



NEW YORK STATE  
DEPARTMENT *of*  
FINANCIAL SERVICES

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**IMMEDIATE PARTICIPATION GUARANTEE  
AND DEPOSIT ADMINISTRATION CONTRACTS  
(Last Updated 12/14/12)**

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**IMMEDIATE PARTICIPATION GUARANTEE  
AND DEPOSIT ADMINISTRATION CONTRACTS  
(Last Updated 12/14/12)**

This outline is current as of 12/14/12. Subsequent changes to statutes, regulations, circular letters, etc., may not be reflected in the outline. In case of any doubt, please contact the Life Bureau.

I) Applicability

I.A) Scope

This product outline covers all immediate participation guarantee contracts and deposit administration contracts delivered in this state funded solely through the insurer's general account. Such contracts are long-term, experience-rated (or direct-rated) contracts, with no specified maturity date, that permit the contractholder/plan to participate in the investment experience of the insurer's general account primarily by means of the insurer's investment year method of allocating investment income. Note that these contracts have been the subject of litigation involving the definition of "guaranteed benefit policy" as such term is used in ERISA §401(b)(2)(B). See Section VI of this outline.

This outline replaces the Immediate Participation Guarantee and Deposit Administration Contracts Outline last updated 8/11/00.

- A.1) The separate account agreement outline should be reviewed to the extent that the contract provides for separate account funding.
- A.2) Please note that if the amounts allocated to the general account do not exceed the amounts committed to retired and terminated employees (i.e., restricted portion) the separate account portion for a market value separate account will be subject to Regulation No. 128.
- A.3) To address *Harris Trust* concerns, insurers should consider transferring all unrestricted or uncommitted amounts to one or more separate accounts.

I.B) Excluded Contracts

- B.1) Group Annuity Contracts Subject to §4223
- B.2) Allocated Group Variable And Separate Account Annuity Contracts
- B.3) Combination Group Fixed And Variable Annuity Contracts
- B.4) Allocated Group Annuity Contracts Not Subject to §4223
- B.5) Guaranteed Interest Contracts
- B.6) Funding Agreements
- B.7) Group Annuity Terminal Funding and Closeout Contracts
- B.8) Separate Account Agreements

- (a) Note that Regulation No. 128 separate account contracts have been used to fund immediate participation guarantee contracts in which part or all of the restricted portion (amounts allocated to the payment of benefits to specific plan participants or beneficiaries) is funded through the separate account.
- (b) Note also that Regulation No. 128 evergreen contracts have largely replaced deposit administration contracts funded through the general account.

#### B.9) Synthetic Guaranteed Investment Contracts

### I.C) Definitions

#### C.1) Annuities

All agreements to make periodical payments for a period certain or where the making or continuance of all or some of a series of such payments, or the amount of any such payment, depends upon the continuance of human life. Section 1113(a)(2). Note that *period certain* annuities were first authorized in New York by Section 1 of Chapter 864 of the Laws of 1985.

#### C.2) Deposit Administration Contract

Group annuity contracts that typically provide for an unallocated fund accumulation for active lives out of which immediate annuities are purchased for individuals at retirement and deferred annuities are purchased for terminated employees with vested benefits. [See former §95.11(d)(2)(ii) of Regulation No. 126 prior to 1994 amendment.]

- (a) The reserves for retired lives shall be at least as much as that based on the minimum valuation basis in effect on the date of purchase.
- (b) There may or may not be high interest guarantees on the active life funds. Typically, interest is credited pursuant to the company's investment year method of allocating investment income pursuant to §91.5 of Regulation No. 33.

#### C.3) Group Annuity Contract

Any policy or contract, except a joint, reversionary or survivorship annuity contract, whereby annuities are payable dependent upon the continuance of the lives of more than one person. Section 4238(a).

- (a) We view group contracts that provide for the purchase of annuities or the payment of annuity benefits for plan participants or their beneficiaries to be group annuity contracts
- (b) Plans funded by group annuity contracts include 401(a), 401(k), 457, 414(d), and 403(b), among others.

#### C.4) Guaranteed Benefit Policy

An insurance policy or contract to the extent that such policy or contract provides for benefits the amount of which is guaranteed by the insurer. Such term includes

any surplus in a separate account, but excludes any other portion of a separate account. See ERISA §401(b)(2)(B).

- (a) ERISA §401(b)(2) provides that in the case of a plan to which a guaranteed benefit policy is issued by an insurer, the assets of such plan shall be deemed to include such policy, but shall not, solely by reason of the issuance of such policy, be deemed to include any assets of such insurer.
- (b) Thus, if an insurer issues a "guaranteed benefit policy" to a plan, the assets of the plan are deemed to include the policy but do not include any of the assets of the insurer.

#### C.5) Immediate Participation Guarantee Contract

Group annuity contracts that typically provide for an unallocated fund accumulation for retired and active lives, with participation by both in the experience of the insurer's general account. [See former §95.11(d)(2)(i) of Regulation No. 126 prior to 1994 amendment.]

- (a) The annuities in the course of payment for retired lives are not considered as being purchased unless the funds fall below a specified level, in which case annuities are actually purchased and the contract becomes a deposit administration contract. Amounts allocated to the payment of benefits to specific plan participants or their beneficiaries (typically at retirement) are guaranteed and the insurer is irrevocably committed to the payment of such benefits. Such allocated amounts are usually referred to as committed or restricted amounts (or portion) of the accumulation fund. The unallocated amounts attributable to active lives (and retired lives for whom annuity benefits are not guaranteed under the contract) are usually referred to as the uncommitted or unrestricted amounts (or portion) of the accumulation fund.
- (b) The reserve for annuities on retired lives and for previously guaranteed annuities on deferred lives shall be at least equal to the reserves, determined in accordance with section 99.6 of Regulation 151, based on the minimum valuation basis assuming such annuities were purchased in the year of valuation, at time of retirement or at time of previous guarantee, provided such method is consistently applied.
- (c) Any portion allocated for active lives may or may not have interest guarantees. Interest is credited pursuant to the company's investment year method of allocating investment income pursuant to §91.5 of Regulation No. 33.

#### C.6) Unallocated Contract

Any contract that does not provide for the maintenance of one or more accounts for each employee or member of all deposits made by or on behalf of such employee or member. This term usually applies to the active life or accumulation fund of a group annuity contract.

- (a) Amounts set aside for retired lives are usually allocated to specific plan

participants. Retired life certificates are issued to such retirees or terminated employees. Annuities are generally purchased under deposit administration contracts. Usually annuities are not actually purchased under immediate participation guarantee contracts.

- (b) The insurer is not required to issue an active life certificate to plan participants. Such certificates are not required for unallocated contracts.
- (c) The insurer is not irrevocably committed to apply under the terms of the contract to the payment of benefits by it to specific plan participants or their beneficiaries or to the purchase of annuities for specific plan participants.

#### C.7) Unallocated amounts

Any funds credited to the accumulation fund which the insurer is not currently irrevocably committed to apply under the terms of the contract to the payment of benefits by it to specific plan participants or beneficiaries or to the purchase of annuities for specific plan participants, adjusted for any accrued experience rating charges or credits, including expenses and administrative, sales and surrender charges provided for under the contract. See §40.2(z) of Regulation No. 139.

#### I.D) Key References

- D.1) Insurance Law: §§ 2123, 3102, 3201, 3204, 3209, 3212, 3223, 4224, 4226, 4231, 4238, 4239, 4240
- D.2) Regulations: Regulation 139 (11 NYCRR 40), Regulation 34-A (11 NYCRR 219)
- D.3) Circular Letters: CL 4 (1963), CL 6 (1963), CL 1 (1964), CL 12 (1976), CL 14 (1997), CL 2 (1998), CL 8 (1999), CL 6 (2004), CL 27 (2008)

#### II) Filing Process

##### II.A) General Information

###### A.1) Prior Approval Requirement

Section 3201(b)(1) provides that 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 the Insurance Law* (standard and generally applicable provisions) and *not inconsistent with law* (federal and state statutory, regulatory and decisional law).

###### A.2) Discretionary Authority for Disapproval

Section 3201(c)(1) and (2) permits the Superintendent to disapprove any policy form that contains provisions that are misleading, deceptive, unfair, unjust, or inequitable or if its issuance would be prejudicial to the interests of policyholders or members. See also §§2123, 3209, 4224, 4226, 4238(e), 4231, 4239.

###### A.3) No Filing Fee

##### II.B) Types of Filings

#### B.1) Prior Approval

Policy forms submitted under §3201(b)(1) of the Insurance Law are subject to the submission rules noted herein, especially Circular Letter Nos. 6 (1963) and 14 (1997). Submissions are generally handled on a first-in, first-out basis.

#### B.2) Alternative Approval Procedure

Section 3201(b)(6) and Circular Letter No. 2 (1998) provide for an expedited approval procedure designed to prevent delays by deeming forms to be approved or denied if the Department or insurer fail to act in a timely manner.

Circular Letter No. 2 (1998) provides that the certification of compliance should make reference to any law or regulation that specifically applies or is unique to the type of contract form submitted. An alternative would be to submit a certification of compliance with the applicable laws and regulations cited in this product outline. A statement that the filing is in compliance with all applicable laws and regulations is not acceptable.

#### B.3) Prior Approval with Certification Procedure

Circular Letter No. 6 (2004) provides for an expedited approval procedure based on an appropriate certification of compliance signed by an officer of the company in the format provided by Circular Letter No. 6 (2004). Certifications that have altered or otherwise modified the language of the certification will not be accepted.

The original signed certification must be provided. The form number of each form and the memorandum of variable material for each form must be listed in the body of the certification. For long lists, it would be acceptable to begin the list in the body of the certification and include the rest of the list in an attachment to the certification. However, it would be unacceptable to list all of the forms in a separate attachment.

The submission letters for paper submissions and the Filing Description for submissions made via the State Electronic Rate and Forms Filing system (SERFF) will need to comply with applicable circular letter and product outline guidance.

Substitution filings/follow-up correspondence with post-approval form changes requested prior to initial issuance of forms will not be permitted for Circular Letter No. 6 (2004) filings.

#### B.4) Out-of-State Filings

Pursuant to §3201(b)(2), domestic insurers must file with the Superintendent all unallocated group annuity contracts and funding agreements intended for delivery outside of the state.

#### II.C) Pre-filed Group Insurance Coverage - Circular Letter 1964-1

Circular Letter 64-1 permits insurers to provide or assume risk for group life and group annuity coverage prior to the filing or approval of such forms. The conditions include the following:

- C.1) Immediate coverage requested to meet specific need of contractholder.
- C.2) Insurer has reasonable expectation of approval or acceptance for filing. The reasonable expectation is usually based on the nature and extent of benefits provided and the similarity of the form (or provisions in the form) to other previously approved forms (or provisions) for the insurer or other insurers.
- C.3) Confirmation letter sent to contractholder by insurer stating:
  - (a) The nature and extent of benefits or change in benefits;
  - (b) The forms may be executed and issued for delivery only after filing with or approval by the Department;
  - (c) An understanding that, if such forms are not filed or approved or are disapproved, the parties will be returned to status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval; and
  - (d) The effective date of coverage (Best Practice).
- C.4) Department Notification
  - (a) A statement explaining the circumstances and reasons for the delay in submitting the forms must be submitted within twelve months for group annuities.
  - (b) A follow-up statement must be submitted every six months until the form is submitted. If the reason for the delay is unacceptable, the Department may pursue a violation under Section 4241 for willful violation of the prior approval requirement.
- C.5) Recommended Practice
  - (a) It is recommended that insurers notify the Department of coverage within 30 days (i.e., copy of the confirmation letter) of coverage and submit forms within six months, notwithstanding the twelve month period noted in Circular Letter 64-1. (Best Practice).
  - (b) Insurers should review pre-filings periodically (monthly) to verify compliance with conditions for pre-filing.
  - (c) Insurers should vigorously pursue approval (or acceptance for out-of-state filings) of pre-filed cases after forms have been submitted to mitigate harm if forms are found not to comply with applicable requirements.

