



STATE OF NEW YORK INSURANCE DEPARTMENT  
REPORT ON EXAMINATION  
OF THE  
AMERICAN PROGRESSIVE LIFE AND HEALTH INSURANCE COMPANY  
OF NEW YORK

CONDITION:

DECEMBER 31, 2003

DATE OF REPORT:

JANUARY 9, 2006

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EXAMINER:

JACQUELINE TUCKER

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

George E. Pataki  
Governor

Howard Mills  
Superintendent

January 9, 2006

Honorable Howard Mills  
Superintendent of Insurance  
Albany, New York 12257

Sir:

In accordance with instructions contained in Appointment No. 22222, dated May 3, 2004 and annexed hereto, an examination has been made into the condition and affairs of American Progressive Life and Health Insurance Company of New York, hereinafter referred to as “the Company” or “American Progressive”, at its home office located at 6 International Drive, Rye Brook, New York 10573.

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 Company violated Section 325(a) of the New York Insurance Law when it failed to document and maintain its board committee minutes. Also, the Company violated Section 1202(b)(2) of the New York Insurance Law when its audit committee failed to meet and fulfill its responsibilities during the examination period. (See item 3C of this report)

The Company violated Section 325(a) of the New York Insurance Law by failing to maintain its books of account at its principal office in this State. (See item 8 of this report)

The Company violated Section 51.7(a)(1) of Department Regulation No. 60 by providing inaccurate, incomplete and misleading Disclosure Statements to prospective contractholders. The Company also violated Section 243.2(b)(1)(iv) of Department Regulation No. 152 by failing to maintain records necessary to reconstruct the solicitation, rating, and underwriting of replacement contracts, as well as other records. Due to the high exception rate found during the review of replaced annuity contracts involving inaccurate, incomplete and misleading Disclosure Statements, the Department informed the Company that remediation was necessary. The Company implemented a plan of remediation that resulted in a total credit to current contractholders' accounts in the amount of \$229,243, and a total reimbursement to former contractholders in the amount of \$94,947. (See item 6A of this report)

The Company is one of the largest writers of Medicare Supplement insurance in New York State. In early 2004, the State Office for the Aging ("SOFA") informed the Department of certain agents of the Company allegedly engaging in high pressure sales tactics when selling Medicare Supplement policies in the northern New York counties. In addition, some agents were also reportedly presenting themselves as representatives from Medicare or from the Elderly Pharmaceutical Insurance Corporation ("EPIC").

Since the allegations involved more than one of the Company's agents in various counties, the Department's Consumer Services Bureau ("CSB") conducted an investigation into the Company's Medicare Supplement sales practices. CSB reviewed copies of all sales and training materials provided to the Company's general agents and soliciting agents and also applications of select agents and agencies. Letters were also sent to insurers whose Medicare Supplement policies were replaced to determine whether the new coverage provided by the Company replaced a policy that was more beneficial to the insured, and whether duplicate

coverage was in place. CSB compared the information on the Company's applications with the information received from each carrier whose policy was replaced. CSB also investigated the reasons given for replacement by each agent to detect trends. CSB coordinated their efforts with the examination team during this examination.

The Company violated Section 52.22(h)(4)(i)(1) of Department Regulation No. 62 by failing to adequately implement procedures to assure that excessive Medicare Supplement insurance was not sold or issued, and by failing to establish auditable procedures for verifying compliance with the Regulation. (See item 7 of this report)

The examiner recommends that the Company refund all premiums collected from those policyholders who were sold duplicative Medicare Supplement coverage. (See item 7 of this report)

The Company violated Section 215.2(b) of Department Regulation No. 34 by failing to establish and maintain a system of control over the content, form and method of dissemination of advertisements for its Medicare Supplement policies. (See item 7 of this report)

The Company violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain a complete advertising file for its Medicare Supplement business. (See item 7 of this report)

The Company violated Section 52.22(b)(9) of Department Regulation No. 62 by failing to provide copies of its Medicare Supplement advertisements to the Superintendent prior to their use. (See item 7 of this report)

The Company violated Section 52.22(h)(4)(i)(2)(iii) of Regulation No. 62 by failing to disclose in cold lead advertisements in a conspicuous manner that the purpose of the method of marketing was the solicitation of Medicare Supplement insurance and that contact would be made by an insurance agent or insurance company. (See item 7 of this report)

The Company violated Section 52.22(g)(3) of Department Regulation No. 62 by failing to provide policyholders with the required Medicare Supplement replacement notices. (See item 7 of this report)

The Company violated Section 4224 of the New York Insurance Law by making or permitting unfair discrimination between individuals of the same class and giving an inducement to certain applicants by failing to collect or charge the applicable Medicare Supplement application fee in all instances. (See item 7 of this report)

The Company violated Section 1505(d)(3) of the New York Insurance Law by failing to notify the Superintendent of its participation in a service agreement with its affiliate, CHCS Services, Inc. (“CHCS”). This is a repeat violation from the prior report on examination. The examiner recommends that the Company recoup from CHCS all monies paid under the aforementioned service agreement with CHCS since the last examination period. (See item 3B of this report)

The Company violated Section 3201(b)(1) of the New York Insurance Law by changing two policy and application forms, which had been approved by the Superintendent, without re-filing the changed forms for approval. (See item 6B of this report)

The Company violated Section 216.4(e) of Department Regulation No. 64 by failing to maintain a log of all consumer complaints. (See item 6C of this report)

The examiner recommends that the Company establish and maintain an independent, adequately resourced, and competently staffed internal audit function to provide management and the audit committee with ongoing assessments of the Company’s risk management processes and the accompanying system of internal control. This is a repeat recommendation from the prior report on examination. (See item 9 of this report)

The examiner’s review of a sample of transactions did not reveal any differences which materially affected the Company’s financial condition as presented in its financial statements contained in the December 31, 2003 filed annual statement. (See item 5 of this report)

## 2. SCOPE OF EXAMINATION

The prior examination was conducted as of December 31, 2000. This examination covers the period from January 1, 2001 through December 31, 2003. As necessary, the examiner reviewed transactions occurring subsequent to December 31, 2003 but prior to the date of this report (i.e., the completion date of the examination).

The examination comprised a verification of assets and liabilities as of December 31, 2003 to determine whether the Company's 2003 filed annual statement fairly presents its financial condition. The examiner reviewed the Company's income and disbursements necessary to accomplish such verification and utilized the National Association of Insurance Commissioners' Examiners Handbook or such other examination procedures, as deemed appropriate, in such review and in the review or audit of the following matters:

- Company history
- Management and control
- Corporate records
- Fidelity bond and other insurance
- Officers' and employees' welfare and pension plans
- Territory and plan of operation
- Market conduct activities
- Growth of Company
- Business in force by states
- Mortality and loss experience
- Reinsurance
- Accounts and records
- Financial statements

The examiner reviewed the corrective actions taken by the Company with respect to the violations and recommendation contained in the prior report on examination. The results of the examiner's review are contained in item 11 of this report.

This report on examination is confined to financial statements and 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 under the laws of the State of New York as a for-profit health insurance company on September 22, 1945 under the name American Progressive Health Insurance Company of New York. It was licensed and commenced business on March 26, 1946. On January 25, 1979, its charter was amended to include the writing of life insurance and annuities. The Company's present name was adopted at that time.

