, that was not filed with and approved by the Superintendent. This form is used to: collect information on the employer; select the investment fund options; and tailor the benefits available under the employer group contract.

The Company violated Section 3201(b)(1) of the New York Insurance Law by using an unapproved policy form in connection with the Equi-Vest product.

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.

Section 216.4(a) of Department Regulation No. 64 states:

“Every insurer, upon notification of a claim, shall, within 15 working days, acknowledge the receipt of such notice. Such acknowledgment may be in writing. If an acknowledgment is made by other means, an appropriate notation shall be made in the claim file of the insurer. Notification given to an agent of an insurer shall be notification to the insurer. If notification is given to an agent of an insurer, such agent may acknowledge receipt of such notice. Unless otherwise provided by law or contract, notice to an agent of an insurer shall not be notice to the insurer if such agent notifies the claimant that the agent is not authorized to receive notices of claims.”

Section 216.5(a) of Department Regulation No. 64 states:

“Every insurer shall establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant's authorized representative, within 15 business days of receipt of notice of claim. An insurer shall furnish to every claimant, or claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving notice of the claim. A claim filed with an agent of an insurer shall be deemed to have been filed with the insurer unless, consistent with law or contract, such agent notifies the person filing the claim that the agent is not authorized to receive notices of claim.”

Section 216.11 of Department Regulation No. 64 states:

“To verify compliance with this Part and related statutes, Insurance Department examiners will investigate the market performance of insurers. To enable department personnel to reconstruct an insurer's activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.”

Variable Annuity Claims

The examiner reviewed a sample of variable annuity claims processed during the examination period. Section 216.4(a) of Department Regulation No. 64 requires an insurer, upon notification of a claim, to acknowledge the receipt of such notice within 15 working days. The acknowledgement may be in writing, but when made through other means, an appropriate notation shall be made in the claim file. In 7 out of 25 claims reviewed (28%), there was no evidence in the claim file that the Company acknowledged receipt of notice of the claim (written or by other means).

In 7 out of the 25 claims reviewed (28%), the agent was involved in the initial claims process. The agent was notified of the claim by the claimant or claimant's representative, however, an acknowledgement (written or by other means) from either the agent or the Company was not contained in the claim file.

The Company violated Section 216.4(a) of Department Regulation No. 64 by failing to acknowledge (in writing or by other means) receipt of notice of the claim.

In addition, there was no record of the date(s) that the agent or the Company furnished the claimant with a notification of all items, statements and forms, if any, required of the claimant in order to pay the claim. As a result, the Company failed to maintain the claim files in a manner that would allow the examiner to reconstruct all events relating to the claims.

The Company violated Section 216.11 of Department Regulation No. 64 by failing to make a notation in the variable annuity claim file or to retain a copy of any and all forms mailed to claimants.

Accelerated Death Benefit Claims

Section 216.11 of Department Regulation No. 64 states:

“To verify compliance with this Part and related statutes, Insurance Department examiners will investigate the market performance of insurers. To enable department personnel to reconstruct an insurer's activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.”

Section 3230 of the New York Insurance Law states, in part:

“ . . . (b) The application to accelerate benefits shall:

- (1) be dated by the insurer upon transmittal and shall be completed and signed by the policy owner not more than thirty days thereafter; and . . .
- (5) contain a statement of the remaining death benefit available to the beneficiary.

(c) Insurers are prohibited from paying accelerated death benefits or special surrender values to the policy owner or certificate holder for a period of fourteen days from the date on which the information specified in subdivision (d) of this section is transmitted in writing to the policy owner or certificate holder. The policy owner or certificate holder shall have the right to rescind the request for such payments at any time during the process of application for said benefits.

(d) Within five days of receipt of an application to accelerate benefits an insurer must provide the policy owner with the following:

- (1) an illustration demonstrating the effect of the accelerated benefit on the policy’s cash value and policy loans;
- (2) a numerical computation of the amount of the death benefit which would be payable upon death;
- (3) a numerical computation of the amount of the death benefit that would be payable upon acceleration; and
- (4) a notice that other means may be available to achieve the intended goal, including a policy loan. . . .”

The examiner’s review of: hard copy documentation maintained in accelerated death benefit claim files; information maintained on the Company’s imaging system, NEWS; and the Company’s written claims processing procedures for 15 accelerated benefit claims processed during the examination period revealed the following issues.