## II.D) Preparation of Forms - Circular Letter 1963-6

### D.1) Duplicates

Filings, except for SERFF, need to be made in duplicate. §I.E.7 of Circular Letter 63-6.

D.2) Form Numbers

Form numbers need to appear in lower left-hand corner of the cover page of the form. §I.D. of Circular Letter 63-6. The lower left-hand corner of the subsequent pages of the form should either contain the same form number as appears on the cover page or should be left blank. The subsequent pages should not contain form numbers that differ from the form number on the cover page.

D.3) Hypothetical Data

All blank spaces for policy forms need to be filled in with hypothetical data. § I.E.1 of Circular Letter 63-6.

D.4) Application

If an application will be attached to the contract, it must be submitted with the contract form for approval. If previously approved, the submission letter should so indicate. §I.E.4 of Circular Letter 63-6.

D.5) Final Format

Policy forms submitted for formal approval should be submitted in the form intended for actual issue. §I.F.1 of Circular Letter 63-6.

D.6) Submissions Made on Behalf of Company

If a filing is made on behalf of the company by another party, a letter of authorization from the company must be submitted by the party authorized to submit the filing.

D.7) Incorporation by Reference

All incorporations by reference should be attached to or accompany the submission. See also Section 3204.

II.E) Submission Letters/SERFF Requirements

E.1) Caption Requirement

For paper filings, the “re” of the submission letter must identify each form and the memorandum of variable material for each form that is being submitted for approval or filed for informational purposes and must be in compliance with Circular Letter No. 8 (1999). Section 3201(b)(6) (“Deemer”) filings must be identified in the “re” or caption. Circular Letter No. 6 (2004) filings must be identified in bold print in the body of the submission letter or in the “re” or caption. Please see the Department’s guidance for SERFF filings available on the Department’s website at <http://www.dfs.ny.gov/insurance/serflife.htm>.

E.2) Submission Letters/SERFF Filing Description - Circular Letter No. 6 (1963) §I.G.

(a) For paper submissions, the submission letter must be submitted in duplicate

and signed by a representative of the company authorized to submit forms for the company.

- (b) For SERFF submissions, the Life Bureau no longer requires that a separate signed cover letter be included with submissions. Instead, any information that would ordinarily be included in the signed Cover Letter must be placed in the SERFF Filing Description. Inclusion of "Please see cover letter" or phrases of similar intent in the filing description section will not be considered as meeting the filing requirements.

Note: References in this outline to submission letter content requirements are also requirements for the SERFF Filing Description unless otherwise noted.

- (c) Advise as to whether or not form is replacing a previously submitted form. If there have not been a substantial number of changes, submit a highlighted copy showing the material differences or changes made to the form. If the changes are too extensive, then a highlighted copy is not required, but the changes must be identified in the submission letter. State whether the previously submitted form was approved, disapproved, withdrawn or otherwise disposed or is still pending approval (under review) with the Department and provide the form number and file number of the such form.
- (d) If a form submitted for approval had previously been submitted for preliminary review, a reference to the previous submission and a statement setting out either (a) that the formal filing agrees precisely with the previous submission or (b) the changes made in the form since the time of preliminary review. Submit a highlighted copy showing the differences or changes made to the form. A redlined copy is helpful.
- (e) If a form is intended to replace a very recently approved form because of an error found in the approved form and the approved form was not issued, the insurer may request to make a substitution of the approved form. The substitution request letter must confirm that the form has not been issued and identify the changes made to the corrected form. The insurer may, under these circumstances, use the same form number on the corrected form being submitted. If the original form was approved in paper format the insurer must also return the stamped original of the approved form to the Department. If, however, the form has been issued, the insurer must place a new form number on the corrected form and need not return the previously approved form. This option is not available for policy forms approved under Circular Letter 6 (2004) filings.
- (f) If the form being submitted is other than a contract (i.e. rider, endorsement, or insert page), give the form number of the contract with which it will be used, or, if for more general use, describe the type or group of such forms as well as whether the pending form(s) will be used with new and/or previously issued/delivered contracts.

- (g) When the policy form is designed as an insert page form, the insurer must submit a statement of the mandatory pages which must always be included in the policy form, and a list of all optional pages, if any, including application forms, together with an explanation of how the form will be used (previously approved forms should be identified by form number and approval date). We object to a company's use of the matrix approach that identifies benefit provisions within a document with separate form numbers. See Circular Letter No. 6 (1963) § I.G.8. and Circular Letter No. 4 (1963) § I.A.2.
- (h) A statement as to how the form will be used as described in Circular Letter 1976-12.
- (i) A description of the benefits/coverage provided. Circular Letter No. 6 (1963) § I.G.2 and 7.
- (j) A description of the type of group contractholder, identified by the relevant paragraph of Section 4238(b).
- (k) A statement describing the type of pension plan or other program funded by the policy.
- (l) A statement as to whether the contract is noncontributory, contributory or funded solely by employee or member contributions. If the policy is contributory for some insureds, or for some levels of insurance, or under some conditions, indicate what situations or conditions would permit or require contributions from the insureds.
- (m) Submission letters should be as detailed as possible explaining any innovative or unique products or features and any special markets intended. (In general, an innovative or unique product or feature would include one that has not been previously approved by the Department for the insurer).
- (n) If the contract does not comply with a specific product outline provision or if the Company has an alternate interpretation of a product outline provision, the submission letter must identify the provision and provide a complete explanation of the Company's position on the issue. Such submissions may not be submitted through the Circular Letter No. 6 (2004) certified process unless the Department has given permission.

### E.3) Resubmissions

If the contract has been previously submitted to the Department and the file was closed or withdrawn, any resubmission of the contract to the Department must be complete by itself, reference the file number of the previously closed file and address all outstanding issues in the new submission letter.

### E.4) Circular Letter No. 14 (1997)

Filings that are incomplete or do not comply with laws and regulations will be closed. See Circular Letter No. 14 (1997). Note a product that does not comply with a specific product outline requirement or which is considered a substantive noncomplying product will be a factor in determining whether a file will be closed, unless a noncompliance explanation is included in the submission letter.

#### E.5) Informational Filing

An informational filing should be identified in the “Re” of the submission letter. All informational filings will be acknowledged by the Department indicating that the information submitted has been placed on file with the Department for informational purposes only. The company should wait for the acknowledgement from the Department that the information has been filed prior to its use. For the submission of an informational filing through SERFF, the company should use a SERFF TOI of “Life – Informational”, a SERFF Sub-TOI of “Form or Rate Related”, a SERFF Filing Type of “Form”, and a SERFF requested Filing Mode of “Informational”.

#### II.F) Attachments

##### F.1) Memorandum of Variable Material

The submission must include a separate detailed Memorandum of Variable Material to explain any variable material in the policy forms other than illustrative material (i.e. names, dates, etc). The Memorandum of Variable Material is subject to approval and must comply with all substantive and procedural filing guidance issued by the Department.

- (a) Variable material must be clearly indicated in the forms (i.e., with bracketing or underlining). How material is designated as variable should be stated in the submission letter and in the Memorandum of Variable Material.
- (b) The Memorandum of Variable Material should be drafted in sufficient detail to determine the scope of variation for each variable item. Where text is variable, the memorandum should include alternative text and/or an explanation of when the bracketed text will be omitted from the form. Similarly, variable numerical items should include the range (i.e. minimum and maximum) of variation. An explanation of variable material that the variations "will conform to law" or "as requested by the policyholder" is not acceptable.
- (c) It should be clear which item in the explanation corresponds to which variable item in the form. One option would be to number the items in the explanation of variable material and place the number of the item from the explanation next to the corresponding variable item in the form.
- (d) Open-face riders or endorsements may be filed for general use in amending illustrative or variable material within the scope of the approved memorandum of variable material for the form being amended. The memorandum should include an explanation to that effect.
- (e) Contracts are typically submitted on a single-case basis for a particular contract

holder. If a contract is submitted on a single-case basis, extensive variability would not be expected. All large cases (i.e. greater than \$2.5 Billion) must be submitted on a single-case basis due to the risks associated with contracts of that size.

#### F.2) Memorandum and Opinion

Section 40.5(e) of Regulation No. 139 requires the filing of a memorandum with the Superintendent describing:

- (a) The method for determining the market-value adjustment;
- (b) The method used to determine the interest rate credited to the unpaid portion of the accumulation fund during the installment period if such rate is more than 1.5% below the net effective rate of interest being credited to the contract at the time of termination or discontinuance; and
- (c) Stating that, in the opinion of the insurance company, the method provides reasonable equity to terminating and continuing contractholders and complies with Regulation No. 139.

#### F.3) Flesch Score Certification -- Readability Requirement

- (a) Where appropriate, provide a Flesch score certification signed by an officer of the company in accordance with Section 3102. The Flesch score must be at least 45. The number of words, sentences and syllables in the form should be set forth as part of the certification. Please refer to the Department's February 18, 1982 letter, available on the Department's website, for a sample certification.

<http://www.dfs.ny.gov/insurance/life/guidance/3102Intro.doc>.

#### (b) Section 3102(b)(1) excludes

- (i) any certificates issued pursuant to a group annuity contract issued to an employer covering persons employed in more than one state,
- (ii) any group insurance policy covering a group of one hundred or more lives, other than dependents, at the date of issue, provided that this exclusion does not apply to certificates delivered or issued for delivery in this state.
- (iii) any group annuity contract which serves as a funding vehicle for pension, profit sharing or deferred compensation plans; provided that this exclusion does not apply to any certificate issued pursuant to such group annuity contract.

#### F.4) Group Annuity Summary Sheet

A completed summary sheet must be included with the submission regardless of the submission method. The summary sheet is available on the Department's website at:

### III) Eligible Group Requirements

#### III.A) Eligible Groups

It is the insurer's responsibility to determine whether the definitional requirements in Section 4238(b) for an eligible group are satisfied at the time of issue and thereafter. The insurer should determine whether all employees or members eligible are covered.

- A.1) Employer/Employee – Section 4238(b)(1)
- A.2) Employer Association – Section 4238(b)(2)
- A.3) Labor Union – Section 4238(b)(3)
- A.4) Employer/Labor Union Trust – Section 4238(b)(4)
- A.5) Association (common Interest, calling, profession) – Section 4238(b)(5)
- A.6) IRA – Section 4238(b)(6)
- A.7) Other Employer Trust – Section 4238(b)(7)
- A.8) Foundation or Endowment Fund – Section 4238(b)(8)
- A.9) Affinity Association – Section 4238(b)(9)
- A.10) Financial Institution – Section 4238(b)(10)
- A.11) Plaintiffs or Claimants – Section 4238(b)(11)

#### III.B) Special Rules For Specific Plan Purchasers

- B.1) N.Y. Education Law, Art. 8-C, §398 *et seq.*—contains special statutory rules relating to tax-sheltered annuity (TSA) programs (referred to in the statute as "Special Annuity Programs").
- B.2) N.Y. State Finance Law §5—basic statutory rules establishing the N.Y. Deferred Compensation Board for the administration of governmental deferred compensation plans (§457 plans) in New York State.
- B.3) New York State Deferred Compensation Board Rules. See 9 NYCRR 9000. The rules impose substantive requirements on the content of annuity contracts (and other contracts) issued to the §457 plans of the State and local governments in New York. See Circular Letter. No. 88-17 (1988)—additional administrative guidance on annuity contracts issued to N.Y. governmental §457 Plans.