Initial resources of \$151,800, consisting of common capital stock of \$101,200 and paid in and contributed surplus of \$50,600 were provided through the sale of 1,012 shares of common stock (with a par value of \$100 each) for \$150 per share. As of December 31, 2003, authorized capital was \$2,500,050, consisting of 16,667 shares of common stock with a par value of \$150 per share. The Company received surplus contributions from its parent of \$1,209,265 and \$3,500,000 in 2002 and 2003, respectively, increasing its paid in and contributed surplus to \$19,966,498 as of December 31, 2003.

In May 1991, John Adams Life Insurance Company of New York ("John Adams"), a New York domiciled life insurance company, acquired 100% of the Company's outstanding stock from Midland National Life Insurance Company, a former parent of the Company. At the same time, John Adams' parent, Universal Holding Corp. ("UHCo"), contributed \$5,100,000 to the paid-in and contributed surplus of the Company. The Company merged with John Adams on July 27, 1991, with the Company being the survivor. On June 20, 1996, UHCo's shareholders approved a corporate name change to Universal American Financial Corp. ("UAFC"). On July 1, 2002, UAFC transferred ownership of the Company to its subsidiary, American Exchange Life Insurance Company ("AmExch"), a Texas domiciled life insurance company.

On May 26, 1993, the Company acquired 100% of the outstanding common stock of American Pioneer Life Insurance Company ("AmPio"), a Florida domiciled life and health insurance company, for \$6,623,308 from the Resolution Trust Company at an auction sale. On July 26, 1996, the Company entered into an agreement to sell, within a five-year period, its interest in AmPio to UAFC. The purchase price totaled \$15.8 million, of which the Company received \$7.9 million cash and \$7.9 million of secured debentures. As of May 30, 1998, the Company had completely divested its interest in AmPio. The secured debentures totaling \$7.9

million which were secured by 100% of AmPio's common stock, were paid down as of December 31, 2003.

On July 30, 1999, AmExch, a wholly owned subsidiary of UAFC, completed an acquisition of various subsidiaries of the former PennCorp Financial Group, Inc. ("PennCorp"), an insurance holding company. The following six insurers were acquired: Pennsylvania Life Insurance Company; Constitution Life Insurance Company; Union Bankers Insurance Company ("Union Bankers"); Marquette National Life Insurance Company; PennCorp Life Insurance Company (Canada); and Peninsular Life Insurance Company (collectively referred to as "PennUnion"). AmExch paid \$130.5 million in cash to PennCorp, and Union Bankers paid a \$6.5 million dividend to a PennCorp subsidiary not included in the acquisition. To finance the acquisition of PennUnion, AmExch issued a \$70 million surplus note to UAFC, and received an additional cash contribution of \$46.3 million from UAFC.

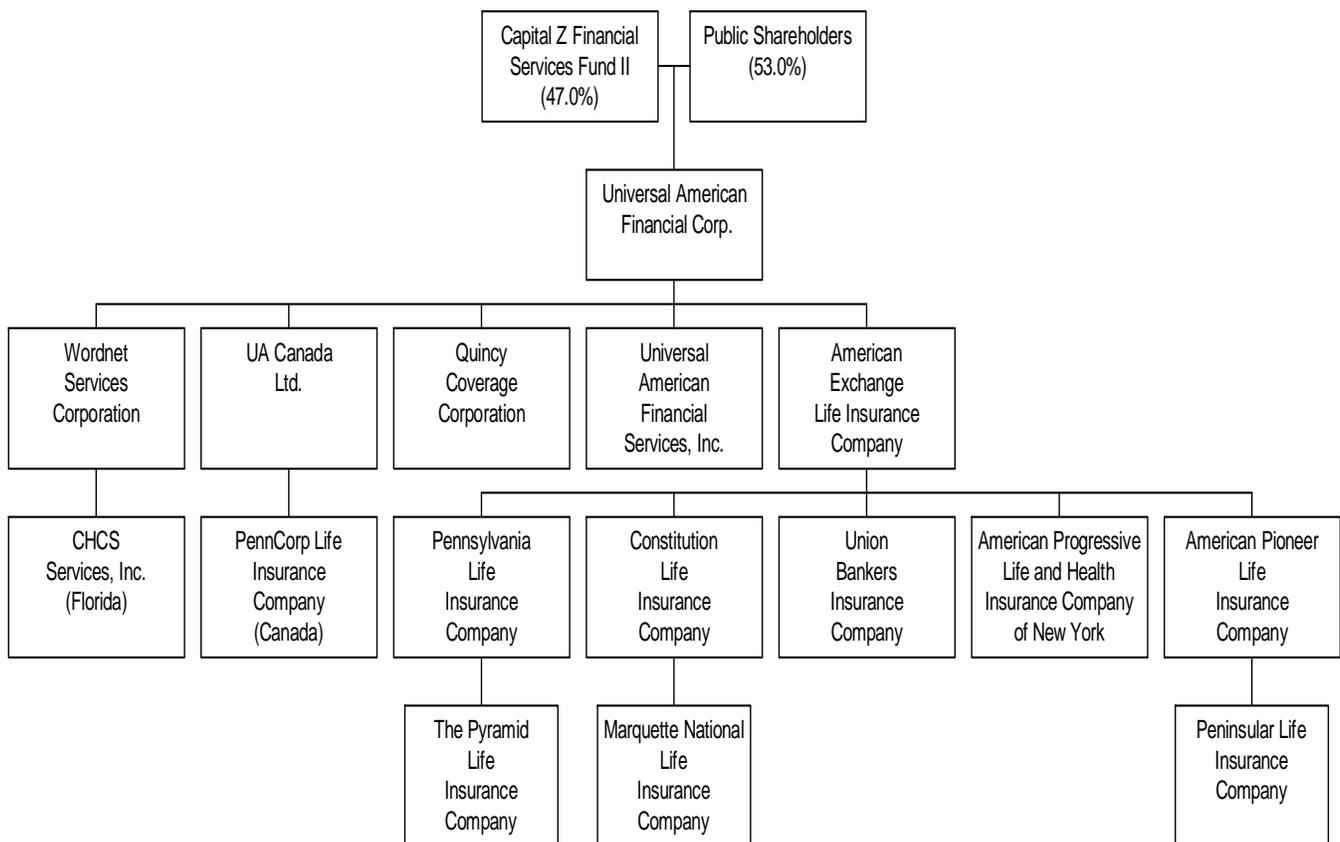
Upon acquisition of PennUnion, AmExch became the insurance holding company of five of the newly acquired insurance companies. PennCorp Life Insurance Company (Canada) became a subsidiary of UA Canada LTD. In addition, as stated above, on July 1, 2002, UAFC transferred ownership of the Company, to its subsidiary AmExch.

To help finance the acquisition of PennUnion, UAFC entered into a Share Purchase Agreement ("SPA") with Capital Z Financial Services Fund II ("Capital Z"), dated December 31, 1998. Concurrent with AmExch's acquisition of PennUnion, UAFC issued approximately 29.4 million shares of its common stock. In accordance with the SPA, Capital Z purchased a majority of UAFC shares, investing approximately \$81 million, and acquiring an approximate 59.7% controlling interest in UAFC. Additionally, as part of the PennUnion transaction, UAFC obtained an \$80 million credit facility (comprised of a \$70 million term loan and a \$10 million revolving loan facility) from a syndicate of lenders. As security for the credit facility, UAFC pledged 100% of its shares of the Company, as well as shares of other affiliates. As of December 31, 2003, Capital Z's interest in UAFC was 47%; the remainder was owned by individual shareholders.

