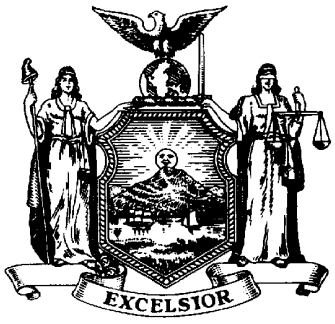

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

REPORT ON MARKET CONDUCT EXAMINATION

OF THE

GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

CONDITION: DECEMBER 31, 2008

DATE OF REPORT: APRIL 30, 2010

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EXAMINER: MARK MCLEOD

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Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

January 22, 2013

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
New York, New York 10004

Sir:

In accordance with instructions contained in Appointment No. 30499, dated March 12, 2010 and annexed hereto, an examination has been made into the condition and affairs of Guardian Life Insurance Company of America, hereinafter referred to as "the Company," at its home office located at Seven Hanover Square New York, NY 10004.

Wherever "Department" appears in this report, it refers to the New York State Department of Financial Services. On October 3, 2011, the Insurance Department merged with the Banking Department to create the New York State Department of Financial Services.

1. EXECUTIVE SUMMARY

The material findings, violations and recommendations contained in this report are summarized below.

- With respect to replacements, the Company violated various Sections of Department Regulation No. 60 by failing to: provide the applicant with a revised Disclosure Statement where the insurance policy issued differed from the life insurance policy for which the applicant applied; provide the existing insurer with a revised Disclosure Statement where the insurance policy issued differed from the life insurance policy for which the applicant applied; and reject the application when the deficiencies contained in the Disclosure Statement were not corrected within 10 days from the date of receipt of the application. (See item 4A of this report)
- The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms in New York that have not been filed with and approved by the Superintendent. The examiner recommends that the Company re-file Policy Form GP-1-SI, along with the listing of variable data with the Department. (See item 4B of this report)
- The Company violated Section 4235(h)(1) of the New York Insurance Law by failing to file its underwriting discretion factor used in connection with the issuance of its group accident and health insurance policy. (See item 4B of this report)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2005 through December 31, 2008. As necessary, the examiner reviewed transactions occurring subsequent to December 31, 2008 but prior to the date of this report (i.e., the completion date of the examination).

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

The examiner reviewed the corrective actions taken by the Company with respect to the market conduct violations and recommendations contained in the prior report on examination. The results of the examiner's review are contained in item 8 of this report.

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

3. DESCRIPTION OF COMPANY

A. History

The Company was incorporated as a stock life insurance company under the laws of New York on April 10, 1860, and commenced business on July 16, 1860 as The Germania Life Insurance Company. In 1918, the Company changed its name to its present name. In 1924, the Company adopted a plan to convert to a mutual company. In 1945, the Company acquired all of its outstanding stock. Effective January 1, 1946, the Company adopted and amended its charter and by-laws and became a mutual company.

On July 1, 2001, the Company merged with Berkshire Life Insurance Company ("BLIC") in a business combination accounted for as a statutory merger. As a statutory merger approved by the New York and Massachusetts insurance departments and by policyowners of both companies, BLIC policyowners became the Company's policyowners. The Company renamed Health Source Insurance Company, a then existing subsidiary, to become Berkshire Life Insurance Company of America ("BLICOA"). Pursuant to a reinsurance treaty effected between BLICOA and the Company, BLICOA reinsured 100% of BLIC's and the Company's existing disability income business.

B. Territory and Plan of Operation

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

The Company is licensed to transact business in all 50 states and the District of Columbia. In 2008, 22.0% of life premiums were received from New York and 10.1% from New Jersey. In 2008, 15.4% of annuity considerations were received from New York, 13.6% from New Jersey, 12.3% from Florida, 10.6% from California, and 10.1% from Georgia.

In 2008, 14.3% of accident and health premiums were received from New York and 12.6% from California. In 2008, 32.7% of deposit type funds were received from New York and 17.2% from Massachusetts.