#### III.C) Non-Recognized Groups

Section 4238 was not modernized to permit Discretionary Groups like those permitted for group life insurance in Section 4216(b)(14) and for group accident and health insurance in Section 4235(c)(1)(M). As such, groups that fail to satisfy the definitional requirements in Section 4238(b) of the Insurance Law are not recognized groups under the Insurance Law. Such group annuity contracts cannot be delivered in this state. However, certificates

covering New York residents under such group annuity contracts delivered out-of-state must be delivered in this State pursuant to Section 3219(b). Group annuity certificates delivered in this state that are funded solely by individual contributions must comply with the provisions of the Insurance Law applicable to individual annuities. Such certificates should be submitted for review and approval. The group annuity contract should be submitted as well. It will be reviewed to ensure that the contract and certificate are not inconsistent. The contract cannot include provisions that invalidate or impair the terms of the certificate.

### III.D) Unauthorized Insurers

- D.1) Section 1101(b)(1) prohibits unlicensed insurers from doing an insurance business in this state by mail or otherwise.
- D.2) Section 1101(b)(2)(B) provides an exception (referred to as the “group exception”) to the prohibition in Section 1101(b)(1) for certain types of group insurance issued outside of New York. The group exception applies to group annuity contracts where the group conforms to the definitions of eligibility in §4238(b) of the Insurance Law, except paragraphs (6) and (7), and the master contracts were lawfully issued without this state in a jurisdiction where the insurer was authorized to do an insurance business.
- D.3) Section 1101(b)(2)(B) excepts from the group exception to the mail order prohibition any transaction with respect to a group annuity contract used in the individual insurance market noted above, including:
  - (a) IRC §408 contracts (IRAs);
  - (b) IRC§403(b) (Tax Sheltered Annuities), and
  - (c) Plans under which payments are derived wholly from funds contributed by the persons covered thereunder. See L.1978, c.428.
- D.4) As such, any New York certificate funded solely by employee or individual contributions is subject to prior approval.

### IV) Contract Provisions

#### IV.A) Cover Page of the Contract and Certificate

##### A.1) Company’s Name and Address

- (a) The New York licensed insurer’s name must appear on the cover page (front or back).
- (b) Full street address of the company’s Home Office (bracketed or underlined to reflect possible future changes) for disclosure purposes on the front or back cover page of the contract. For changes applicable to new business, an information filing is required. For changes applicable to existing business, an endorsement setting forth the new address must be submitted for approval and sent to all holders of in-force contracts. Please refer to the guidance

available on the Department's website.

- (c) In addition to the home office address, the full street address of the administrative or service office (if different than the home office address) may be set forth on the front or back cover of each contract. The administrative or service office address, if any, should be bracketed or underlined to reflect possible future changes. (An informational filing is required for such changes.)
- (d) The forms must exclude any references to an insurer not licensed to do business in New York. Section 3201(c)(1).
- (e) If the name of another entity is included on the cover page (insurance group designation, name of the licensed parent company or licensed affiliate, etc.) or if a logo, trademark or other device is included, such name or device shall not be displayed in a manner that would have a 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 obligations under the contract. See §3201(c)(1). This would apply to applications as well.

#### A.2) Form Identification Number

A form identification number (consisting of numerical digits, letters or both) must appear in the lower left-hand corner of the cover page pursuant to §I. D. of Circular Letter No. 6 (1963). (Each form number should be sufficiently unique so as to distinguish the form from all others used by the insurer.)

#### A.3) Brief Description of Contract – Participation Status

- (a) A description of the contract, such as "Immediate Participation Guarantee Contract" or "Deposit Administration Contract".
- (b) There must be a statement indicating whether the contract is participating or nonparticipating in the divisible surplus of the company. This requirement generally applies to contracts funded through the insurer's general account. See §II.F.1. of Circular Letter No. 4 (1963).

#### A.4) Officer's Signatures

- (a) The signature of at least one officer of the company is needed to execute the contract as a matter of contract law.
- (b) Signatures should be denoted as variable material.
- (c) When the signature is changed, the insurer should notify the Department for informational purposes. The contracts do not need to be re-filed.

#### IV.B) Standard Provisions

Every group annuity contract delivered or issued for delivery in this state and every certificate used in connection therewith shall contain in substance the following provisions to the extent that such provisions are applicable or provisions which are more favorable to

the annuitants or not less favorable to annuitants and more favorable to the contractholders. See §3223.

B.1) Grace Period – §3223(a)

There shall be a 31-day grace period following the due date of any required payment after the first payment within which the payment may be made. During such grace period, the contract shall continue in full force.

- (a) This provision applies if a payment is required to pay any fee or expense charges or if the contractholder is required to make additional contributions.
- (b) If the contract continues in force without penalty, no grace period provision is necessary.

B.2) Entire Contract -- §3223(b)

A provision specifying the document or documents, which shall include the contract and, if a copy is attached thereto, the application of the contractholder, constituting the entire contract between the parties. See also §3204. We do not require a copy of the pension plan even though many contracts refer to the underlying pension plan.

B.3) Misstatement of Age or Sex -- §3223(c)

A provision for the equitable adjustment of the benefits payable or of the payments to be made to the insurer if the age or sex of any person, or of any other fact affecting the amount or date of payment by or to the insurer has been misstated.

- (a) The Arizona vs. Norris decision held that Title VII of the Civil Rights Act of 1964 prohibits an employer from offering its employees a retirement benefit option where a woman is paid a lower monthly retirement benefit than a man who has made the same contributions.
- (b) We have permitted misstatement provisions that omit the reference to sex.
- (c) §3219(a)(5) requires that the interest rate to be charged or credited to underpayments and overpayments be specified in the contract and cannot exceed six percent. (Best Practice)--The §3223(c) provision should also state whether and how much interest will be charged against or credited to such underpayments and overpayments. The rate must be the same for overpayments and underpayments. We may question any rate above six percent.

B.4) Retired Life Certificate -- §3223(e)

- (a) A provision stating that the insurer shall issue for delivery to each person to whom annuity benefits are being paid thereunder a certificate setting forth a statement in substance of the benefits to which such person is entitled under the contract.

- (b) The retired life certificate should include the following provisions:
  - (i) Entire contract provision.
  - (ii) Misstatements provision.
  - (iii) A provision identifying the insurer, including the mailing address.
  - (iv) A provision describing the annuity benefit and any limitations, if any, on the insurer's guarantees with respect to such benefit, including the amount and frequency of annuity payments, the minimum number of payments, any refund features and survivorship rights, etc.
  - (v) A facility of payment provision. Note that such provision should not conflict with Article 81 of the New York Mental Hygiene Law and the Americans with Disability Act. In New York, until a person is found to be legally incompetent to handle annuity payments and no guardian has been appointed, the insured is entitled to such payments.
  - (vi) A beneficiary provision.
- (c) Note that §3223(e) does not require that an immediate annuity actually be purchased. The statute merely requires that annuity benefits are being paid. This includes contracts that provide for non-guaranteed benefits, i.e., benefits that are not guaranteed by the company and are paid by the company at the direction of the contractholder. If non-guaranteed benefits are provided, the retired life certificate should clearly describe any limitations on the insurer's guarantees under the certificate.
- (d) The retired life certificate should be submitted for review, unless a previously approved certificate will be used. In such case, the submission letter should specify the form number, file number and approval date. Please note that retired life certificates are considered policy forms as defined in §3201(a).

#### B.5) Active Life Certificate – §3223(d)

The Department has not required an active life certificate when a general account contract is unallocated, even if it is contributory. Chapter 172 of the Laws of 1982 amended §160(d) [now §3223(d)] of the Insurance Law to eliminate the requirement for an active life certificate for contributory plans if the contract does not provide for the maintenance of one or more accounts for each annuitant.

#### B.6) Governing Law

- (a) Pursuant to §3103(b), no annuity contract delivered or issued for delivery in this state shall provide that the rights or obligations of the insured or of any person rightfully claiming thereunder, with respect to an annuity contract upon a person resident in this state, shall be governed by the laws of any jurisdiction other than this state.

- (b) For group annuity contracts delivered out-of-state, the governing law provision must make it clear that New York law governs certificates delivered in this state, where the certificates are funded solely by contributions by the persons covered thereunder.

#### IV.C) Plan Benefit Rule Provisions In Regulation No. 139

Although immediate participation guarantee and deposit administration contracts usually fund defined benefit plans, the plan benefit rules provisions of Regulation No. 139 are included here because deposit administration contracts also fund defined contribution plans.

##### C.1) Plan Benefit Rule -- §40.4(a) of Regulation 139

Any contract issued in connection with a defined contribution plan which provides the contractholder with the right to withdraw from the contract the amounts required to pay lump sum benefits of the participant's individual account balance as they arise in accordance with the provisions of the plan upon bona fide termination of employment must provide for such withdrawals to be made on a basis pursuant to which neither the amount withdrawn from the contract nor the amount of the remaining principal balance of the accumulation fund following such withdrawal is adjusted to reflect changes in interest rates or asset values since the receipt of funds.

- (a) Contracts do not need to be benefit responsive. However, if the contract is benefit responsive, it must comply with this rule.
- (b) The lump sum payment cannot be subject to a market value adjustment. The interest rate credited cannot be affected by such withdrawals until the next reset date.
  - (i) We have approved an interest adjusted withdrawal provision, which permits the insurer to recognize the gain or loss due to the difference between the actual and expected plan withdrawals in calculating the next reset rate. As long as the estimated withdrawal activity is factored into the guarantees, we believe that there is good faith compliance with §40.4(a) because the initial rate guarantee will not be illusory or misleading. For deposit administration contracts, this feature is the norm.
  - (ii) We have also approved "make whole" provisions in GICs which require repayment of withdrawals from the contract from the next available cash flow as long as there is no penalty for nonpayment. We have permitted graded surrender charges in certain contracts that are designed solely to recoup acquisition expenses. The insurer should describe all acquisition expenses and explain how such expenses will be amortized (i.e., identify the charge and recoupment period) so that we can verify that the charge is not excessive and does not reflect other factors such as

disintermediation, liquidity, cash flow, asset depreciation etc. Generally, the charge must be premium based, that is, not based on the accumulation value. We will permit accumulation-based charges that are capped at a percentage of premium (not to exceed the percentage that reflects acquisition expenses) which gradually reduce as acquisition expenses are recouped.

- (iii) Please note that no surrender charge is permitted if the participant's account value is applied to purchase an annuity.

#### C.2) Betterment of Rates -- §40.4(b)

For any group annuity contract funding a defined contribution plan, the contract must provide that any annuity benefit purchased with respect to an amount equal to the plan participant's account value as determined at the time of its commencement shall not be less than that which would be determined by the application of such amount to purchase a single consideration immediate annuity offered by the company to the same class of contracts.

- (a) The betterment of rates provision ensures that annuities will be purchased on a new money basis. As such, contracts funding defined benefit plans should also include this provision to the extent that annuities are provided for under the contract. If the contractholder cannot purchase annuities on a new money basis, it can be argued that the interest rate guarantees are misleading.
- (b) This provision/concept was borrowed from §4223(a)(1)(E) of the Insurance Law, except that the entire accumulation value is applied to provide the annuity.
- (c) Section 4231(e)(1) and (g)(2) address the issue of whether the annuities must provide for the distribution of dividends.
  - (i) Pursuant to §4231(e)(1), any policies or contracts described in §4231(g)(2) and deferred annuity providing a period of deferment of annuity payments not in excess of one year can be issued on a nonparticipating basis.
  - (ii) Section 4231(g)(2) provides, in part, that dividends need not be distributed on any deferred annuity contract for the period following the period of deferment of annuity payments nor on any group annuity contract providing deferred annuities for a class or classes of participants in a qualified pension or profit sharing plan who have terminated their participation under such plan, or with respect to which class or classes further contributions have been discontinued under the plan and notice of such discontinuance has been given to the commissioner of internal revenue (or regulatory authority of such other jurisdiction).

#### C.3) Allocated Share of Benefit Payments -- §40.4(c)

In the event that there is more than one funding vehicle or cash is available under a defined contribution plan, a contract need not provide for withdrawals (in accordance with the plan benefit rule) in an amount in excess of the contract's allocated share of benefit payments as determined pursuant to the agreement of the insurance company and contractholder.