#### B. Holding Company

The Company is a wholly owned subsidiary of AmExch, a life and accident and health insurance holding company domiciled in Texas. AmExch is a subsidiary of UAFC, a publicly-

traded company (Nasdaq ticker symbol UHCO). As of December 31, 2003, Capital Z, a Bermuda limited partnership based in New York, held a 47.0% interest in UAFC; the remainder was owned by individual shareholders. Capital Z is managed by Capital Z Partners, LP, a New York-based global alternative asset management firm. An organization chart reflecting the relationship between the Company and significant entities in its holding company system as of December 31, 2003 follows:



The Company had two service agreements in effect during the examination period. One service agreement, effective 4/13/98, included several affiliates.

Type of Agreement and Department File Number	Effective Date	Provider(s) of Service(s)	Recipient(s) of Service(s)	Specific Service(s) Covered	Income/ (Expense)* For Each Year of the Examination
Service Agreement Department file number 29980	8/1/02	Universal American Financial Services, Inc. ("UAFS")	the Company	Advice and assistance with tax, actuarial and investment compliance matters; government relations support services, strategic planning and general management services; and office and systems support.	2001 - \$(5,003,044) 2002 - \$(8,346,136) 2003 - \$(6,778,741)
Service Agreement Department file number 25327	4/13/98	the Company	Various affiliates	The Company shall make available the services of its executive officers to various affiliates.	2001 - \$305,708 2002 - \$461,723 2003 - \$512,054
		AmPio	the Company	Telephone verification, policy administration, underwriting, policy issue, premium billing, claims, policyowner services, actuarial services, compliance and EDP services.	2001 - \$(145,908) 2002 - \$(44,172) 2003 - \$0
		Worldnet Services Corp. ("Worldnet")	the Company	New business, underwriting, phone verification, premium billing, claim services, other miscellaneous policy administration.	2001 - \$(25,263) 2002 - \$(432,619) 2003 - \$(289,306)
Amendment No. 1	4/1/05				
Amendment No. 2	4/1/05	CHCS	the Company	New business, underwriting, phone verification, premium billing, claim services, other miscellaneous policy administration.	2001 - \$(671,141) 2002 - \$(1,619,897) 2003 - \$(3,070,284)

\*Amount of Income or (Expense) Incurred by the Company

During the examination period, the increase in charges paid to CHCS was due to the increase in new business and claim benefits paid for the three year period under review. The Company reported direct premiums of \$46.6 million in 2001, \$88.7 million in 2002 and \$136.9 million in 2003. The Company reported claim benefits of \$23.3 million in 2001, \$37.1 million in 2002 and \$43.4 million in 2003.

Section 1505(d) of the New York Insurance Law states, in part:

“The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period . . . (3) rendering of services on a regular or systematic basis . . . ”

CHCS, a third party administrator, was acquired by UAFC in August 2000. At that time, CHCS took over certain functions previously performed by WorldNet under the terms of the aforementioned service agreement dated April 13, 1998. The prior report on examination cited the Company for a violation of Section 1505(d)(3) of the Insurance Law for failing to notify the Superintendent of the services rendered by CHCS on behalf of the Company on a regular or systematic basis. The Company started receiving services from CHCS in January 2000. The Company did not submit the agreement to the Department until November 2004, at the request of the examiner. The agreement was finally approved on May 4, 2005.

The Company violated Section 1505(d)(3) of the New York Insurance Law by failing to notify the Superintendent of its participation in the service agreement with its affiliate CHCS. This is a repeat violation from the prior report on examination.

The examiner recommends that the Company recoup from CHCS all monies paid under the aforementioned service agreement with CHCS since the last examination period.

The Company maintains a federal income tax allocation agreement with its parent and affiliates.

### C. Management

The Company's by-laws provide that the board of directors shall be comprised of not less than nine and not more than 21 members, provided that within one year following the end of the calendar year in which the Company exceeds \$500,000,000 in admitted assets, the number of directors shall be increased to not less than 13 directors. Directors are elected for a period of one

year at the annual meeting of the stockholders held in March of each year. As of December 31, 2003, the board of directors consisted of nine members. Meetings of the board are held in March and December of each year.

The nine board members and their principal business affiliation, as of December 31, 2003, were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>	<u>Year First Elected</u>
Michael A. Barasch New York, NY	Partner Barasch, McGarry, Salzman, Penson & Lim	1999
Richard A. Barasch New York, NY	Chairman of the Board, President and Chief Executive Officer American Progressive Life and Health Insurance Company of New York	1991
David F. Bolger* Ridgewood, NJ	President Bolger & Company	1999
Gary W. Bryant Longwood, FL	Executive Vice President American Progressive Life and Health Insurance Company of New York	2000
William H. Cushman New Hartford, CT	Vice President American Progressive Life and Health Insurance Company of New York	2001
Walter L. Harris* New York, NY	President Tanenbaum-Harber Co.	1991
Harry B. Henshel* Scarsdale, NY	Vice Chairman Bulova Corporation	1999
Jeffrey Laikind* New York, NY	Managing Director Shikiar Asset Management	1995
Robert A. Waegelein Pawling, NY	Executive Vice President and Chief Financial Officer American Progressive Life and Health Insurance Company of New York	1991

\* Not affiliated with the Company or any other company in the holding company system

The examiner's review of the board of directors' minutes indicated that meetings were well attended and that each director attended a majority of meetings.

Section 325(a) of the New York Insurance Law states, in part:

“Every domestic insurer . . . shall . . . keep and maintain at its principal office in this state . . . the minutes of any meetings of its shareholders, policyholders, board of directors and committees thereof . . .”

Section 1202(b)(2) of the New York Insurance Law states, in part:

“The board of directors of a domestic life insurance company shall establish one or more committees comprised solely of directors who are not officers or employees of the company . . . Such committee or committees shall have responsibility for recommending the selection of independent certified public accountants, reviewing the company's financial condition, the scope and results of the independent audit and any internal audit, nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed by such committee or committees to be principal officers of the company and recommending to the board of directors the selection and compensation of such principal officers and . . . recommending to its board of directors any plan to issue options to its officers and employees for the purchase of shares of stock . . .”

On numerous occasions throughout the examination, the examiner requested the minutes of the board committee meetings. However, none were provided to the examiner. After further investigation, it was revealed that the audit committee, which is the committee that is comprised solely of independent directors in accordance with Section 1202(b)(2) of the New York Insurance Law, met once during the examination period, in August 2002, and minutes of the committee meeting were not documented. There is no evidence to indicate that the audit committee fulfilled any of its responsibilities required under the New York Insurance Law during the examination period.

The Company violated Section 325(a) of the New York Insurance Law when it failed to document and maintain board committee minutes.

The Company violated Section 1202(b)(2) of the New York Insurance Law when its audit committee failed to meet and fulfill its responsibilities during the examination period.

The following is a listing of the principal officers of the Company as of December 31, 2003:

<u>Name</u>	<u>Title</u>
Richard A. Barasch	Chairman, President and Chief Executive Officer
Robert A. Waegelein	Executive Vice President and Chief Financial Officer
Gary W. Bryant	Executive Vice President
Michael A. Colliflower	Senior Vice President, Legal and General Counsel

William M. Daly	Senior Vice President, Marketing
Neil Lund	Senior Vice President and Chief Actuary
Bradley D. Leonard	Senior Vice President and Actuary
Donald M. Gray	Treasurer
Joan M. Ferrarone	Corporate Secretary

Judy M. Borrell, Vice President of Administration, is the designated consumer services officer per Section 216.4(c) of Department Regulation No. 64.

In July 2004, Bradley D. Leonard resigned as Senior Vice President and Actuary.