4. MARKET CONDUCT ACTIVITIES

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

A. Advertising and Sales Activities

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

1. Advertising

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

> "(a) Advertising file. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised . . . ."

Neither the Company's GEAR system nor the advertisement logs provided to the examiner contain a notation attached to each advertisement that indicates the form number of any policy that was advertised.

The Company violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain, within its accident and health advertising files, the form numbers of the policies advertised.

The Company maintains information on its accident and health advertisements in two formats: a GEAR electronic repository and a separate advertising log. A review of the advertising file provided by the Company revealed that the advertisements are divided into two categories. Home office-produced ("HO") advertisements are produced for national distribution, while agent/agency-produced advertisements are produced for distribution in the geographic region of the agency. The identification of an advertisement as HO for national distribution

lacks adequate detail to describe the manner and extent of distribution, and in some cases, are not accurate notations of the manner and extent of distribution for compliance with Department Regulation No. 34. For example, a Company HO advertisement (2005-7435) which is described as being produced for national distribution advertises a product that is not available in all states. Different products are marketed in different states so the examiner was unable to determine the extent of distribution for the HO advertisements. In addition, five of the eight advertisements that the examiner determined to be not in compliance with Department Regulation No. 34 were not used by the Company during the examination period, even though they appeared in the Company advertising log as being an HO advertisement that is distributed nationally. The manner and extent of the advertisements is maintained by the Company's business units and not in the GEAR system or the separate advertising file.

The examiner recommends that the Company integrate its GEAR system with the information contained in its advertising log maintained by the business units to enhance its ability to determine the manner and extent of distribution for its accident and health advertising files.

b) Section 219.4(e) of Department Regulation No. 34-A states:

> "(e) The words free, no cost, without cost, no additional cost, at no extra cost, without additional cost, or words of similar import, may not be used with respect to any benefit or service being made available with the policy. An advertisement may specify the charge for a benefit or a service, or may state that a charge is included in the premium, or use other appropriate language."

The examiner's review revealed that one of the Company's Flexible Solutions - Variable Universal Life (VUL) advertisements stated that "Guaranteed Coverage Rider (GCR) to age 80 will automatically be added to all policies at no additional cost if all underwriting requirements are met," while another of the Company's advertisements states that "With this option, a Guaranteed Coverage is included at no additional cost that will guarantee, up to age 85, that the policy will not lapse, provided that the required premiums are paid and other conditions are met." Both advertisements failed to specify the charge for the benefit or service, or state that a charge is included in the premium, or use other appropriate language in its advertisements as required by Section 219.4(e) of Department Regulation No. 34-A.

The Company violated Section 219.4(e) of Department Regulation No. 34-A by using the words "at no additional cost" to describe additional or guaranteed coverage, with respect to advertisements for its Flexible Solutions VUL product.

c) Section 219.5(a) of Department Regulation No. 34-A states, in part:

> "(a) Each insurer shall maintain at its home office a complete file containing a specimen copy of every printed, published or prepared advertisement hereafter disseminated in this state, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. In order to be complete, the file must contain all advertisements whether used by the company, its agents or solicitors or other persons . . . ."

Neither the Company's GEAR system nor the advertisement logs provided to the examiner contain a notation attached to each advertisement that indicates the form number of any policy that was advertised.

The Company violated Section 219.5(a) of Department Regulation No. 34-A by failing to maintain, within its life insurance advertising files, the form numbers of the policies advertised.

A review of the advertising file provided by the Company revealed that the life insurance advertisements are divided into two categories. Home office-produced advertisements are produced for national distribution, while agent/agency-produced advertisements are produced for distribution in the geographic region of the agency.