- (a) Usually IPG and DA contracts are the plan's sole funding vehicle or, at least, the plan's sole fixed income funding option. Such contracts are long term contracts that require ongoing contributions. The discontinuance of contributions typically triggers the discontinuance and termination provisions of the contract.
- (b) This provision operates much like a coordination of benefits provision. If the contract is silent as to its allocable share, benefits will be paid as if it is the only funding vehicle.
- (c) We have approved last-in, first-out provisions; first-in, first-out provisions; pro-rata provisions; buffer fund provisions and combination provisions.

#### C.4) Participant Directed Investment Option -- §40.4(d)

Although unallocated contracts generally are not used to fund participant directed plans, contracts which fund a participant directed investment option (under which each contribution allocated to such option is credited with a specified rate of interest to a stated maturity date which rate and maturity date are disclosed to the participant prior to the allocation) may provide that any withdrawals (other than withdrawals on account of bona fide termination of employment due to death or disability of the participant on whose behalf the withdrawal is made) be postponed until the stated maturity date for the contribution.

- (a) In such cases, the contract may permit withdrawals prior to maturity for the contribution that are subject to a negative market value adjustment and/or surrender charge. We have not required positive market-value adjustments.
- (b) Such contracts must have at least one option for participants age 55 and over on the date contributions are received where the maturity date will not exceed five years. The "age 55" rule in §40.4(b) is similar to §44.3(t) in Regulation No. 127.
- (c) The exception to the plan benefit rule is intended to recognize contracts that are similar to modified guaranteed annuities authorized by Chapter 864 of the Laws of 1985 and Regulation 127.

#### C.5) Plan Amendments or Changes In Plan Administration -- §40.4(e)

If the plan terms or the manner in which plan is administered materially change after issue, withdrawals from the contract to pay plan benefits are not subject to the plan benefit rule.

- (a) Contracts should include this provision to protect against antiselection.
- (b) If the insurer determines that the amendment or change will not adversely

affect the insurer's rights and liabilities under the contract, benefit payments will continue to be subject to the plan benefit rule.

C.6) Bona Fide Termination of Employment -- §40.4(f)

The contract can include procedures or conditions in order to establish that a requested contractual withdrawal is being made in accordance with a bona fide termination of employment and in accordance with the plan provisions.

- (a) Termination of employment means the cessation of an employment relationship with an employer, multiple employer or membership in an employee organization sponsoring the plan, including cessations due to retirement, death, and disability.
- (b) Termination of employment does not include:
  - (i) Any temporary absence,
  - (ii) A change in position or other occurrence qualifying as a temporary break in service under the plan,
  - (iii) Transfer or other change of position resulting in employment by an entity controlling, controlled by, or under common control with the employer,
  - (iv) Cessation of an employment relationship resulting from a reorganization, merger, or sale or discontinuance of all or any part of the plan sponsor's business. [The risk for these transactions is typically not considered by the insurer in making the guarantees provided in the contract. Such transaction may result in unexpected withdrawal activity that was not priced for when the contract was issued.]
  - (v) Plan termination or partial plan termination.

C.7) Non-Benefit Related Withdrawals and Transfers

- (a) For withdrawals that are not subject to §40.4(a), an insurer should protect against anti-selection. Such withdrawals are usually paid out at market value.
- (b) We have permitted insurers to make a certain percentage of such withdrawals from 10% to 20% on a book value basis annually. This percentage is often called the free corridor amount.

C.8) Clone Contract Provision

- (a) We have approved provisions that provide for the issuance of a substantially similar GIC with the same maturity date and interest rate in the event of a partial termination triggered by a reorganization, merger, or sale or discontinuance of all or part of the plan sponsor's business.
- (b) The clone contract should satisfy the insurer's underwriting requirements.
- (c) The cost of the conversion can be prorated among the two surviving contracts or covered by the plan sponsor. In any event, the actual charges, if any, should

be specified in the contract.

#### C.9) Competing Funds Provision

We have approved provisions, which limit deposits and/or transfers to competing fixed income funds offered by the plan to plan participants. This provision is designed to ensure that all scheduled deposits are made to the contract and to prevent transfers to other fixed income or stable value funds when interest rates increase.

#### IV.D) Regulation No. 139 Contract Termination Provisions

##### D.1) General Notes

Pursuant to §40.5(a) of Regulation No. 139, the contract termination rules apply to *unallocated amounts* under group annuity contracts other than *guaranteed interest contracts*.

- (a) **Non-GIC Products-** The term *guaranteed interest contract* is defined in §40.2(j) to mean a contract which guarantees principal and either:
  - (i) provides a specified rate of interest on amounts deposited with an unqualified right to withdraw the accumulation fund upon the expiration of the time period for which the amount deposited and the specified rate of interest are guaranteed under the contract, either in a lump sum or in installments over a period less than five years with the amount and timing of each such installment specified in the contract (i.e., fixed rate, fixed maturity GICs); or
  - (ii) provides an indeterminate rate of interest for an indefinite period with an unqualified right to withdraw the accumulation fund at least once a year in either a lump sum, subject to a surrender charge no greater than seven percent, or in substantially equal periodic, at least annual, installments over a period less than five years which does not reflect investment experience of the underlying assets.
- (b) **Unallocated Amounts.** The term *unallocated amounts* is defined in §40.2(z) of Regulation No. 139. See I.C.6. above. As such, the portion of a contract that funds annuity payments of retired and terminated vested employees under an immediate participation guarantee arrangement do not have to include termination provisions that comply with §40.5 of Regulation No. 139.
- (c) **Plan Type A Contracts.** The termination rules in §40.5 of Regulation No. 139 are intended to apply only to Plan Type A contracts and not Plan Types B or C contracts. Such contracts are defined as follows in §4217(c)(4)(D)(iii)(V) of the Insurance Law:
  - (i) Plan Type A: The policyholder may withdraw funds only (i) with an adjustment to reflect changes in interest rates or asset values since the receipt of funds by the insurance company, or (ii) without such

adjustment but in installments over five years or more, or (iii) as an immediate annuity.

- (ii) Plan Type B: The policyholder may not withdraw funds before the expiration of the interest rate guarantee or, if withdrawals are permitted before the expiration of such guarantee, may withdraw funds only (i) with an adjustment to reflect changes in interest rates or asset values since the receipt of the funds by the insurance company, or (ii) without such adjustment but in installments over five years or more. At the end of the interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or in installments over less than five years.
- (iii) Plan Type C: The policyholder may withdraw funds before the expiration of the interest rate guarantee in a single sum or installments over less than five years either (i) without adjustment to reflect changes in interest rates or asset values since the receipt of funds by the insurance company, or (ii) subject to only a fixed surrender charge stipulated in the contract as a percentage of the fund.

#### D.2) Contract Termination Options Under Regulation No. 139

- (a) Section 40.5(c) of Regulation No. 139 provides that the contract shall permit the contractholder, upon the discontinuance or termination of any such contract, to withdraw unallocated amounts credited to the accumulation fund on any basis or bases provided for under the contract, provided that the contract contains in substance:
  - (i) The ten-year book value installment withdrawal option described in §40.5(d) of Regulation No. 139.
  - (ii) The five-year installment withdrawal option described in §40.5(e) of Regulation No. 139;
  - (iii) A lump sum withdrawal option; or
  - (iv) One or more corresponding options which in the opinion of the superintendent are fair and equitable for the terminating contractholder, remaining contractholders and other policyholders of the insurance company.
- (b) Pursuant to §40.5(c), group annuity contracts must permit a contractholder to terminate or discontinue the contract at least once each contract year upon providing the insurance company with reasonable advance notice.

#### D.3) U.S. DOL Termination Rules For Transition Policies

- (a) ERISA Regulation §2550.401c-1 Definition of “Plan Assets” prescribes the requirements transition policies must satisfy so that supporting general account assets are not considered plan assets under ERISA. Paragraph (e) of §2550.401c-1 provides that within 90 days of written notice by a policyholder

to an insurer, the insurer must permit the policyholder to exercise the right to terminate or discontinue the policy and to elect to receive without penalty either a lump sum or ten year book value installment.

- (b) Under the regulation, the policyholder must have the option to select one of two payout alternatives, both of which must be made available by the insurer.
- (c) The Department stated in the preamble to the proposed regulation that the proposed termination provisions were designed to protect the interests and rights of plans by ensuring that they were not locked into relationships which had become economically disadvantageous.

#### D.4) Lump Sum Payment

- (a) Both §40.5(c) and ERISA Regulation §2550.401c-1(e) require a lump sum payment representing all unallocated amounts in the accumulation fund.
- (b) §2550.401c-1(e) provides that the term penalty does not include a market value adjustment or the recovery of costs actually incurred which would have been recovered by the insurer but for the termination or discontinuance of the policy, including any unliquidated acquisition expenses, to the extent not previously recovered by the insurer.
- (c) §2550.401c-1(h)(7) defines the term market value adjustment as an adjustment to the book value of the accumulation fund to accurately reflect the effect on the value of the accumulation fund of its liquidation in the prevailing market for fixed income obligations, taking into account the future cash flows that were anticipated under the policy. An adjustment is a market value adjustment within the meaning of this definition only if the insurer has determined the amount of the adjustment pursuant to a method which was previously disclosed to the policyholder, and the method permits both upward and downward adjustments to the book value of the accumulation fund.
  - (i) The US DOL was not persuaded that application of an upward market value adjustment on termination of a Transition Policy would produce inequitable results or cause significantly larger numbers of policyholders to terminate.
  - (ii) An annuity contract that meets all of the conditions in Rule 151 of the Securities Act of 1933 comes within the "safe harbor" and is deemed to be an annuity contract within the meaning of §(3)(a)(8) of the Securities Act of 1933 exempt from the application of federal securities laws. However, the safe harbor is not available for a contract that permits a lump sum payment subject to a market-value adjustment.

#### D.5) Ten Year Book Value Installment Option

- (a) Section 40.5(d) provides for a withdrawal option in which the contractholder may withdraw all unallocated amounts of the accumulation fund on an installment payment basis which provides for

- (i) the repayment of all the unallocated amounts in level installments over a period not to exceed 10 years; and
  - (ii) the crediting of interest to the unpaid portion of such accumulation fund during the installment payment period at a rate of interest not less than 1.5 % below the net effective rate of interest being credited to the contract at the time of its termination or discontinuance.
- (b) ERISA Regulation §2550.401c-1(e)(2) provides for a book value payment of all unallocated amounts in the accumulation fund under the policy in approximately equal annual installments, over a period of no longer than 10 years, together with interest computed at an annual rate which is no less than the annual rate which was credited to the accumulation fund under the policy as of the date of the contract termination or discontinuance, minus one percentage point.
- (c) The contract's allocable share of plan benefit payments may change after discontinuance. In LIFO plans, the new or replacing contract may be looked to first. We have allowed insurers to offset future installments by the amount of plan benefit payments made between each installment payment.

#### D.6) Five Year Installment or Lump Sum Market Value Option

- (a) Section 40.5(e) provides that group annuity contract must provide at least one withdrawal option pursuant to which the unallocated amounts of the accumulation fund to which the contractholder is entitled are payable within five years. Such option (which may either be an immediate lump sum or equal installment option) may, if the insurance company elects, provide
- (i) for market value adjustments of the unallocated amounts of the accumulation fund payable on withdrawal; or
  - (ii) for an adjustment in the interest rate credited on the unpaid balance during the period of repayment.
- (b) If a market value adjustment is used by the insurance company for the option satisfying this subdivision, then the method shall not preclude the market value of the unallocated amounts of the accumulation fund from being greater than the book value or unadjusted transfer value of such fund.