#### D. 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 write business in 23 states and the District of Columbia. In 2003, the majority of life premiums and annuity considerations (77% and 88%, respectively) were received from New York. The majority of accident and health premiums were received from New York (46%), Pennsylvania (25%) and Connecticut (14%). Policies are written on a non-participating basis.

The Company primarily markets accident and health products on both an individual and group basis. The products are marketed to the senior age group and include Medicare Supplement, hospital indemnity, nursing home and home healthcare, dental, and comprehensive long-term care insurance.

In addition to the above-mentioned products, the Company offers a simplified issue graded death benefit whole life product, and a simplified issue whole life product, both targeted toward the senior market.

The Company also writes nonqualified, qualified and tax-sheltered annuity plans. In July and August 2003, the Company introduced two new annuity products: a flexible premium deferred annuity, and a single premium deferred annuity, with a 1.5% guaranteed rate. Simultaneously, the Company withdrew its 4% guaranteed rate annuity product.

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

#### E. Reinsurance

As of December 31, 2003, the Company had reinsurance treaties in effect with 16 companies, of which 13 were authorized or accredited. The Company's life and accident and health insurance business is reinsured on a coinsurance and yearly renewable term basis. Reinsurance is provided on an automatic and facultative basis.

The maximum retention limit for individual life contracts is \$50,000. The total face amount of life insurance ceded as of December 31, 2003, was \$158,589,982, which represents 46% of the total face amount of life insurance in force. Reserve credit taken for reinsurance ceded to unauthorized companies, totaling \$1,708,557, was supported by letters of credit and funds withheld.

In 2002, the Company increased its retention limit on its Medicare Supplement policies from 50% to 75%. In 2003, the Company stopped reinsuring all new sales of its Medicare Supplement business.

As of December 31, 2003, the Company assumed business from one insurer, American Life Insurance Company of New York. The total face amount of life insurance assumed as of December 31, 2003, was \$16,192,111.

#### 4. SIGNIFICANT OPERATING RESULTS

Indicated below is significant information concerning the operations of the Company during the period under examination as extracted from its filed annual statements. Failure of items to add to the totals shown in any table in this report is due to rounding.

The following table indicates the Company's financial growth (decline) during the period under review:

	<u>December 31,</u> <u>2000</u>	<u>December 31,</u> <u>2003</u>	<u>Increase</u> <u>(Decrease)</u>
Admitted assets	<u>\$99,693,275</u>	<u>\$166,266,148</u>	<u>\$66,572,873</u>
Liabilities	<u>\$90,134,036</u>	<u>\$156,074,613</u>	<u>\$65,940,577</u>
Common capital stock	\$ 2,500,050	\$ 2,500,050	\$ 0
Gross paid in and contributed surplus	15,257,233	19,966,498	4,709,265
Unassigned funds (surplus)	<u>(8,198,044)</u>	<u>(12,275,013)</u>	<u>(4,076,969)</u>
Total capital and surplus	<u>\$ 9,559,239</u>	<u>\$ 10,191,535</u>	<u>\$ 632,296</u>
Total liabilities, capital and surplus	<u>\$99,693,275</u>	<u>\$166,266,148</u>	<u>\$66,572,873</u>

The Company's invested assets as of December 31, 2003 were mainly comprised of bonds (84%), and cash and short-term investments (15%). The majority (97%) of the Company's bond portfolio, as of December 31, 2003, was comprised of investment grade obligations.

The following indicates, for each of the years listed below, the amount of life insurance issued and in force by type (in thousands of dollars):

<u>Year</u>	<u>Individual</u> <u>Whole Life</u>		<u>Individual</u> <u>Term</u>	
	<u>Issued</u>	<u>In Force</u>	<u>Issued</u>	<u>In Force</u>
2001	\$11,179	\$252,048	\$190	\$106,990
2002	\$14,133	\$178,432	\$ 25	\$ 95,286
2003	\$35,759	\$195,423	\$ 0	\$ 84,716

The increase in individual whole life insurance issued is a result of the Company's expansion of its senior life product into additional states. In 1999, the Company decided to stop

writing all universal life insurance and term insurance business. The term issues in 2001 and 2002 were the result of additional purchase options or riders that were purchased on existing in-force policies. No new term insurance was sold in 2003.

The ordinary lapse ratio for each of the examination years was 7.7% in 2001, 6.7% in 2002 and 10.0% in 2003.

The following has been extracted from the Exhibits of Annuities in the filed annual statements for each of the years under review:

	<u>Ordinary Annuities</u>		
	<u>2001</u>	<u>2002</u>	<u>2003</u>
Outstanding, end of previous year	1,745	1,667	1,734
Issued and increases during the year	122	281	1,241
Other net changes during the year	<u>(200)</u>	<u>(214)</u>	<u>(151)</u>
Outstanding, end of current year	<u>1,667</u>	<u>1,734</u>	<u>2,824</u>

The increase in ordinary annuities issued in 2003 is due to the Company's marketing of its 4% guaranteed interest rate product. This product was withdrawn from the market in August 2003, and was replaced with a 1.5% guaranteed interest rate annuity.

The following has been extracted from the Exhibits of Accident and Health Insurance in the filed annual statements for each of the years under review:

	<u>2001</u>	<u>Ordinary</u> <u>2002</u>	<u>2003</u>	<u>2001</u>	<u>Group</u> <u>2002</u>	<u>2003</u>
Outstanding, end of previous year	47,260	61,819	74,251	1,243	1,425	1,477
Issued during the year	20,118	22,634	12,925	308	213	125
Other net changes during the year	<u>(5,559)</u>	<u>(10,202)</u>	<u>(18,376)</u>	<u>(126)</u>	<u>(161)</u>	<u>(193)</u>
Outstanding, end of current year	<u>61,819</u>	<u>74,251</u>	<u>68,800</u>	<u>1,425</u>	<u>1,477</u>	<u>1,409</u>

In 2001 and 2002, the increase in "Issued during the year" for the ordinary accident and health insurance business was because HMO providers, within the Company's writing territories, withdrew from the Medicare program. These former HMO enrollees enrolled with the Company. The withdrawal of HMO providers began in 1999, peaked in 2002, and stabilized in 2003, resulting in a decrease in ordinary issues for 2003. The group accident and health

insurance policies reported were association groups. The decrease in group accident and health insurance was due to the withdrawal of several associations.

The following is the net gain (loss) from operations by line of business after federal income taxes but before realized capital gains (losses) reported for each of the years under examination in the Company's filed annual statements:

	<u>2001</u>	<u>2002</u>	<u>2003</u>
Ordinary:			
Life insurance	\$ 427,026	\$ 27,882	\$ (216,805)
Individual annuities	673,905	418,997	(636,396)
Total ordinary	<u>\$1,100,931</u>	<u>\$ 446,879</u>	<u>\$ (853,201)</u>
Accident and health:			
Group	\$ 50,014	\$ 62,606	\$ 128,226
Other	<u>(684,228)</u>	<u>(2,326,845)</u>	<u>(2,267,188)</u>
Total accident and health	<u>\$ (634,214)</u>	<u>\$(2,264,239)</u>	<u>\$(2,138,962)</u>
Total	<u>\$ 466,717</u>	<u>\$(1,817,360)</u>	<u>\$(2,992,163)</u>

In 2001, the loss in the other accident and health insurance line of business was due to approximately \$0.6 million of losses on a discontinued block of major medical business, and approximately \$0.1 million due to adverse experience on a discontinued block of disability insurance. The remaining loss is the result of strain associated with the significant growth in the Medicare Supplement business. The bulk of the change between 2001 and 2002 was due to the federal income tax expense. This line of business lost approximately \$1.3 million from operations in 2001 and 2002, but the reduction in federal income tax expense of \$0.4 million in 2001 resulted in a loss of \$684,228, while in 2002 a federal income tax expense of \$952,542 resulted in a loss of \$2.3 million.