In 6 out of 15 (40%) accelerated death benefit claims selected for review, the examiner was unable to determine the following:

- the date that the Company or its agent received initial notice of the owner’s wish to accelerate benefits under the policy;
- whether or not the Living Benefits Rider claim form (or application for benefits) was completed and signed within 30 days of transmittal by the Company in compliance with Section 3230(b)(1) of the New York Insurance Law;
- if the Company provided the information required by Section 3230(d) of the New York Insurance Law to the policyowner upon receipt of the application for benefits. The Company stated that the computations were not based upon the amount of benefit requested to be accelerated under the policy as required; and

- if the Company waited the mandatory 14 days upon receipt of the application for benefits before paying the Living Benefits Rider claim as required by Section 3230(c) of the New York Insurance Law. The Company acknowledged that their procedures did not provide for the mandatory 14 day waiting period.

The above findings indicate a pattern of lack of internal controls in following the procedural requirements of the applicable statutes and regulation.

The Company violated Section 216.11 of Department Regulation No. 64 by failing to maintain the date that the Company or its agent received notice from the policyowner of their wish to accelerate benefits.

The Company violated Section 3230(b)(1) of the New York Insurance Law by failing to date the accelerated benefit application upon transmittal.

The Company violated Section 3230(d) of the New York Insurance Law by failing to provide the information required for accelerated benefit claims.

The Company violated Section 3230(c) of the New York Insurance Law by failing to wait the 14 days before paying the accelerated benefit claim.

Cash Surrenders

Section 216.11 of Department Regulation No. 64 states:

“To verify compliance with this Part and related statutes, Insurance Department examiners will investigate the market performance of insurers. To enable department personnel to reconstruct an insurer’s activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.”

The examiner reviewed a sample of 30 annuity surrender transactions processed during the current examination period. The examiner’s review revealed the following issues.

In 24 out of the 30 (80%) surrenders reviewed, none of the documents relating to the surrender transaction were date stamped upon receipt by the Company, including the written request for surrender of the contract.

In addition, the Company's annuity surrender procedures require form #129-1441 (*"Request For Service/Disbursement Form For SPDA IRA and NQ Markets Form"*) to be completed by the policyowner. The Company will accept a written request from the policyowner in lieu of form #129-1441. In 8 out of the 30 (26.7%) surrenders reviewed, neither form #129-1441 nor a written request was in the claim file.

Also, in 4 out of the 30 (13.3%) surrenders reviewed, the Company was unable to provide copies of payment documents such as the cancelled checks that were issued to the policyowner for the surrender proceeds payable under the policy.

The Company violated Section 216.11 of Department Regulation No. 64 by failing to: date stamp surrender documents; use either the approved request form or obtain a written request from the policyowner; and provide payment documents all of which are necessary to allow Department personnel to reconstruct the insurer's activities relating to the claim.

Universal Life Annual Statements

Section 4221(a) of the New York Insurance Law states, in part:

"In the case of policies issued on or after the operative date of this section as defined in subsection (p) hereof, no policy of life insurance, except as stated in subsection (o) hereof, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions . . .

(7) That the company shall . . . mail to each such holder at least once each policy year or within sixty days after the end of a policy year a statement as of a date during such year as to the death benefit, cash surrender value and loan value under the policy . . ."

A review of universal life specimen disclosure documents revealed that the notices mailed to policyholders during the examination period did not specify the policy loan value.

The Company violated Section 4221(a)(7) of the New York Insurance Law by failing to provide statements containing the policy loan value at least annually to universal life policyholders.

5. PRIVACY

The examiner reviewed various elements of the Company's privacy and safeguarding activities affecting customers and consumers to determine compliance with applicable statutes and regulations, the operating rules of the Company, and internal control standards deemed adequate by the Department. The review included an evaluation of the Company's documented privacy and safeguarding policies and procedures; internal, external and compliance audit workpapers; and management and internal control reports. The examination included a review of the following:

- privacy notices;
- opt out and opt in notices, if applicable;
- disclosure of non-public personal information (financial and health);
- redisclosure and reuse of non-public personal information (financial and health) received and disclosed; and
- the written information security program for the protection of customer information.

The examiner also conducted limited tests and other procedures, as deemed appropriate, in the review of privacy and safeguarding activities.

The examiner's review of the monitoring and control process in place over the activities of third party administrators ("TPAs") included privacy and safeguarding to ensure that customer non-public health and financial information was adequately protected and that such information was only being used for the administration of the outsourced business as agreed upon.