#### D.7) Corresponding Options

- (a) As noted above, §40.5(c) of Regulation No. 139 permits one or more corresponding options that in the opinion of the superintendent are fair and equitable for the terminating contractholder, remaining contractholders and other policyholders of the insurance company.
- (b) In determining whether a corresponding contract option is satisfactory, the superintendent may consider, among other factors, the degree to which the terms of such option reflect the maturity characteristics (e.g., expected pattern

of principal repayments and investment yield to repayment) of those investments in the insurance company's general account whose investment results are allocated to the contract under the insurance company's method of investment income allocation.

- (c) A company cannot rely on the corresponding option provision to circumvent the lump sum requirement. One insurer wanted to prohibit the lump sum payment for five years. We argued that this would give the insurer a competitive advantage.
- (d) We have permitted an insurer to use a "natural maturity" installment in lieu of the five-year installment. However, we insisted that the insurer provide a ten-year book value installment. Section 40.5(d) is intended to be a true book value payment, whereas the five-year installment is intended to be the financial equivalent of an MVA.
- (e) In one case, we told an insurer that we would consider a five year installment as satisfying both the ten year and five year installment option even though the interest rate was not fixed at discontinuance. The insurer never followed up with our offer. It appeared that the company's contract was closer to a Type C contract than a Type A contract and interest was not based upon the insurer's investment year method of allocating income at the contract level.

#### D.8) Other Termination Rules

- (a) Pursuant to §40.5(f) of Regulation No. 139, separate withdrawal options are not required to satisfy the conditions of the subdivision (d) ten-year book value installment option and the subdivision (e) five-year installment option if a single withdrawal option satisfies both conditions.
- (b) Pursuant to §40.5(g) of Regulation No. 139, once a contractholder elects a withdrawal option under the contract at contract discontinuance or termination, it is no longer necessary for any other withdrawal option under the contract to remain electable.
- (c) Pursuant to §40.5(h) of Regulation No. 139, the subdivision (d) ten-year book value installment option and the subdivision (e) five-year installment option may provide that payments thereunder supersede all payments from unallocated amounts otherwise provided for under the contract.
- (d) Pursuant to §40.5(i) of Regulation No. 139, a group annuity contract may provide that the insurance company has the right to change the method for determining a market value adjustment upon at least 31 days prior written notice to the contractholder.
- (e) Pursuant to §40.5(j) of Regulation No. 139, any requested modification of the application of §40.5 by an insurance company shall be accompanied by an explanation of the basis for such modification, and shall be permitted only if, in the opinion of the superintendent, it

- (i) would achieve the purpose of §40.5 (i.e., termination provisions that are fair and equitable for terminating contractholders, remaining contractholders and other policyholders of the insurance company); and
- (ii) would not be prejudicial to the interests of the insurance company's policyholders.

#### D.9) Market-Value Adjustment Provision

- (a) Section 40.2(o) of Regulation 139 defines market-value adjustment as an adjustment for increasing or decreasing the accumulation fund in the event of full or partial surrender or contract termination to reflect changes in interest rates or asset values since the receipt of funds by the insurer *according to a formula described in the contract*. §3204- Entire Contract\_of the Insurance Law requires that the MVA formula be incorporated in the contract or attached to the contract.
  - (i) The market-value adjustment formula should be sufficiently clear so that the contractholder can calculate the adjustment at any time.
  - (ii) The factors used in the calculation should be sufficiently definite and not based on items solely within the insurer's discretion. For example, the formula can refer to an outside index or to rates guaranteed or credited under the contract. If the formula referred to the insurer's earnings rate on supporting assets, we would require justification because the contractholder cannot verify such rate.
  - (iii) The market-value adjustment's purpose is to provide reasonable equity to terminating and continuing contractholders.
  - (iv) The market-value adjustments for IPG and DA contracts are designed to approximate the market value of supporting assets (i.e., asset-based adjustments). Note that the adjustments for separate account GICs (and general account GICs) are generally liability-based adjustments that reflect the changes in interest rates since the receipt of contract funds and the remaining duration of the interest rate guarantee.
- (b) As noted above, §40.5(i) of Regulation 139 gives the insurer in contracts other than GICs the right to change the method for determining the market-value adjustment upon at least 31 days prior written notice to the contractholder.
- (c) ERISA §2550.401c-1(h)(7) defines the term market value adjustment as an adjustment to the book value of the accumulation fund to accurately reflect the effect on the value of the accumulation fund of its liquidation in the prevailing market for fixed income obligations, taking into account the future cash flows that were anticipated under the policy. An adjustment is a market value adjustment within the meaning of this definition only if
  - (i) the insurer has determined the amount of the adjustment pursuant to a method which was previously disclosed to the policyholder, and

- (ii) the method permits both upward and downward adjustments to the book value of the accumulation fund.
- (d) Two-Way MVA – Section 40.5(e) of Regulation No. 139 provides that the method for determining the market-value adjustment shall not preclude the market value of the unallocated amounts of the accumulation fund from being greater than the book value or unadjusted transfer value of such fund. However, we have not interpreted this language to require a two-way market-value adjustment. Nevertheless, pursuant to ERISA §2550.401c-1(h)(7), it appears that all transition policies will need to be amended to permit both upward and downward adjustments to the book value of the accumulation fund.
- (e) The extent of discretionary control retained by the insurer in calculating the market-value adjustment will be a factor in determining whether the insurer is a fiduciary with respect to the contract. See *Ferry v. Mutual Life Insurance Company of New York*, 868 F. Supp 764 (W.D.Pa.1994).

#### D.10) Liquidated Damages Provision

- (a) Section 40.2(m) of Regulation 139 defines liquidated damages as the charges or adjustments which may become applicable in the event contributions are not made in the amounts or on the dates specified in the contract and which reasonably reflect the actual losses anticipated by the insurer in making commitments in advance of the receipt of the specified contributions.
  - (i) A liquidated damages provision is not common in either IPG or DA contract because the interest rate guarantees applicable to future deposits are not significant.
  - (ii) A liquidated damages provision is an alternative to contract termination in the event that the contractholder fails to make a scheduled contribution.
- (b) We have objected to provisions that provide for a fixed charge or fixed interest rate reduction for any such failure to contribute
- (c) The method for calculating the charge should be set forth in the contract. The contractholder should be able to calculate the adjustment from the terms of the contract. Many insurers use an explicit formula similar to the market-value adjustment formula.

#### D.11) Liquidity Protection Provision

- (a) Deferral Provisions. ERISA §2550.401c-1(e)(2) provides that notwithstanding paragraphs (e)(1) and (e)(2), the insurer may defer, for a period not to exceed 180 days, amounts required to be paid to a policyholder under this paragraph for any period of time during which regular banking activities are suspended by State or federal authorities, a national securities exchange is closed for trading (except for normal holiday closings), or the Securities and Exchange

Commission has determined that a state of emergency exists which may make such determination and payment impractical.

- (b) We encourage insurers to include a contractual liquidity protection provision in all group annuity contracts. We have not objected to a six-month deferral provision. In addition, we have permitted insurers to make monthly installments over a ten to twelve month period for lump sum payments in excess of a specified amount (e.g., \$100 million).
- (c) The Department and insurers need to monitor the liquidity exposure in their group annuity contracts. The market-value adjustment formula may reflect a close approximation of the market value of supporting assets under normal circumstances; but it may not reflect the liquidation value if assets need to be sold in times of distress. Supporting general account assets need to be as liquid as the withdrawal options under the contracts. An insurer should consider a diversification requirement applicable to contractholders. No single contractholder should have a disproportionate share of the insurer's liquid contracts.

#### D.12) Insurer-Initiated Amendments and Unilateral Amendments

- (a) The Department has reservations concerning contractual provisions that permit the insurer to make unilateral amendments. However, because of the long-term nature of immediate participation guarantee and deposit administration contracts we have permitted insurers to reserve the right to make certain unilateral changes. Generally, we have approved such provisions provided the contractholder receives advance written notice of the proposed change and is allowed to terminate the contract under existing contract terms.
- (b) ERISA Regulation §2550.401c-1(f) provides that in the event the insurer makes an insurer-initiated amendment, the insurer must provide written notice to the plan at least 60 days prior to the effective date of the insurer-initiated amendment.
  - (i) The notice must contain a complete description of the amendment and must inform the plan of its right to terminate or discontinue the policy and withdraw all unallocated funds without penalty by sending a written request within such 60 day period to the name and address contained in the notice.
  - (ii) The plan must be offered the election to receive either a lump sum or an installment payment as described in paragraph (e)(1) and (e)(2) of §2550.401c-1(e).
  - (iii) An insurer-initiated amendment shall not apply to a contract if the plan fiduciary exercises its right to terminate or discontinue the contract within such 60-day period and to receive a lump sum or installment payment.

- (c) The term insurer-initiated amendment is defined in paragraphs (h)(8)(i), (ii) and (iii) of §2550.401c-1 as:
- (i) An amendment to a Transition Policy made by an insurer pursuant to a unilateral right to amend the policy terms that would have a material adverse effect on the policyholder; or
  - (ii) Any of the following unilateral changes in the insurer's conduct or practices with respect to the policyholder or the accumulation fund under the policy that result in a material reduction of existing or future benefits under the policy, a material reduction in the value of the policy or a material increase in the cost of financing the plan or plan benefits:
    - (I) A change in the methodology for assessing fees, expenses, or other charges against the accumulation fund or the policyholder;
    - (II) A change in the methodology used for allocating income between lines of business, or product classes within a line of business;
    - (III) A change in the methodology used for determining the rate of return to be credited to the accumulation fund under the policy;
    - (IV) A change in the methodology used for determining the amount of any fees, charges, expenses, or market value adjustments applicable to the accumulation fund under the policy in connection with the termination of the contract or withdrawal from the accumulation fund;
    - (V) A change in the dividend class to which the policy or contract is assigned;
    - (VI) A change in the policyholder's rights in connection with the termination of the policy, withdrawal of funds or the purchase of annuities for plan participants; and
    - (VII) A change in the annuity purchase rates guaranteed under the terms of the contract or policy, unless the new rates are more favorable for the policyholder.
- (d) An insurer-initiated amendment is material if a prudent fiduciary could reasonably conclude that the amendment should be considered in determining how or whether to exercise any rights with respect to the policy, including termination rights.
- (e) For purposes of this definition, the following amendments or changes are not insurer-initiated amendments:
- (i) Any amendment or change which is made with the affirmative consent of the policyholder. With respect to affirmative consent the US DOL rejected negative elections. It is not sufficient for the insurer to send notice of a prospective change to the policyholder with appropriate lead

time during which the policyholder has time to object to the change.

- (ii) Any amendment or change which is made in order to comply with the requirements of section 401(c) of the ERISA and §2550.401c-1; or
  - (iii) Any amendment or change which is made pursuant to a merger, acquisition, demutualization, conversion, or reorganization authorized by applicable State law, provided that the premiums, policy guarantees, and the other terms and conditions of the policy remain the same, except that a membership interest in a mutual insurance company may be eliminated from the policy in exchange for separate consideration (e.g., shares of stock or policy credits).
- (f) The Insurance Department and the U.S. DOL recognize that many Transition Policies (immediate participation guarantee and deposit administration contracts) represent long term relationships that may require minor changes over time.

#### IV.E) Other Provisions

##### E.1) Credit Rating Downgrade Provisions

- (a) Circular Letter No. 2 (1992) states that the Department will not approve a credit rating bailout provision which would permit the contractholder to terminate the contract prior to maturity at book value in the event the insurer's credit rating downgrade. The provision is considered unfair, unjust and inequitable pursuant to §3201(c)(2).
  - (i) Waiver of a surrender charge or market value adjustment upon credit rating downgrade would be unfair, unjust and inequitable to persisting contractholders who would be required to subsidize the withdrawal activity of other contractholders. Surrender charges and market-value adjustments are designed to protect against disintermediation.
  - (ii) A credit rating bailout provision would enhance the probability of a panic run that could impair or threaten the solvency of the insurer and result in regulatory intervention under Article 74.
- (b) Circular Letter No. 2 (1992) also states that we will disapprove any such provision submitted by a domestic insurer for use outside of New York on the grounds that the issuance would be prejudicial to the interests of policyholders pursuant to §3201(c)(6).
- (c) We have disapproved any credit rating downgrade provision included in a group annuity contract funding a pension plan that gives the contractholder the right to terminate a contract prior to maturity even if the withdrawals are subject to a negative market-value adjustment because the provision will increase the risk of disintermediation.