In 2003, the loss in the other accident and health insurance line of business was primarily driven by a \$0.9 million loss from the discontinued major medical block of business. An additional \$0.6 million of the loss was the result of retroactive payments to the New York Stabilization Pool Assessment, which was unexpected and not reserved. An additional \$0.2 million of the loss was directly related to start-up costs on the Medicare Advantage program that the Company officially rolled-out in 2004. Also, this line of business was allocated approximately 80% of the Company's general insurance expenses. The Company's general

expenses increased by approximately \$1.7 million in 2003, which increased the expenses allocated to this line of business by over \$1 million.

The loss in the individual life insurance line of business in 2003 was directly related to the expansion of the senior life product into additional states, resulting in new business strain on this product. The Company also began retaining 100% of its new issues in 2003 (previously reinsured at 50%). The increased retention also contributed to the additional strain, as reinsurance allowances are normally favorable in the first year.

The following ratios, applicable to the accident and health insurance business of the Company, have been extracted from Schedule H for each of the indicated years:

	<u>2001</u>	<u>2002</u>	<u>2003</u>
Premiums earned	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>
Incurred losses	74.6%	74.4%	72.7%
Commissions	7.9	9.4	13.9
Expenses	<u>27.5</u>	<u>22.4</u>	<u>19.1</u>
	<u>110.0%</u>	<u>106.2%</u>	<u>105.7%</u>
Underwriting results	<u>(10.0)%</u>	<u>(6.2)%</u>	<u>(5.7)%</u>

## 5. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital and surplus as of December 31, 2003, as contained in the Company's 2003 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Company's financial condition as presented in its financial statements contained in the December 31, 2003 filed annual statement.

### A. ASSETS, LIABILITIES, CAPITAL AND SURPLUS AS OF DECEMBER 31, 2003

#### Admitted Assets

Bonds	\$134,837,853
Stocks:	
Common stocks	9,428
Cash, cash equivalents and short term investments	23,950,028
Contract loans	2,104,286
Investment income due and accrued	1,826,855
Premiums and considerations:	
Uncollected premiums and agents' balances in the course of collection	264,274
Deferred premiums, agents' balances and installments booked but deferred and not yet due	1,257,090
Reinsurance:	
Amounts recoverable from reinsurers	116,366
Other amounts receivable under reinsurance contracts	496,308
Net deferred tax asset	779,033
Electronic data processing equipment and software	11,566
Receivables from parent, subsidiaries and affiliates	<u>613,061</u>
 Total admitted assets	 <u>\$166,266,148</u>

Liabilities, Capital and Surplus

Aggregate reserve for life policies and contracts	\$129,109,793
Aggregate reserve for accident and health contracts	13,815,592
Liability for deposit-type contracts	62,968
Contract claims:	
Life	601,450
Accident and health	6,557,809
Premiums and annuity considerations for life and accident and health contracts received in advance	887,424
Contract liabilities not included elsewhere:	
Interest maintenance reserve	1,004,434
General expenses due or accrued	564,197
Taxes, licenses and fees due or accrued, excluding federal income taxes	161,947
Current federal and foreign income taxes	311,641
Amounts withheld or retained by company as agent or trustee	276,933
Amounts held for agents' account	473,023
Remittances and items not allocated	864,699
Miscellaneous liabilities:	
Asset valuation reserve	90,253
Funds held under reinsurance treaties with unauthorized reinsurers	183,561
Payable to parent, subsidiaries and affiliates	379,442
Due to reinsurer	632,552
Miscellaneous contingent reserve	<u>96,895</u>
 Total liabilities	 <u>\$156,074,613</u>
 Common capital stock	 \$ 2,500,000
 Gross paid in and contributed surplus	 19,966,498
Unassigned funds (surplus)	<u>(12,275,013)</u>
Surplus	\$ <u>7,691,485</u>
Total capital and surplus	\$ <u>10,191,485</u>
 Total liabilities, capital and surplus	 <u>\$166,266,098</u>

B. CONDENSED SUMMARY OF OPERATIONS

	<u>2001</u>	<u>2002</u>	<u>2003</u>
Premiums and considerations	\$27,670,720	\$53,458,901	\$106,183,106
Investment income	6,665,912	6,392,190	7,086,607
Commissions and reserve adjustments on reinsurance ceded	7,128,153	12,330,053	8,890,572
Miscellaneous income	<u>150,041</u>	<u>84,155</u>	<u>91,092</u>
 Total income	 <u>\$41,614,826</u>	 <u>\$72,265,299</u>	 <u>\$122,251,377</u>
Benefit payments	\$23,370,560	\$37,119,585	\$ 43,425,980
Increase in reserves	1,844,813	8,445,783	50,524,928
Commissions	9,110,761	16,952,774	19,481,763
General expenses and taxes	6,330,682	9,716,601	11,350,642
Increase in loading on deferred and uncollected premium	187,099	278,872	(58,014)
 Total deductions	 <u>\$40,843,915</u>	 <u>\$72,513,615</u>	 <u>\$124,725,299</u>
Net gain (loss)	\$ 770,911	\$ (248,316)	\$ (2,473,922)
Federal and foreign income taxes incurred	<u>304,194</u>	<u>1,569,045</u>	<u>518,241</u>
 Net gain (loss) from operations before net realized capital gains	 \$ 466,717	 \$ (1,817,361)	 \$ (2,992,163)
Net realized capital losses	<u>(1,010,245)</u>	<u>(1,097,816)</u>	<u>(287,159)</u>
 Net loss	 <u>\$ (543,528)</u>	 <u>\$ (2,915,177)</u>	 <u>\$ (3,279,322)</u>

The increase in premiums and annuity considerations in 2002 was mainly due to the large increase in sales in Medicare Supplement policies as a result of the continued expansion into northeastern states, and the effects of HMO providers withdrawing from territories where the Company markets its products.

The increase in premiums and annuity considerations and the increase in reserves in 2003 was mainly attributed to the significant increase in sales of the Company's 4% guaranteed annuity product. In addition, the increase in premiums was also the result of the Company retaining more of its Medicare Supplement business due to a change in the terms of its reinsurance contract.

C. CAPITAL AND SURPLUS ACCOUNT

	<u>2001</u>	<u>2002</u>	<u>2003</u>
Capital and surplus, December 31, prior year	\$ <u>9,559,239</u>	\$ <u>10,051,289</u>	\$ <u>10,065,313</u>
Net income	\$ (543,528)	\$(2,915,177)	\$(3,279,322)
Change in net unrealized capital gains (losses)	491,053	26,219	59,118
Change in net deferred income tax	0	415,181	(119,057)
Change in non-admitted assets and related items	947,053	196,829	442
Change in asset valuation reserve	246,924	598,798	(34,959)
Cumulative effect of changes in accounting Principles	(649,434)	482,909	0
Surplus adjustments: Paid in	<u>0</u>	<u>1,209,265</u>	<u>3,500,000</u>
Net change in capital and surplus for the year	\$ <u>492,050</u>	\$ <u>14,024</u>	\$ <u>126,222</u>
Capital and surplus, December 31, current year	\$ <u>10,051,289</u>	\$ <u>10,065,313</u>	\$ <u>10,191,535</u>

6. MARKET CONDUCT ACTIVITIES OF LIFE INSURANCE POLICIES  
AND ANNUITY CONTRACTS

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

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

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 . . . (6) Where the required forms are received with the application and found to be in compliance with this Part, maintain copies of: any proposal, including the sales material used in the sale of the proposed life insurance policy or annuity contract; proof of receipt by the applicant of the "IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts;" the signed and completed "Disclosure Statement;" and the notification of replacement to the insurer whose life insurance policy or annuity contract is to be replaced indexed by agent and broker, for six calendar years or until after the filing of the report on examination . . . whichever is later . . .”