The Company is in the process of implementing a bi-annual self-assessment of its TPAs in order to ascertain that non-public confidential information is used only to service Company business and not for the benefit of the vendor's business, however, this process has not been fully implemented as of the date of this report.

The Company stated the following with regard to privacy assessments or evaluations conducted by its business units of TPAs.

“ . . . Business areas with TPAs in place prior to the examination period would also communicate to the Privacy Office of any privacy or safeguarding deficiencies but no formal reporting process exists . . . ”

The examiner recommends that the Company institute a formal communication channel (documented process) whereby the Company's Privacy Officer is notified of any privacy and

safeguarding deficiencies noted when the Company's business unit's audit or review the functions of TPAs.

The Company stated in writing that it monitors and oversees the activities of its TPAs, including privacy and safeguarding of customer non-public financial and health data, by business area review of SAS 70 reports. However, the examiner's review revealed that the Company did not obtain SAS 70 reports issued in 2003, 2004, and 2005 until such reports were requested by the examiner. The Company did not review the 2003, 2004, or 2005 SAS 70 reports which could provide meaningful insight with regard to the existence of or lack of internal controls with regard to activities or services provided under third party service contracts. The Company's current system of monitoring and oversight activities with regard to outsourced functions, and more specifically the privacy and safeguarding standards of its third party service providers, should be enhanced. This lack of monitoring and lack of oversight by the Company of its TPAs heightens the Company's reputational, litigation and regulatory risk due to possible loss or misuse of customer information by TPAs in addition to the risk that TPAs may not be treating its customers fairly. Although the Company has stated that it has taken steps to mitigate this risk, the Company has been unable to provide sufficient evidence to fully document the control process(es) in place or that control procedures have been fully implemented as of the date of this report.

The establishment and implementation of adequate controls over third party servicing entities and the review of these controls are the responsibility of the Company's management, including the board of directors and specifically the audit committee.

Management should determine through periodic review of the controls whether control procedures continue to be effective and relevant by addressing risks associated with the outsourcing of work to TPAs or whether these controls need to be adapted to accommodate changes in the operating environment and/or regulatory requirements.

The examiner recommends that the Company develop and implement a plan to improve the Company's control over TPA activities, including how third party service providers secure Company customer nonpublic personal health and financial information.

The examiner also recommends that the audit committee of the board increase their level of involvement and oversight over the Company's system of safeguarding Company customer personal non public financial and health information with regard to services outsourced to third parties.

6. DISASTER RECOVERY AND BUSINESS CONTINUITY

The examiner's review of third party service agreements revealed that two of five agreements do not contain a provision for disaster recovery and business continuity. One way to mitigate a risk of loss is to plan for it and develop an action plan on how to deal with possible losses of customer data, systems, operational sites, etc. In order to ascertain that TPAs have taken adequate measures to reasonably assure that there is no interruption in the services that the TPAs provide, they must have current, relevant disaster recovery and business continuity plans. The objective of a disaster recovery plan is to provide reasonable assurance that data, systems and operations can be successfully recovered and be available to users in the event of a disaster. The objective of a business continuity plan is to reasonably ensure that the recovery of critical business processes could take place in the event of a disaster. The Company should ensure that the plans in place at the situs of the TPA operations are valid.

While the Company stated in writing that it has current policies and procedures in place to ensure that newly executed agreements with TPAs include language related to business continuity requirements, where deemed appropriate, the Company has not provided sufficient evidence to support that claim.

The examiner recommends that the Company develop a monitoring and control process to determine that TPAs have adequately prepared for and tested disaster recovery and business continuity plans in place at the TPA to ensure that outsourced operations and policyholder data can be recovered in the event of a disaster situation. This process should include an evaluation and assessment of each TPA to ensure that adequate measures have been taken to plan for the recovery of data, systems, operations, as well as critical business processes for those operations that the TPAs perform under service agreements with the Company.

The examiner further recommends that the Company implement a procedure to review the results of any disaster recovery and/or business continuity tests performed at the TPA.

7. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following are the violations 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 Society violated Section 219.5(a) of Department Regulation No. 34-A by failing to maintain a complete file of all the advertisements used during the examination period.</p> <p>The examiner's review of a sample of Company advertisements revealed that it maintained a specimen copy of every advertisement. However, the Company did not maintain information relating to the extent of distribution in its advertising files.</p>
B	<p>The Society violated Section 51.6(b)(2) of Department Regulation No. 60 by failing to require with, or as part of, each application a copy of the proposals, including the sales materials used in the sale of life insurance policies.</p> <p>The Company instituted procedures whereby the representative must submit and certify on a standardized form whether: 1) he/she used any sales material approved by the Company; 2) any individualized sales material was used; or 3) no sales materials were used in the transaction. The examiner's review of a sample of replacement transactions processed after February 2003 indicated that a copy of the sales proposal, sales illustration, or sales materials used in the sale of life insurance policies were submitted with the application as required by Section 51.6(b)(2) of Department Regulation No. 60 or the representative certified that no sales materials were used at the point of sale.</p>
C	<p>The Society violated Section 3207(c) of the New York Insurance Law by issuing policies of life insurance on the lives of minors under the age of four years and six months, wherein the face amounts of the policies were in excess of the specified limit.</p> <p>The Company incorporates a review for compliance with Section 3207 of the New York Insurance Law as part of the underwriting quality control program conducted at the National Operations Center of the Company. In addition, the requirements of Section 3207 of the New York Insurance Law were reviewed and reinforced with the Company's underwriting staff at the National Operations Center. Based upon the examiner's review of a sample of life insurance policies issued on the lives of minors where the application was taken after February 2003, the Company complied with limits prescribed under Section 3207(b) of the New York Insurance Law.</p>

<u>Item</u>	<u>Description</u>
D	<p>The Society violated Section 2611 of the New York Insurance Law by using HIV testing consent forms that failed to conform to the requirements of this section.</p> <p>The Company changed its procedures to require New York Notice and Consent Form, 180-320A-NY, for all applications submitted regardless of the residence of the proposed insured. Based upon the examiner's review of HIV consent forms required under Section 2611 of the New York Insurance Law, the Company revised the consent forms used in New York to include the toll-free telephone number of the New York State Health Department.</p>
E	<p>The Society violated Section 3201(b)(1) of the New York Insurance Law by using unapproved policy forms in connection with its group annuity business.</p> <p>The policy forms have been filed and approved. However, the examiner's review of group variable annuity policy forms used during the examination period revealed that the Company used one unapproved annuity policy form in violation of Section 3201(b)(1) of the New York Insurance Law.</p>
F	<p>The Society violated Section 3214(c) of the New York Insurance Law for failing to pay interest at the rate of interest currently paid by the insurer on proceeds left under the interest settlement option from the date of death of the insured in connection with a death claim.</p> <p>Based upon the examiner's review of a sample of life claims processed after February 2003, it appears that the Company implemented procedures to ensure that the interest paid on death claims was calculated using the appropriate rate of interest, the rate of interest currently paid by the Company on proceeds left under the interest settlement option.</p>

8. SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in this report:

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
A	The examiner recommends that the Company either add a statement to these advertisements showing the assets under management of the Company or cease use of these advertisements.	7
B	The Company violated Section 219.5(a) of Department Regulation No. 34-A by failing to maintain a notation relating to the manner and extent of distribution of any policy advertised.	8
C	The Company violated Section 4226(b) of the New York Insurance Law and Section 51.6(b)(3) of Department Regulation No. 60 by failing to use comparisons that conform to all the requirements established by the Superintendent by regulation, reduce the surrender values and death benefit values for the hypothetical rates of return on the Appendix 10B Disclosure Statements by investment fund level charges during the examination period and examine the Appendix 10B Disclosure Statements for the variable annuity replacements and ascertain that they were accurate and met the requirements of the New York Insurance Law and Department Regulation No. 60.	9
D	The Company violated Section 51.6(b)(3) of Department Regulation No. 60 in all cases where it failed to examine and ascertain that a composite Appendix 10A Disclosure Statement was required and to provide such in situations where more than one existing policy was being replaced.	10
E	The Company violated Section 51.6(b)(7) of Department Regulation No. 60 in all cases where it failed to correct deficiencies involving Appendix 10A Disclosure Statements or reject the application within ten days from date of receipt of the application.	10
F	The Company violated Section 51.6(b)(9) of Department Regulation No. 60 in all cases where it failed to provide a revised Appendix A Disclosure Statement when the insurance policy issued differed from the policy applied for.	11
G	The Company violated Section 51.6(b)(3) of Department Regulation No. 60 in the cases where it failed to examine the Appendix 10A Disclosure Statements to ascertain that they were accurate and met the requirements of the New York Insurance Law and the Regulation. The Company also violated Sections 243.2(b)(1) and (8) of Department Regulation No. 152 in the cases where it failed to maintain the information used to complete the Disclosure Statement that was received from the company being replaced.	12