##### E.2) Market Value Make-Up/Advance Interest Credit Provisions

- (a) The Department has permitted provisions that enable insurers to credit an initial book value amount in excess of the actual contribution to the contract. The amount of the excess credit is equal to the market-value adjustment charged on the transfer of funds from the plan sponsor's terminating contract. The excess credit, also called a book-in, allows the plan sponsor to maintain book value accounting at the plan participant level. In order to recoup the excess credit, the insurer will credit a reduced interest rate designed to amortize the excess credit over the life of the contract.
- (b) The Department has permitted the use of these provisions under the following conditions and circumstances:
  - (i) The advance interest credit or book-in amount cannot exceed 10% of the market value of the amount deposited. The Department will consider book-ins that exceed this amount on a case-by-case basis taking into account the safeguards in place to address the risk assumed by the company.
  - (ii) The book-in provision can only be used with unallocated contracts funding defined contribution plans and the funds cannot derive from equity separate account agreements. This provision should not be used to recover losses on equity investments.
  - (iii) The insurer must not be proactive in using book-ins as a marketing strategy. Book-ins should only be used as a business conservation measure or in limited cases at the request of a plan sponsor. Book-ins used in connection with new business should represent a small percentage of new business and only a small number (i.e., less than ten) per year. As an alternative, we would consider an aggregate book-in limit, the amount of which will depend on the circumstances of each insurer.
  - (iv) The contract must provide that in the event that the contract is terminated or discontinued prior to the date on which the advance credit is fully amortized, the unrecouped amount will be deducted as a separate charge prior to any final payment to the contractholder.
  - (v) The insurer must notify the Department each year of the circumstances of each book-in, including the credit provided (dollar value and as a percentage of the initial deposit), the amortization period and the source of funds (business conservation or new business). Such notification is not required if the insurer has (1) fewer than 20 book-ins per year or a total book-in amount of less than \$5 million per year and (2) an aggregate book-in amount of less than \$25 million.

### E.3) Purchase Rate Guarantee/Unilateral Change

- (a) The mortality and interest basis for guaranteed purchase rates should be stated

in the contract. Companies can make unilateral changes in guaranteed annuity purchase rates for new contributions.

- (b) Although we have approved expense loads in the past, we may question and require justification for the use of any expense loading when conservative guaranteed purchase rates are used
- (c) N.Y. Circular Letter. No. 83-14 (1983)—*Contract Approval Procedures to Comply With Norris decision & Amplification of Circular Letter 83-14*—describes special review and conditional approval procedures for policy form amendments designed primarily to comply with the unisex mortality pricing requirements of the *Norris* decision.

#### E.4) Dividend Provision

For participating GICs, we have permitted language to the effect that due to the nature of guarantees under the contract no dividends are anticipated. Insurers typically credit GICs with a current or spot rate, in which no interest in excess of the rate guaranteed is anticipated.

#### E.5) Interest Crediting Provision

- (a) The contract should state the guaranteed interest rates, the period or periods for which such guarantees apply and any minimum interest rate guarantees.
  - (i) Usually IPG and DA contracts provide for initial interest guarantees for a five-year period.
  - (ii) The minimum interest should probably be set between 1.0% and 3.0% and the insurer should not reserve the right to reduce the minimum interest rate guarantee unilaterally for existing funds. In the past, IPG and DA contracts merely guaranteed principal (i.e., 0%), subject to the right to recoup losses in future years. See discussion below at VI.E. 2.(a) concerning guaranteed benefit policies.
- (b) The contract should describe the method of determining interest rates in excess of the guaranteed rates and describe how withdrawals, transfers and payments will affect the amount credited under the contract.
  - (i) IPG and DA contracts credit interest pursuant to the insurer's investment year method of allocating investment income. Under such method the interest rate credited reflects the timing of deposits and withdrawals and the earnings rate available at such times.
  - (ii) The contract should indicate whether negative cash flow in any deposit period is separately tracked (i.e., the tracking of negative deposit cells and the charging of interest at that IYM cell's interest rate).
  - (iii) For defined contribution plans, plan benefit withdrawals made at book value in accordance with §40.4(a) should not affect future interest rates credited under the contract until the next reset date.

- (iv) Withdrawals subject to a market-value adjustment should not affect future interest declarations. It appears that such treatment would be a double recovery attributable to the withdrawal.
- (v) See Edward A. Green, *"The Case for Refinement in Methods of Allocating Investment Income,"* (TSA, XIII, 308) 1961.

V) Advertising and Disclosure

V.A) Regulation 139 Disclosure Requirements - Section 40.3

- A.1) Written statement and/or specimen contract with a statement citing location in contract of disclosures required by paragraphs (1),(3),(4),(5),(6),(9) and (10) of §40.3(b) of Regulation 139. See §40.3(a).
- (a) Statement indicating any restrictions as to amount and timing of contributions, and penalties for non-payment. §40.3(b)(1)
  - (b) Description of the right to discontinue contributions to contract, and penalties resulting from such action. §40.3(b)(2)
  - (c) Statement of all current fees and charges that are or may be assessed against the contractholder or deducted from the contract, including a description of the extent and frequency to which such fees and charges may be modified and the extent to which they take precedence over other payments. §40.3(b)(3)
  - (d) Statement of the interest rates and/or method of determination of rates and a description as to how any withdrawals, transfers or payments will affect the amount of interest credited. §40.3(b)(4)
  - (e) Description of expense, interest and benefit guarantees under the contract and any rights to modify or eliminate such guarantees, including the right to apply surrender charges or market-value adjustments to plan benefit payments if there are plan amendments or changes in the manner of plan administration. §40.3(b)(5)
  - (f) Description of the contractholder's and participant's right to withdraw funds (or apply to purchase annuities), along with a description of any charges, fees or market-value adjustments applicable to such withdrawals or a statement that no such withdrawals or payment are permissible prior to maturity or the happening of a certain event. §40.3(b)(6)
  - (g) Statement indicating any pro rata, percentage or other limitations which may apply to benefit payments to be purchased or provided under the contract when the plan is not funded entirely under the contract. §40.3(b)(7)
  - (h) Statement that contractholder or participant withdrawals under the contract are to be made in a FIFO or LIFO basis or other applicable basis. §40.3(b)(8)
  - (i) Statement that the contract may be amended, including any right of the insurer to unilaterally amend the contract. §40.3(b)(9)

- (j) Statement, if applicable, that any dividends and experience rate credits are subject to the insurer's discretion. §40.3(b)(10)
- (k) Statement, if applicable, concerning supporting assets' affect on withdrawal timing. §40.3(b)(11)
- (l) Statement that the contractholder or plan sponsor is solely responsible for determining whether the contract is a suitable funding vehicle. §40.3(b)(12)
- (m) Statement, if applicable, that the insurer does not have responsibility to reconcile participants' individual account balances with the accumulation fund balance where the insurer does not maintain individual account balances. §40.3(b)(13)

V.B) U.S. DOL ERISA Regulation §2550.401c-1

Definition of "Plan Assets" – Insurance Company General Accounts

B.1) General Requirements

ERISA Regulation §2550.401c-1(c) requires an insurer to furnish the initial and annual information to a plan fiduciary acting on behalf of a plan to which a Transition Policy has been issued.

- (a) The US DOL believes that it is important for plan fiduciaries to be provided with the information necessary to adequately assess the financial strength of an insurer, the suitability of a particular policy for the plan, as well as the appropriateness of continuing a plan's investment in such policy.
  - (i) A plan fiduciary need not replicate all of an insurer's internal cost calculations in order to make these assessments.
  - (ii) However, the information necessary to calculate the exact dollar amount of the charges, fees or adjustments upon contract terminations must be disclosed to plan fiduciaries. In order for the termination provisions in the regulation to be meaningful, plan fiduciaries must have access to the information necessary to calculate and monitor the charges that would be assessed against a Transition Policy in the event of termination.
  - (iii) Accordingly, upon the request of a plan fiduciary, the insurer must provide the formula actually used to calculate the market value adjustment, if any, applicable to the unallocated amount in the accumulation fund upon distribution of a lump sum payment to the policyholder, the actual calculation as of a specified date of the applicable market value adjustment, including a description of the specific variables used in the calculation, the value of each of the variables, and a general description of how the value of each of the variables was determined.

B.2) Initial Disclosure

The insurer must provide to the plan, either as part of an amended policy, or as a separate written document, the disclosure information set forth below:

- (a) A description of the method by which any income and any expense of the insurer's general account are allocated to the policy during the term of the policy and upon its termination, including:
  - (i) A description of the method used by the insurer to determine the fees, charges, expenses or other amounts that are, or may be, assessed against the policyholder or deducted by the insurer from any accumulation fund under the policy, including the extent and frequency with which such fees, charges, expenses or other amounts may be modified by the insurance company;
  - (ii) A description of the method by which the insurer determines the return to be credited to any accumulation fund under the policy, including a description of the method used to allocate income and expenses to lines of business, business segments, and policies within such lines of business and business segments, and a description of how any withdrawals, transfers, or payments will affect the amount of the return credited;
  - (iii) A description of the rights which the policyholder or plan participants have to withdraw or transfer all or a portion of any accumulation fund under the policy, or to apply the amount of a withdrawal to the purchase of guaranteed benefits or to the payment of benefits, and the terms on which such withdrawals or other applications of funds may be made, including a description of any charges, fees, credits, market value adjustments, or any other charges or adjustments, both positive and negative;
  - (iv) A statement of the method used to calculate any charges, fees, credits or market value adjustments, and, upon the request of a plan fiduciary, the insurer must provide within 30 days of the request:
    - (I) The formula actually used to calculate the market value adjustment, if any, to be applied to the unallocated amount in the accumulation fund upon distribution of a lump sum payment to the policyholder, and
    - (II) The actual calculation, as of a specified date that is no earlier than the last contract anniversary preceding the date of the request, of the applicable market value adjustment, including a description of the specific variables used in the calculation, the value of each of the variables, and a general description of how the value of each of those variables was determined.
    - (III) If the formula is based on interest rate guarantees applicable to new contracts of the same class or classes, and the duration of the

assets underlying the accumulation fund, the contract must describe the process by which those components are ascertained or obtained. If the formula is based on an interest rate implicit in an index of publicly traded obligations, the identity of the index, the manner in which it is used, and identification of the source or publication where any data used in the formula can be found, must be disclosed;

- (b) A statement describing the expense, income and benefit guarantees under the policy, including a description of the length of such guarantees, and of the insurer's right, if any, to modify or eliminate such guarantees;
- (c) A description of the rights of the parties to make or discontinue contributions under the policy, and of any restrictions (such as timing, minimum or maximum amounts, and penalties and grace periods for late payments) on the making of contributions under the policy, and the consequences of the discontinuance of contributions under the policy; and
- (d) A statement of how any policyholder or participant-initiated withdrawals are to be made: first-in, first-out (FIFO) basis, last-in, first-out (LIFO) basis, pro rata or another basis.