Section 51.7(a) of Department Regulation No. 60 states, in part:

“No insurer, agent or broker shall: (1) make or give any deceptive or misleading information in the “Disclosure Statement” or in any proposal, including the sales material used in the sale of the proposed life insurance policy or annuity contract . . .”

The examiner reviewed a sample of 117 replaced annuity contracts that were issued during the examination period. The examiner noted instances where the Disclosure Statements were not properly completed, which resulted in inaccurate, incomplete and misleading comparisons between the replaced contract and the contract that was issued by the Company. Specifically, the examiner noted the following:

- 49 of the 117 replaced contracts had surrender charges. For 37 of the 49 contracts, the Company used the replaced policy account value before surrender charge instead of the

surrender value to be invested, to compare the replacing contract to the replaced contract. This caused the replacing contract to appear to be a better value than the replaced contract;

- the Company used the “Death Benefit” amount to complete the “Surrender Value” in Section C of the Disclosure Statement for 19 contracts. As a result, the replacing contract appeared to be a better value than the replaced contract;
- the “Surrender value to be invested” was not stated in Part C of the Disclosure Statement for 64 contracts;
- required information, such as interest guaranteed rate or interest crediting rate, was not provided in the comparison for the “Proposed Annuity Contract” in Part B of the Disclosure Statement Form for 74 contracts;
- illustrations used by the Company for the sale of the contracts were not on file for 12 contracts. Therefore, there was no documentation to support the values used for the replacing contract in Part C of the Disclosure Statements; and,
- the Important Notice Regarding Replacement or Change of Life Insurance or Annuity Contracts (“Important Notice Regarding Replacement”) was not found in 7 files.

The Company violated Section 51.7(a)(1) of Department Regulation No. 60 by providing inaccurate, incomplete and misleading Disclosure Statements to prospective contractholders. Additionally, the Company violated Section 51.6(b) of Department Regulation No. 60 by failing to maintain copies of sales proposals, and by failing to maintain proof of receipt by the applicant of the Important Notice Regarding Replacement.

Section 243.2(b) of Department Regulation No. 152 states, in part:

“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 . . . A policy record shall include . . . (iv) Other information necessary for reconstructing the solicitation, rating, and underwriting of the contract . . . (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.”

During the review of the 117 replaced annuity contracts, the examiner noted that not all of the documentation necessary to reconstruct the replacement transactions was maintained in the contract files. Specifically, the examiner noted the following:

- documentation from the replaced insurer to support the replaced contract values used in Part C of the Disclosure Statement was not on file for five contracts;
- authorization letters necessary to obtain information from the replaced insurer were not on file for 29 contracts; and
- letters requesting information from the replaced insurers were not found in 38 files. As a result, the examiner could not determine the time it took to receive responses from the replaced insurers.

The Company violated Section 243.2(b)(1)(iv) of Department Regulation No. 152 by failing to maintain records necessary to reconstruct the solicitation, rating, and underwriting of replacement contracts as well as other records.

Due to the high exception rate found during the review of replaced annuity contracts involving inaccurate, incomplete and misleading Disclosure Statements, the Department informed the Company that remediation was necessary. The Company implemented a plan of remediation that resulted in a total credit to current contractholders' accounts in the amount of \$229,243, and a total reimbursement to former contractholders in the amount of \$94,947.

#### B. Underwriting and Policy Forms

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

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

“(a) In this article, “policy form” means any policy . . . and any application . . .  
(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 consistent with law . . .”

A review of the Company's policy forms in use revealed that two policy forms (SPDA-91(Rev 4/97) and FPA-91(4/97)), and two application forms (HIO-93NY(1/2000) and APRTC/HHC(3/99)NY) were altered from the original forms that were submitted and approved by the Department.

The Company violated Section 3201(b)(1) of the New York Insurance Law by changing two policy and application forms, which had been approved by the Superintendent, without re-filing the changed forms for approval.

### 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(e) of Department Regulation No. 64 states:

"As part of its complaint handling function, an insurer's consumer services department shall maintain an ongoing central log to register and monitor all complaint activity."

The Company's complaint handling procedures describes a complaint as "any written communication which primarily expresses a grievance against the Company's insurance practices, products, or related matters". The Company does not record verbal complaints in the complaint log. If a complaint is received by phone, the Company tries to resolve the complaint over the phone; if it can't be resolved in that manner, the complainant is instructed to file a formal complaint with the Department.

The Company violated Section 216.4(e) of Department Regulation No. 64 by failing to maintain a log of all consumer complaints.

## 7. MEDICARE SUPPLEMENT INSURANCE

The Company is one of the largest writers of Medicare Supplement insurance in New York State. In early 2004, SOFA informed the Department of certain agents of the Company allegedly engaging in high pressure sales tactics when selling Medicare Supplement policies in the northern New York counties. In addition, some agents were also reportedly presenting themselves as representatives from Medicare or from EPIC.

Since the allegations involved more than one of the Company's agents in various counties, the Department's CSB conducted an investigation into the Company's Medicare Supplement sales practices. CSB reviewed copies of all sales and training materials provided to the Company's general agents and soliciting agents and also applications of select agents and agencies. Letters were also sent to insurers whose Medicare Supplement policies were replaced to determine whether the new coverage provided by the Company replaced a policy that was more beneficial to the insured, and whether duplicate coverage was in place. CSB compared the information on the Company's applications with the information received from each carrier whose policy was replaced. CSB also investigated the reasons given for replacement by each agent to detect trends. CSB also coordinated their efforts with the examination team during this examination.

Section 52.22(h)(4) of Department Regulation No. 62 states, in part:

“(i) Standards for marketing: (1) An issuer, directly or through its agents or other producers, shall:

(i) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(ii) Establish marketing procedures to assure excessive insurance is not sold or issued...

(iv) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and health insurance and the types and amount of any such insurance.

(v) Establish auditable procedures for verifying compliance with this subdivision.

(2) In addition to the practices prohibited in article 24 of the Insurance Law, the following acts and practices are prohibited . . .

(iii) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.”

The Company uses the services of general agents to seek and recruit other agents. CSB found that, prior to 2004, the Company did not provide training to either its general agents or soliciting agents, and it did not monitor their activities closely. In addition, the Company was aware that some of its agencies created their own sales leads and provided training for their agents. However, the Company generally took a “hands off” approach, since it considered its general agents to be independent contractors.

A review of policyholder applications and confirmations that were sent to insureds revealed that a number of the Company’s Medicare Supplement policyholders had duplicative Medicare Supplement policies with other carriers and some policyholders even had duplicative Medicare Supplement policies with the Company. Other policyholders had duplicative coverage under a Medicare Advantage plan or other health insurance.

The Company violated Section 52.22(h)(4)(i)(1) of Department Regulation No. 62 by failing to adequately implement procedures to assure that excessive insurance was not sold or issued, and by failing to establish auditable procedures for verifying compliance with the Regulation.

The examiner recommends that the Company refund all premiums collected from those policyholders who were sold duplicative coverage.