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
H	The Company violated Section 51.6(b)(4) of Department Regulation No. 60 in the cases where it failed to furnish the existing insurer a copy of the sales material used in the sale of the proposed variable annuity contract, and the completed Appendix 10B Disclosure Statement, within ten days of receipt of the application.	12
I	The Company violated Section 51.6(e) of Department Regulation No. 60 in the cases where it failed to date stamp variable annuity and life insurance policy replacement documents upon receipt.	13
J	The Company violated Section 2611(a) of the New York Insurance Law by failing to obtain written informed consent prior to subjecting the applicant to HIV-related testing.	13
K	The examiner recommends that the Company refrain from changing policy form numbers after the policy forms are approved by the Superintendent.	14
L	The Company violated Section 3201(b)(1) of the New York Insurance Law by using an unapproved policy form in connection with the Equi-Vest product.	14
M	The Company violated Section 216.4(a) of Department Regulation No. 64 by failing to acknowledge (in writing or by other means) receipt of notice of the claim.	16
N	The Company violated Section 216.11 of Department Regulation No. 64 by failing to make a notation in the variable annuity claim file or to retain a copy of any and all forms mailed to claimants.	16
O	The Company violated Section 216.11 of Department Regulation No. 64 by failing to maintain the date that the Company or its agent received notice from the policyowner of their wish to accelerate benefits.	18
P	The Company violated Section 3230(b)(1) of the New York Insurance Law by failing to date the accelerated benefit application upon transmittal.	18
Q	The Company violated Section 3230(d) of the New York Insurance Law by failing to provide the information required for accelerated benefit claims.	18

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
R	The Company violated Section 3230(c) of the New York Insurance Law by failing to wait the 14 days before paying the accelerated benefit claim.	18
S	The Company violated Section 216.11 of Department Regulation No. 64 by failing to: date stamp surrender documents; use either the approved request form or obtain a written request from the policyowner; and provide payment documents all of which are necessary to allow Department personnel to reconstruct the insurer's activities relating to the claim.	19
T	The Company violated Section 4221(a)(7) of the New York Insurance Law by failing to provide statements containing the policy loan value at least annually to universal life policyholders.	19
U	The examiner recommends that the Company institute a formal communication channel (documented process) whereby the Company's Privacy Officer is notified of any privacy and safeguarding deficiencies noted when the Company's other business areas audit or review the functions of TPAs.	20
V	The examiner recommends that the Company develop and implement a plan to improve the Company's control over TPA activities, including how third party service providers secure Company customer nonpublic personal health and financial information.	21
W	The examiner also recommends that the audit committee of the board increase their level of involvement and oversight over the Company's system of safeguarding Company customer personal non public financial and health information with regard to services outsourced to third parties.	21
X	The examiner recommends that the Company develop a monitoring and control process to determine that TPAs have adequately prepared for and tested disaster recovery and business continuity plans in place at the TPA to ensure that outsourced operations and policyholder data can be recovered in the event of a disaster situation. This process should include an evaluation and assessment of each TPA to ensure that adequate measures have been taken to plan for the recovery of data, systems, operations, as well as critical business processes for those operations that the TPAs perform under service agreements with the Company.	22
Y	The examiner further recommends that the Company implement a procedure to review the results of any disaster recovery and/or business continuity tests performed at the TPA.	22

Respectfully submitted,

_____/s/_____
Eden M. Sunderman
Associate Insurance Examiner

Respectfully submitted,

_____/s/_____
Anthony Mauro
Associate Insurance Examiner

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

Eden M. Sunderman and Anthony Mauro, being duly sworn, deposes and says that the foregoing report, subscribed by them, is true to the best of their knowledge and belief.

_____/s/_____
Eden M. Sunderman

_____/s/_____
Anthony Mauro

Subscribed and sworn to before me

this _____ day of _____

APPOINTMENT NO. 30200

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:

EDEN SUNDERMAN

AND

ANTHONY MAURO

as the proper persons to examine into the affairs of the

AXA EQUITABLE LIFE INSURANCE COMPANY

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

COMPANY

with such other information as they 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 24th day of September, 2008



ERIC R. DINALLO
Superintendent of Insurance

Eric R. Dinallo
Superintendent