The identification of an advertisement as HO for national distribution lacks adequate detail to describe the manner and extent of distribution, and in some cases, are not accurate notations of the manner and extent of distribution for compliance with Department Regulation No. 34-A. For example, a Company HO advertisement (#2006-8911) which is described as being produced for national distribution advertises a product that is not available in all states. Therefore, it is misleading to note that the extent of distribution of advertisement 2006-8911 is a national distribution when in fact the products advertised are not available nationwide.

With respect to advertisement #2008-3142 (for Guardian's ULtraMax Gold Universal Life product) and advertisement #2008-3188 (for EstateGuard® Whole Life) there are no notations on the advertisements of where the advertised products are distributed, and whether or not available nationally. Different products are marketed in different states so the examiner was unable to determine the extent of distribution for the HO advertisements. The manner and extent

of the advertisements is maintained by the Company's business units and not in the GEAR system or the separate advertising file.

The examiner recommends that the Company integrate its GEAR system with the information contained in its advertising log maintained by the business units to enhance its ability to determine the manner and extent of distribution for its life insurance advertising files.

2. Replacements

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

> "Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall…
> (5) Submit quarterly reports within thirty days of the end of each quarter, beginning at the end of the first full calendar quarter after the effective date of this Part, to the Superintendent of Insurance, indicating which insurers, if any, have failed to provide the information as required in Section 51.6(c)(2) herein;…"

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

> "Where a replacement has occurred or is likely to occur, the insurer whose life insurance policy or annuity contract is to be replaced shall…
> (2) Within twenty days of receipt of a request from a licensee of the Department, for information necessary for completion of the "Disclosure Statement" with respect to the life insurance policy or annuity contract proposed to be replaced, together with proper authorization from the applicant, furnish the required information simultaneously to the agent or broker of record of the existing life insurance policy or annuity contract being replaced and the agent or broker and insurer replacing the life insurance policy or annuity contract. This information shall include the insurer's customer service telephone number, the current status of the existing life insurance policy or annuity contract and the currently illustrated dividends/interest and other non-guaranteed costs and benefits."

In 3 of the 5 (60%) cases, the agent indicated that approximations were used to complete the Disclosure Statement provided to the applicant, instead of information provided by the company being replaced. However, the Company failed to identify the offending companies in quarterly reports it submitted to the Department during the exam period.

The Company violated Section 51.6(b)(5) of Department Regulation No. 60 by failing to submit a complete report to the Superintendent, indicating which insurers failed to provide the information required by Section 51.6(c)(2) of Department Regulation No. 60.

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

> "Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall…
> (9) In the event the life insurance policy or annuity contract issued differs from the life insurance policy or annuity contract applied for, ensure that the requirements of this Part are met with respect to the information relating to the life insurance policy or annuity contract as issued, including but not limited to the revised "Disclosure Statement," any revised or additional sales material used and acknowledgement by the applicant of receipt of such revised material."

In 10 out of 35 (29%) internal and external replacement transactions reviewed, the examiner noted that the Company did not provide the applicant with a revised Disclosure Statement even though the policy was issued "other than as applied for," where there was a change due to a rated policy or difference in the face amount of insurance.

The Company violated Section 51.6(b)(9) of Department Regulation No. 60 by failing to provide the applicant with a revised Disclosure Statement where the insurance policy issued differed from the life insurance policy for which the applicant applied.

In 12 out of 19 (63%) external replacement transactions reviewed where the Company did provide the applicant with a revised Disclosure Statement where one was required, the Company failed to furnish the revised Disclosure Statement to the companies being replaced.