Section 215.2(b) of Department Regulation No. 34 states:

“Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised.”

Section 215.17(a) of Department Regulation No. 34 states, in part:

“ . . . Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement . . . which shall indicate the manner and extent of distribution and the form number of any policy advertised . . . ”

Section 52.22 (b)(9) of Department Regulation No. 62 states:

“An issuer shall provide, prior to its use, a copy of any advertisement for a Medicare Supplement insurance policy or certificate intended for use in this State whether through written, radio or television medium to the superintendent for review. Such advertisement shall comply with all applicable regulations and laws of this State.”

An agency of the Company used “lead cards” which were mailed to potential applicants informing them that someone would be contacting them to schedule a meeting. The “lead cards” did not inform the potential applicant that the person contacting them was an insurance agent or that the purpose of the meeting was to sell insurance. The agency’s training material specifically advises agents to avoid mentioning insurance on the “lead cards” or in responding to inquiries by prospects. The “lead cards” were not submitted to the Company for review, nor were they submitted to the Department for review.

The Company violated Section 215.2(b) of Department Regulation No. 34 by failing to establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies.

The Company violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain a complete advertising file.

Additionally, the Company violated Section 52.22(b)(9) of Department Regulation No. 62 by failing to provide, prior to its use, copies of Medicare Supplement “lead cards” to the Superintendent for review.

Further, the Company violated Section 52.22(h)(4)(i)(2)(iii) of Regulation No. 62 by failing to disclose in cold lead advertisements in a conspicuous manner that the purpose of the method of marketing was the solicitation of insurance and that contact would be made by an insurance agent or insurance company.

Section 52.22(g)(3) of Department Regulation No. 62 states, in part:

“If a Medicare supplement or Medicare select policy or certificate replaces another Medicare supplement policy or certificate, a Medicare select policy or certificate, a Medicare+Choice plan . . . , then the replacing issuer must provide the policyholder or certificateholder with the following written notice:

‘Your application for the Medicare supplement insurance policy (certificate) issued by this company indicates that you intended to terminate existing Medicare supplement insurance coverage, Medicare select coverage, Medicare+Choice plan or health maintenance organization (HMO) issued Medicare cost contract and replace it with the coverage applied for with this company. Duplicate coverage is unnecessary and you should terminate one of your existing coverages if more than one such plan is still in force.’

At the option of the issuer, such notice shall either be included with the first premium due notice mailed to the policyholder or certificateholder after the replacement coverage is issued, or sent separately within 30 days of the date of

the first premium due notice, but in no event shall such notice be provided later than six months after issuance of the replacement policy or certificate.”

The examiner reviewed a sample of 30 Medicare Supplement policies that were issued during the examination period. The files did not contain the written notice required by Section 52.22(g)(3) of Department Regulation No. 62. The Company replaced approximately 44,000 policies during the examination period.

The Company violated Section 52.22(g)(3) of Department Regulation No. 62 by failing to provide policyholders with the required written replacement notice.

Section 4224 of the New York Insurance Law states, in part:

“(b) No insurer doing in this state the business of accident and health insurance...and no officer or agent of such insurer and no licensed insurance broker, and no employee or other representative of such insurer, agent or broker shall:

(1) make or permit any unfair discrimination between individuals of the same class in the amount of premiums, policy fees, or rates charged for any policy of accident and health insurance, or in the benefits payable thereon, or in any of the terms or conditions of such policies, or in any other manner whatsoever . . .

(c) No such life insurance company... and no officer, agent, solicitor or representative thereof . . . and no licensed insurance broker and no employee or other representative of any such insurer, agent or broker, shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to any person to insure . . . or interdependent with any policy of life insurance or annuity contract . . . any valuable consideration or inducement whatever not specified in such policy or contract . . .”

Effective November 1, 2001, the Company instituted a policy application fee for each Medicare Supplement policy application. The fee of \$25 was to be charged to all individuals applying for Medicare Supplement policies. If a husband and wife applied for a policy at the same time, they were only charged one fee for both applications.

The examiner reviewed a sample of 288 Medicare Supplement policies. The examiner found 16 instances where the agent did not collect the application fee from the applicant. In these instances, the fees were either paid by the agent by money order or check, or deducted from the agent’s commission account.

The Company violated Section 4224 of the New York Insurance Law by making or permitting unfair discrimination between individuals of the same class and giving an inducement to certain applicants by failing to collect or charge the applicable application fee in all instances.

## 8. FINANCIAL RECORDS

An insurer's books of account include, but are not necessarily limited to, the general ledger, investment ledger, journals, cash book, subsidiary ledgers and all worksheets supporting annual, quarterly and other statements and reports filed with or submitted to supervisory and regulatory authorities.

Section 325(a) of the New York Insurance Law states, in part:

“Every domestic insurer . . . shall, except as hereinafter provided, keep and maintain at its principal office in this state . . . its books of account . . .”

The Company does not maintain its books of account at its principal office in New York. Some of the books of account were maintained on the Company's server, which is located in Pensacola, Florida. The examiner was not granted direct access to the books of account which were maintained on the server.

The Company violated Section 325(a) of the New York Insurance Law by failing to maintain its books of account at its principal office in this State.

## 9. INTERNAL AUDIT

Internal audit is an integral part of corporate governance that also includes the audit committee, the board of directors, senior management and the external auditors. In particular, internal auditors and audit committees are mutually supportive. Consideration of the work of internal auditors is essential for the audit committee to gain a complete understanding of the Company's operations. Internal audit identifies strategic, operational and financial risks facing the organization and assesses controls put in place by management to mitigate those risks. In the case of the Company, duties normally delegated to the audit committee are the fiduciary responsibility of the outside committee (which is comprised of the Company's unaffiliated directors).

In response to the examination planning questionnaire and the response to the prior report on examination, the Company indicated that the internal audit staff of UAFC performs audits of the insurance companies in the holding company system. The audits are performed on a functional basis, not by company. In response to the examiner's request for all internal audits that pertained to the Company, the examiner was provided with the following five internal audit reports: (1) American Progressive Annuities - Agent Fraud Audit; (2) Litigation Audit; (3) Officer Expense Reimbursement Audit; (4) UAFC Suspense Accounts and UAFC Policy Loans; (5) UAFC Cash Management Exit Audit.

The "American Progressive Annuities - Agent Fraud Audit" was conducted as a result of the Company receiving many complaints from annuitants of possible misuse of funds by their agent. Company transactions were also included in the UAFC Suspense Accounts Audit. The remaining reports did not indicate whether or not any Company activity was included in the audits. Since the internal audit reports which involve the Company are extremely limited, it does not appear that the Company has an adequate internal audit function.

The examiner recommends that the Company establish and maintain an independent, adequately resourced, and competently staffed internal audit function to provide management and the audit committee with ongoing assessments of the Company's risk management processes and the accompanying system of internal control. To the extent that audits performed by an affiliate on a functional basis are intended to encompass the activities of the Company, it should be clear from the audit workpapers that Company transactions or activities are specifically included in the samples reviewed by internal audit. Although the Company stated that they

instituted an independent internal audit function as a response to the recommendation contained in the prior report on examination, there is only one employee in the internal audit department and the Company is outsourcing most of the internal audit functions.

#### 10. DISASTER RECOVERY

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 Company out-sources its mainframe computer operations to Infocrossing, Inc., which is responsible for the disaster recovery plan. The examiner reviewed a SAS 70 report, which was issued by an independent CPA firm, covering the disaster recovery plan services provided by Infocrossing, Inc. The report indicated that Infocrossing, Inc. had an acceptable disaster recovery plan in place as of November 1, 2001. The examiner was unable to obtain a more recent SAS 70 report as of the completion date of the examination.