### B.3) Annual Disclosure

At least annually and not later than 90 days following the period to which it relates, an insurer shall provide the following information to each plan to which a Transition Policy has been issued:

- (a) The balance of any accumulation fund on the first day and last day of the period covered by the annual report;
- (b) Any deposits made to the accumulation fund during such annual period;
- (c) An itemized statement of all income attributed to the policy or added to the accumulation fund during the period, and a description of the method used by the insurer to determine the precise amount of income;
- (d) The actual rate of return credited to the accumulation fund under the policy during such period, stating whether the rate of return was calculated before or after deduction of expenses charged to the accumulation fund;
- (e) Any other additions to the accumulation fund during such period;
- (f) An itemized statement of all fees, charges, expenses or other amounts assessed against the policy or deducted from the accumulation fund during the reporting year, and a description of the method used by the insurer to determine the precise amount of the fees, charges and other expenses;
- (g) An itemized statement of all benefits paid, including annuity purchases, to participants and beneficiaries from the accumulation fund;

- (h) The dates on which the additions or subtractions were credited to, or deducted from, the accumulation fund during such period;
- (i) A description, if applicable, of all transactions with affiliates which exceed one percent of group annuity reserves of the general account for the prior reporting year;
- (j) A statement describing any expense, income and benefit guarantees under the policy, including a description of the length of such guarantees, and of the insurer's right, if any, to modify or eliminate such guarantees. However, the information on guarantees does not have to be provided annually if it was previously disclosed in the insurance policy and has not been modified since that time;
- (k) A good faith estimate of the amount that would be payable in a lump sum at the end of such period pursuant to the request of a policyholder for payment or transfer of amounts in the accumulation fund under the policy after the insurer deducts any applicable charges and makes any appropriate market value adjustments, upward or downward, under the terms of the policy; and
- (l) An explanation that the insurer will make available promptly upon request of a plan, copies of the following publicly available financial data or other publicly available reports relating to the financial condition of the insurer:
  - (i) National Association of Insurance Commissioners Statutory Annual Statement, with Exhibits, General Interrogatories, and Schedule D, Part 1A, Sections 1 and 2 and Schedule S--Part 3E;
  - (ii) Rating agency reports on the financial strength and claims-paying ability of the insurer;
  - (iii) Risk adjusted capital ratio, with a brief description of its derivation and significance, referring to the risk characteristics of both the assets and the liabilities of the insurer;
  - (iv) Actuarial opinion of the insurer's appointed actuary certifying the adequacy of the insurer's reserves as required by New York State Insurance Department Regulation 126 and comparable regulations of other States; and
  - (v) The insurer's most recent SEC Form 10K and Form 10Q (stock companies only).

Pursuant to the Preamble to the final regulation, the initial annual report must be provided within 18 months after publication of the final regulation (i.e., July 5, 2001) and the subsequent reports must be provided at least annually, not later than 90-days following the period to which it relates.

#### B.4) Alternative Separate Account Arrangements

- (a) ERISA Regulation §2550.401c-1(d) provides that, in general, an insurer must

provide the plan fiduciary with the following additional information at the same time as the initial disclosure required under §2550.401c-1(c)(3):

- (i) A statement explaining the extent to which alternative contract arrangements supported by assets of separate accounts of insurers are available to plans;
  - (ii) A statement as to whether there is a right under the policy to transfer funds to a separate account and the terms governing any such right; and
  - (iii) A statement explaining the extent to which general account contracts and separate account contracts of the insurer may pose differing risks to the plan.
- (b) An insurer will be deemed to comply with item (iii) above if the disclosure provided to the plan includes the following statement:
- (i) Contractual arrangements supported by assets of separate accounts may pose differing risks to plans from contractual arrangements supported by assets of general accounts. Under a general account contract, the plan's contributions or premiums are placed in the insurer's general account and commingled with the insurer's corporate funds and assets (excluding separate accounts and special deposit funds). The insurance company combines in its general account premiums received from all of its lines of business. These premiums are pooled and invested by the insurer. General account assets in the aggregate support the insurer's obligations under all of its insurance contracts, including (but not limited to) its individual and group life, health, disability, and annuity contracts. Experience rated general account policies may share in the experience of the general account through interest credits, dividends, or rate adjustments, but assets in the general account are not segregated for the exclusive benefit of any particular policy or obligation. General account assets are also available to the insurer for the conduct of its routine business activities, such as the payment of salaries, rent, other ordinary business expenses and dividends.
  - (ii) An insurance company separate account is a segregated fund that is not commingled with the insurer's general assets. Depending on the particular terms of the separate account contract, income, expenses, gains and losses associated with the assets allocated to a separate account may be credited to or charged against the separate account without regard to other income, expenses, gains, or losses of the insurance company, and the investment results passed through directly to the policyholders. While most, if not all, general account investments are maintained at book value, separate account investments are normally maintained at market value, which can fluctuate according to market conditions. In large measure, the risks associated with a separate account

contract depend on the particular assets in the separate account.

- (iii) The plan's legal rights vary under general and separate account contracts. In general, an insurer is subject to ERISA's fiduciary responsibility provisions with respect to the assets of a separate account (other than a separate account registered under the Investment Company Act of 1940) to the extent that the investment performance of such assets is passed directly through to the plan policyholders. ERISA requires insurers, in administering separate account assets, to act solely in the interest of the plan's participants and beneficiaries; prohibits self-dealing and conflicts of interest; and requires insurers to adhere to a prudent standard of care. In contrast, ERISA generally imposes less stringent standards in the administration of general account contracts that were issued on or before December 31, 1998.
- (iv) On the other hand, State insurance regulation is typically more restrictive with respect to general accounts than separate accounts. However, State insurance regulation may not provide the same level of protection to plan policyholders as ERISA regulation. In addition, insurance company general account policies often include various guarantees under which the insurer assumes risks relating to the funding and distribution of benefits. Insurers do not usually provide any guarantees with respect to the investment returns on assets held in separate accounts. Of course, the extent of any guarantees from any general account or separate account contract will depend upon the specific policy terms.
- (v) Finally, separate accounts and general accounts pose differing risks in the event of the insurer's insolvency. In the event of insolvency, funds in the general account are available to meet the claims of the insurer's general creditors, after payment of amounts due under certain priority claims, including amounts owed to its policyholders. Funds held in a separate account as reserves for its policy obligations, however, may be protected from the claims of creditors other than the policyholders participating in the separate account. Whether separate account funds will be granted this protection will depend upon the terms of the applicable policies and the provisions of any applicable laws in effect at the time of insolvency.

#### V.C) Rules Governing Advertisements of Life Insurance and Annuity Contracts

See Regulation 34-A.

#### VI) ERISA Aspects

VI.A) *John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank*, 510 U.S. 86 (1993). The Supreme Court in *John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank* determined that a guaranteed annuity contract backed by the insurer's general account gave rise to "plan assets" in the general account and that the insurer was a fiduciary with respect to those assets.

- A.1) ERISA imposes special duties and obligations on "fiduciaries" with respect to employee benefit plans. Section 3(21) defines a fiduciary in part by reference to the person's activities with respect to the "assets" of an employee benefit plan. A person is a fiduciary to the extent that the person exercises discretionary authority or control over the management of a plan or its assets. Sections 403 and 404 of ERISA require fiduciaries with responsibility for the management of plan assets to act prudently and exclusively for the benefit of plan participants and beneficiaries in the management of plan assets.
- A.2) In addition to the general fiduciary responsibility requirements of ERISA, the prohibited transaction restrictions of §406 apply to transactions involving the assets of a plan.
  - (a) §406(a)(1)(D) prohibits the direct or indirect transfer of plan assets to, or the use of plan assets by or for the benefit of, a party in interest.
  - (b) §406(b)(1) prohibits a fiduciary from dealing with the assets of the plan in his own interest or for his own account.
  - (c) Transactions in violation of §406 could result in a 15% excise tax penalty under §4975 of the Internal Revenue Code or a five percent civil penalty under §502(i) of ERISA and, if uncorrected, penalties may equal 100% of the amount involved with respect to the prohibited transaction.
- VI.B) Prohibited Transaction Class Exemption 95-60, 60 Fed. Reg. 35925 (July 12, 1995). The Labor Department issued an administrative class exemption that provides limited relief from these provisions soon after the Supreme Court's decision in Harris Trust. However such exemptions did not provide relief from ERISA's general fiduciary responsibility rules.
- VI.C) Small Business Job Protection Act of 1996, PL. 104-188 (SBJPA). This bill amended ERISA by adding a new §401(c). The new section is intended to address the insurance industry's concerns regarding the status of assets held in insurers' general accounts in the wake of the Supreme Court's decision in John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank.
- VI.D) U.S.DOL ERISA Regulation §2550.401c-1 Definition of "Plan Assets" – Insurance Company General Accounts
  - D.1) This regulation sets forth the requirements an insurer must satisfy so that the general account assets supporting a transition policy will not be plan assets under ERISA. The preamble to the regulation provides that insurance companies that comply with the specific requirements of the regulation will be shielded from the fiduciary responsibility and prohibited transaction rules under ERISA that would otherwise apply to them as a result of the Harris Trust decision.
  - D.2) The term Transition Policy is defined in §2550.401c-1(h)(6) to mean:
    - (a) A policy or contract of insurance (other than a guaranteed benefit policy described in §401(b)(2)(B) of ERISA) that is issued by an insurer to, or on behalf of, an employee benefit plan on or before December 31, 1998, and which is

supported by the assets of the insurer's general account. The discussion of the *Economic Analysis Under Executive Order 12866* in the preamble to the regulation states:

Transition Policies are general account contracts issued on or before December 31, 1998 which are, at least in part, not guaranteed benefit policies. *In particular, the value of the benefit provided is related to the investment performance of the insurer's general account.* [Emphasis added.]

- (b) A policy will not fail to be a Transition Policy merely because the policy is amended or modified:
  - (i) To comply with the requirements of section 401(c) of the Act and this section; or
  - (ii) Pursuant to a merger, acquisition, demutualization, conversion, or reorganization authorized by applicable State law, provided that the premiums, policy guarantees, and the other terms and conditions of the policy remain the same, except that a membership interest in a mutual insurance company may be eliminated from the policy in exchange for separate consideration (e.g., shares of stock or policy credits).

D.3) The requirements applicable to transition policies include the following:

- (a) Approval of the purchase of the transition policy by an independent fiduciary;
- (b) Initial and annual disclosure note above in V.B;
- (c) Disclosure of alternative separate account arrangements noted above in V.B;
- (d) Termination procedures discussed above in IV.D.
- (e) Special notice and termination rights for insurer-initiated amendments noted above in IV.D.12.

D.4) ERISA Regulation §2550.401c-1(g) provides that an insurer shall manage those assets of the insurer which are assets of such insurer's general account (irrespective of whether any such assets are plan assets) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, taking into account all obligations supported by such enterprise.

- (a) This prudence standard differs from the prudence standard set forth in section 404(a)(1)(B) of the ERISA.
- (b) Under the prudence standard provided in this paragraph, prudence must be determined by reference to all of the obligations supported by the general account, not just the obligations owed to plan policyholders.
- (c) The prudence standard contained in paragraph (g) addresses the conflict

between State insurance laws which require that general account assets be managed so as to maintain equity among all contractholders, policyholders, creditors and shareholders and the ERISA fiduciary rules which require that plan assets be managed solely in the interests of, and for the exclusive purpose of, providing benefits to plan participants and their beneficiaries.

#### VI.E) Guaranteed Benefit Policies

E.1) *General Note.* In general, there is much uncertainty as to whether and which general account contracts funding ERISA-covered employee benefit plans are affected by the *Harris Trust* decision. The uncertainty arises primarily from the questions as to what constitutes a guaranteed benefit policy under ERISA.

(a) In *Harris Trust*, the Court stated:

*In sum, we hold that to determine whether a contract qualifies as a guaranteed benefit policy, each component of the contract bears examination. A component fits within the guaranteed benefit policy exclusion only if it allocates investment risk to the insurer. Such an allocation is present when the insurer provides a **genuine guarantee of an aggregate amount of benefits payable to retirement plan participants and their beneficiaries.** As to a contract's "free funds" --funds in excess of those that have been converted into guaranteed benefits--**these indicators are key: the insurer's guarantee of a reasonable rate of return on those funds and the provision of a mechanism to convert the funds into guaranteed benefits at rates set by the contract.** While another contract, with a different mix of features, might satisfy these requirements, *GAC 50* does not. Indeed, *Hancock* provided no real guarantee that benefits in any amount would be payable from the free funds. We therefore conclude, as did the Second Circuit, that the free funds are "plan assets," and that *Hancock's* actions in regard to their management agreement and disposition must be judged against ERISA's fiduciary standards. [Emphasis added.]*

(b) Thus far, traditional deposit administration ("DA") or immediate participation guarantee ("IPG") group annuity contracts issued to defined benefit plans that provide for policyholder participation in the investment experience of the general account have been the focus of most "guaranteed benefit policy" litigation.