The examiner also reviewed the Company's disaster recovery plan for its servers, PCs and related software and data files, which is handled by affiliates of the Company. The plan failed to address basic information such as, but not limited to, the location of the Company's servers, the storage of critical data and software, and the results of any test procedures. The examiner requested this information several times during the on-site examination. Subsequent to the on-site examination, the Company indicated that a more detailed disaster recovery plan was embedded within an affiliate's disaster recovery plan. Although the examiner requested additional documentation to support this assertion, the Company failed to provide this detail. The examiner deems the Company's disaster recovery plan insufficient.

The examiner recommends that the Company augment its current disaster recovery plan. Such a plan should address data retrieval procedures, telecommunications recovery procedures, disaster declaration approval procedures, and physical recovery location. The plan should contain provisions to ensure periodical testing. The disaster recovery plan should be aligned with the business continuity plans, approved, and periodically reviewed by management to ensure that it meets the needs of the business. Documentation of the disaster recovery test plan and results (indicating problems found or successful completions) and documentation of management approval of the plan should be maintained.

## 11. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following are the violations and comment 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 1505(d)(3) of the New York Insurance Law by failing to notify the Superintendent of its participation in the Service Expense Reimbursement and Cost Sharing Agreement with its affiliate, PFI, Inc.</p> <p>The Service Expense Reimbursement and Cost Sharing Agreement with UAFS (formerly, PFI, Inc.) was submitted to the Department on January 24, 2002. The agreement was approved on August 1, 2002.</p>
B	<p>The Company violated Section 1505(d)(3) of the New York Insurance Law by failing to notify the Superintendent of its agreement with CHCS, whereby CHCS renders services on behalf of the Company on a regular or systematic basis.</p> <p>The Company filed an amendment for this agreement with the Department on November 23, 2004. As of the date of the report, the Department had not approved the agreement.</p>
C	<p>The Company violated Section 308(a) of the New York Insurance Law when it failed to file a copy of its tax allocation agreement with the Department within 30 days of its effective date, as advised by Department Circular Letter No. 33 (1979).</p> <p>The Company filed the agreement with the Department on March 13, 2002. The agreement was approved by the Department on March 31, 2003.</p>
D	<p>The examiner recommended that the Company establish and maintain an independent, adequately-resourced, and competently-staffed internal audit function to provide management and the audit committee with ongoing assessments of the Company's risk management processes and the accompanying system of internal control.</p> <p>Although the Company stated that the position of Director of Internal Audit was created by the fourth quarter of 2002, there is only one employee in the internal audit department and most of the work is outsourced. The internal audits are performed on a functional basis, not by company. As a result, it does not appear that the Company has an adequate independent internal audit function.</p>

## 12. 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 Company violated Section 1505(d)(3) of the New York Insurance Law by failing to notify the Superintendent of its participation in the Service Expense Reimbursement and Cost Sharing Agreement with its affiliate CHCS. This is a repeat violation from the prior report on examination.	10
B	The examiner recommends that the Company recoup from CHCS all monies paid under the aforementioned service agreement with CHCS since the last examination period.	10
C	The Company violated Section 325(a) of New York Insurance Law by failing to keep and maintain the minutes of the board committee meetings.	12
D	The Company violated Section 1202(b)(2) of the New York Insurance Law when its audit committee failed to meet and fulfill its responsibilities during the examination period.	12
E	The Company violated Section 51.6(b) of Department Regulation No. 60 by failing to maintain copies of sales proposals, and by failing to maintain proof of receipt by the applicant of the Important Notice Regarding Replacement.	23 – 24
F	The Company violated Section 51.7(a)(1) of Department Regulation No. 60 by providing inaccurate, incomplete and misleading Disclosure Statements to prospective contractholders.	23 – 24
G	The Company violated Section 243.2(b)(1)(iv) of Department Regulation No. 152 by failing to maintain records necessary for reconstructing the solicitation, rating, and underwriting of replacement contracts, as well as other records.	24 – 25
H	The Company violated Section 3201(b)(1) by changing two policy and application forms, which had been approved by the Superintendent, without refileing the changed forms for approval.	25 - 26
I	The Company violated Section 216.4(e) of Department Regulation No. 64 by failing to maintain a log of all consumer complaints.	26

- J The Company violated Section 52.22(h)(4)(i)(1) of Department Regulation No. 62 by failing to adequately implement procedures to assure that excessive Medicare Supplement insurance was not sold or issued, and by failing to establish auditable procedures for verifying compliance with the Regulation. 27 – 28
- K The examiner recommends that the Company refund all premiums collected from policyholders who were sold duplicative Medicare Supplement coverage. 28
- L The Company violated Section 215.2(b) of Department Regulation No. 34 by failing to establish and maintain a system of control over the content, form and method of dissemination of advertisements for its Medicare Supplement policies. 28 – 29
- M The Company violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain a complete advertising file for its Medicare Supplement business. 28 – 29
- N The Company violated Section 52.22(b)(9) of Department Regulation No. 62 by failing to provide, prior to their use, copies of Medicare Supplement advertisements to the Superintendent for review. 28 – 29
- O The Company violated Section 52.22(h)(4)(i)(2)(iii) of Regulation No. 62 by failing to disclose in cold lead advertisements in a conspicuous manner that the purpose of the method of marketing was the solicitation of Medicare Supplement insurance and that contact would be made by an insurance agent or insurance company. 27 – 29
- P The Company violated Section 52.22(g)(3) of Department Regulation No. 62 by failing to provide policyholders with the required Medicare Supplement replacement notice. 29 – 30
- Q The Company violated Section 4224 of the New York Insurance Law by making or permitting unfair discrimination between individuals of the same class, and giving an inducement to certain Medicare Supplement applicants by failing to collect or charge the applicable application fee in all instances. 30 – 31
- R The Company violated Section 325(a) of the New York Insurance Law by failing to maintain its books of accounts at its principal office in this state. 32

- S The examiner recommends that the Company establish and maintain an independent, adequately resourced, and competently staffed internal audit function to provide management and the audit committee with ongoing assessments of the Company's risk management processes and the accompanying system of internal control. This is a repeat recommendation from the prior report on examination. 33 - 34
- T The examiner recommends that the Company augment its current disaster recovery plan. 34



APPOINTMENT NO. 22222

**STATE OF NEW YORK**  
**INSURANCE DEPARTMENT**

I, GREGORY V. SERIO, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**JACQUELINE TUCKER**

*as a proper person to examine into the affairs of the*

**AMERICAN PROGRESSIVE LIFE AND HEALTH  
INSURANCE COMPANY OF NEW YORK**

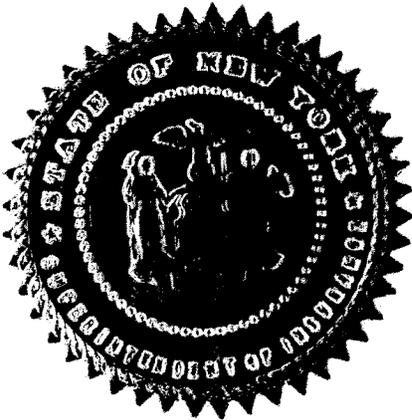
*and to make a report to me in writing of the condition of the said*

**COMPANY**

*with such other information as she 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 3rd day of May, 2004*



**GREGORY V. SERIO**  
Superintendent of Insurance

*Gregory V. Serio*  
Superintendent