(c) However, the same analysis has been extended to contracts issued to other types of employee benefit plans, including defined contribution pension plans, life insurance, and premium stabilization reserves held in connection with insured health plans, as well as guaranteed investment contracts. See *Steen v. John Hancock Life Ins. Co.*, 106 F.3d 904 (9th Cir. 1997) (401(b)(2) issue relating to premium stabilization reserve not reached; case decided on collateral estoppel grounds); *Moreland v Behl*, 1996 U.S. Dist. LEXIS 5653 (N.D. Cal. 1996) (analysis of cash value portion of life insurance contract); *Ferry a Mutual Life Ins. Co. of New York*, 868 F. Supp. 764 (W.D. Pa. 1994) (GICs). *Rapides Regional*

Medical Center v. American United Life Insurance Company, 938 F Supp. 380 (W.D. La. 1996).

- (d) ERISA Regulation §2550.401c-1 sets forth the changes required for transition policies for insurers to benefit from the limitations on liability specified in the regulation. It is not clear whether such changes will turn such transition policies into guaranteed benefit policies or whether such changes on previously approved forms will convert such contracts into guaranteed benefit policies marketable to new issues.

E.2) *Key Features* -- Under *Harris Trust*, the insurer must assume investment risk under each component of the insurance contract for that component to qualify as a "guaranteed benefit policy." In its decision, the Supreme Court required a *guarantee of a reasonable rate of interest and a mechanism to convert such funds into guaranteed benefits at a price set by the contract*. Based on a review of applicable law under §401(b)(2) of ERISA, and §3(a)(8) of the 1933 Act, it appears that the following features of a contract will be given weight in determining whether an insurer assumes investment risk with respect to unallocated amounts under the contract.

- (a) *Guarantees of Principal and interest*. While guarantee of principal alone is insufficient to qualify as an assumption of investment risk, when combined with a permanent minimum interest rate, an unallocated component may constitute a guaranteed benefit policy. See *Associates in Adolescent Psychiatry v. Home Life Ins. Co.*, 941 R2d 561 (7<sup>th</sup> Cir. 1991); *Moreland v Behl*, 1996 U.S. Dist. LEXIS 5653; *Peoria Union Stock Yards Co. Retirement Plan v. Penn Mutual Life Ins. Co.*, 698 R2d 320, 324-25 (7<sup>th</sup> Cir. 1983); *Otto v. Variable Annuity Life Ins. Co.*, 814 F.2d 1127, 1132 (7<sup>th</sup> Cir. 1986); *Harper-Wyman Co. v Connecticut General Life Ins. Co.*, 1991 U.S. Dist. LEXIS 18080 (N.D. Ill. 1991); See also Rule 151 (a minimum interest rate generally equal to state nonforfeiture law).
  - (i) The provision of guaranteed interest rates above a guaranteed minimum rate ("additional amount" or "excess interest rates") is further evidence of assumption of investment risk with respect to unallocated funds. In this regard, one-year guaranteed rates set and declared in advance provide strong support for guaranteed benefit policy status.
  - (ii) There is little authority considering an arrangement in which excess interest rates are guaranteed for periods of less than one year. The SEC has provided some analysis relating to excess interest rates in its discussion of the safe harbor provided under Rule 151. While Rule 151 requires excess interest to be guaranteed for one-year, insurers may increase excess interest rates during the year, provided that the new rate is protected against reduction for a further one year period.
  - (iii) Insurers may provide separate twelve-month guarantees with respect to each payment received and consolidate the guarantees using a calendar

or contract year system.

- (b) *Market Value Adjustments.* Because market-value adjustments limit the investment risk assumed by insurers, application of the market value adjustment may threaten a contract's qualification for the guaranteed benefit policy exception.
- (i) Under the safe harbor Rule 151, the SEC did not permit MVAs, because they may operate to reduce principal and interest amounts otherwise guaranteed.
  - (ii) The SEC has made clear, that insurers issuing contracts with market-value adjustments may choose to rely on §3(a)(8) without Rule 151 safe harbor protection.
  - (iii) For GICs, insurers should consider only using liability based adjustment formula. In Prohibited Transaction Exemption 81-82, the U.S. Department of Labor granted an exemption from the prohibited transaction rules for separate account GICs. The DOL did not believe that any market-value adjustment requirements were necessary for separate account GICs “so long as the adjustment is not made with reference to the investment performance of a separate account”.
  - (iv) Asset-based market-value adjustment formulas in general account GICs may raise concerns with the DOL. In any event, the standards applicable to market-value adjustments should be the same for general account and separate account GICs. We may question an asset-based formula if the assets do not appear to closely match the contractual guarantees, especially with respect to duration.
- (c) *Discretion to Amend the Contract.* An insurer may undermine guarantees of principal and interest if it retains too much authority to amend guarantees provided in the contract. The contract should not give the insurer discretion to change key contract terms, including retroactively amending the contract's guarantees.
- (d) *Annuity Purchase Rates.* In Harris Trust, the Court required a mechanism to convert the accumulation funds into guaranteed benefits at retirement at rates set by the contract. According to the Court, without a “guarantee regarding conversion price, plan participants are undeniably at risk...”
- (i) The minimum annuity purchase rates constitute the kind of conversion mechanism contemplated by *Harris Trust*.
  - (ii) These principles have also been applied to life insurance contracts with cash values.
  - (iii) Before Rule 151, SEC Release 6051 provided that insurance contracts had to assume mortality risk to qualify for the §3(a)(8) exemption, (e.g., through long term guaranteed annuity purchase rates). Such rates were

prohibited from being significantly lower than the rates available "commercially;" otherwise the insurer would not be considered to have assumed sufficient risk. Release 6051 allowed contracts to offer alternative settlement options, including lump sum payout or current-rate-if-better options. For group annuity contracts, a five-year annuity purchase rate was deemed generally sufficient.

- (iv) In contrast to *Harris Trust* and Release 6051, the SEC determined not to include any kind of mortality risk requirement (such as annuity purchase rates) in Rule 151. However, the agency indicated that it was not concluding that "consideration of mortality risk has no place in a (sec)3(a)(8) analysis outside of the safe harbor."

- E.3) *Traditional Guaranteed Interest Contracts*. In the preamble to the final regulation the US DOL's determined that certain "traditional" guaranteed investment contracts (GICs) constitute guaranteed benefit policies within the meaning of section 401(b)(2)(B) of the Act. Under a traditional GIC, an insurance company promises to pay a guaranteed rate of interest for a fixed period (i.e., until a stated maturity date) with the rate of interest being a fixed rate (e.g., 6.0%) guaranteed for the fixed period, or a rate which is periodically reset by reference to an independently maintained index (e.g., LIBOR). Under this type of GIC, the principal invested is guaranteed to be repaid at maturity, and the rate of return on the amount invested is not dependent on the performance of the assets in the insurer's general account or any other assets.
- E.4) *Allocated Group Annuity Contracts*. The preamble to the regulation also provides minimal guidance as to definition of guaranteed benefit policy. The discussion in the preamble of the *Impact on the Insurance Industry – Amount of Assets Affected* suggests that the allocated portions of general account group insurance contracts and allocated group annuity contracts are excluded because the benefits from the contracts are guaranteed and the employee benefit plans do not participate in the risk associated with those contracts.
- E.5) Rule 151 Under the Securities Act of 1933 and "Individual" Deferred Annuity Contracts.
  - (a) Courts interpreting the guaranteed benefit policy exemption have relied on decisions construing the insurance policy exemption under §3(a)(8) of the Securities Act of 1933. In *SEC V. Variable Annuity Life Insurance Company*, 359 U.S. 65 (1959), the Court held that a contract providing for variable payments based on the investors' stake in a special investment portfolio is not an "annuity contract." The Court reasoned that because there was no guarantee of any investment return, the entire investment risk was borne by the purchaser of the annuity. Where there is no transfer of risk, the exemption does not apply. See also *SEC v. United Benefit Life Insurance Company*, 387 U.S. 202 (1965).

- (b) The SEC has established a nonexclusive "safe harbor" for "annuity and optional annuity" contracts under §3(a)(8) of the Securities Act of 1933 whereby investment risk is deemed to have been allocated to the insurer if, among other conditions, the contract's value is not dependent on the performance of a separate account, the insurer has guaranteed the principal amount and interest credited (less administrative expenses), and the insurer guarantees that the interest rate credited to the account will not change more frequently than annually. See Rule 151 [17 C.F.R. §230.151], as explained in Release 6645 (May 26, 1986).
  - (c) The safe harbor in Rule 151 is not available for a contract that permits a lump sum payment subject to a market value adjustment. However, the Rule provides that the presence of a market value adjustment does not raise a presumption with respect to §3(a)(8). See Definition of Annuity Contract or Optional Annuity Contract, Securities Act Release No. 33-6645 (May 29, 1986).
  - (d) Several States do not allow market value adjustments in individual annuity contracts that are subject to State nonforfeiture laws. Other States do not allow market value adjustments in individual annuity contracts except with respect to "modified guaranteed annuities" (MGAs).
  - (e) In the discussion of the *Lump Sum Payment* in the preamble of the regulation, one commentator suggests that individual annuity contracts, including modified guaranteed annuities ("MGAs"), are not covered by the regulation (i.e., no transition policy are MGAs). If so, individual annuity contracts must be guaranteed benefit policies.
- E.6) *Guaranteed Separate Account Contracts.* In 1983, the US DOL issued an Advisory Opinion 83-S 1A (Sept. 21, 1983) concluding that assets held by an insurance company in a separate account that is maintained solely in connection with fixed contractual obligations of the insurance company are not "plan assets" for purposes of ERISA "if neither the amount payable (or credited to) the plan or to any participant or beneficiary of the plan (including an annuitant) is affected in any way by the investment performance of the separate account."
- (a) This opinion addressed "guaranteed investment contracts" and "nonparticipating fixed annuity contracts" that provide "guarantees of return of the principal amount deposited under the contract (plus accrued interest) on a fixed date or dates in the future and the crediting of interest at a rate fixed under the contract."
  - (i) The advisory opinion request asked for confirmation that these contracts would qualify as "guaranteed benefit policies" for purposes of §401(b)(2) of ERISA notwithstanding the apparent exclusion for separate account contracts.
  - (ii) Although the opinion quotes the language of §401(b)(2), the Department did not directly address the question of whether these contracts would

constitute guaranteed benefit policies under §401(b)(2).

- (b) Before issuing Advisory Opinion 83-S1A, the Department granted a class exemption, Prohibited Transaction Class Exemption 81-82, 46 Fed. Reg. 46443 (Sept. 19, 1981), that provided relief from 406(a) of ERISA to permit insurance companies to engage in a broad range of transactions with persons who may be parties in interest with respect to plans holding contracts backed by a guaranteed contract separate account.
- (c) In 1996, the Department revoked PTE 81-82 based on the Department's conclusion that, in light of 29 CFR 2510.3-101(h), which addresses the "plan asset" status of guaranteed contract separate accounts, the exemptive relief provided by these proposed and final class exemptions was unnecessary. In 29 CFR 2510.3-101(h), a plan investment in a separate account will not cause the separate account to hold "plan assets" if the separate account is maintained solely in connection with fixed contractual obligations of the insurance company under which the amounts payable, or credited, to the plan and to any participant or beneficiary of the plan (including an annuitant) are not affected in any manner by the investment performance of the separate account.