The Company violated Section 51.6(b)(9) of Department Regulation No. 60 by failing to provide the existing insurer with a revised Disclosure Statement.

b) Section 51.5 of Department Regulation No. 60 states, in part:

> "Each agent and broker shall:
> …
> (c)Where a replacement has occurred or is likely to occur . . .
> (2) Notify the insurer whose policy or contract is being replaced and the insurer replacing the life insurance policy or annuity contract of the proposed replacement. Submit to the insurer whose policy or contract is being replaced a list of all life insurance policies or annuity contracts proposed to be replaced, as well as the policy or contract number for such policies or contracts, together with the proper authorization from the applicant, and request the information necessary to complete the "Disclosure Statement" with respect to the life insurance policy or annuity contract proposed to be replaced. In the event the insurer whose coverage is being replaced fails to provide the information in the prescribed time, the agent or broker replacing the life insurance policy or annuity contract may use, and the insurer replacing the life insurance policy or annuity contract shall review and may accept, good faith approximations based on the information available;…"

In 11 out of 34 (32%) external replacement transactions reviewed, where the agent indicated on the Disclosure Statement that proposals and other sales material were used, the replacement notification letter sent to the company being replaced did not indicate whether sales materials/illustrations were being sent.

The examiner recommends that the Company indicate on its replacement notification letter to the company being replaced whether sales materials and/or illustrations were used along with the notification.

c) The examiner requested information from the Company pertaining to its replacement transactions. However, the data file that was provided to the examiner contained replacement transactions for two subsidiaries, Guardian Insurance and Annuity Company (GIAC) and BLICOA. 155 (4%) of the 3,792 policies in the Company's replacement transaction listing were issued by either GIAC or BLICOA.

The examiner recommends that the Company implement procedures to ensure that the Company's replacement transactions information is maintained segregated from those of its subsidiaries, GIAC and BLICOA.

B. Underwriting and Policy Forms

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

1. Section 3201(b)(1) of the New York Insurance Law states, in part:

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

In 25 out of 84 (30%) group health and group life applications and underwriting files reviewed, the examiner did not find a match for two Policy Forms in the Department's Policy Form Database. The Company stated that these policy forms were withdrawn, but did not indicate the date the forms were withdrawn. The examiner's review disclosed that the Company utilized these policy forms with several group health and group life policies issued in New York during the examination period.

In 73 out of 84 (87%) group health and group life applications and underwriting files reviewed, the examiner did not find a match for seven policy form numbers in the Department's Policy Form Database. Upon inquiry, the Company acknowledged in writing that it was unable to locate the approval for the policy forms. The Company utilized these policy forms to issue several group health and group life policies in New York during the examination period.

In 75 out of 84 (or 89%) group health and group life applications and underwriting files reviewed, the Company utilized policy forms to issue policies in New York that differed from the form approved by the Department.

In 62 out of 84 (74%) group health and group life applications and underwriting files reviewed, the examiner was unable to verify the approval status for several group health and group life policy forms utilized during the examination period. The actual forms utilized by the Company contained no indication of filing status or approval status by the Department.

In 56 out of 84 (67%) group accident and health and group life applications and underwriting files reviewed, the examiner was unable to verify the approval status of application forms used to write group accident and health and group life insurance in New York during the examination period.

The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms in New York that have not been filed with and approved by the Superintendent.

2. In 74 out of 84 (88%) group health and group life new issues reviewed, the examiner did not find a match for Policy Form GP-1-SI in the Department's Policy Form Database. Policy Form GP-1-SI contains the policy contract language that is used by the Company to issue the majority of its group life and group health policies in New York. The Company indicated that the form was approved in 1956 with variable text. However, the form is not listed on the Department's approval letter of December 18, 1956. In addition, this form is different from the policy form used to issue group health and group life policies during the examination period.

The examiner recommends that the Company re-file Policy Form GP-1-SI, along with the listing of variable data with the Department.

3. Section 4235(h) of the New York Insurance Law states, in part:

> "(1) Each domestic insurer...doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of such fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer, other than as agent or broker to any individuals, firms or corporations pertaining to such class of business, whether transacted within or without the state.
>
> (2) An insurer may revise such schedules from time to time, and shall file such revised schedules with the superintendent….."

The examiner noted that the Company used an underwriting discretionary discount of 19.4% to lower the medical coverage monthly billed premium from $46,220.06 to $37,261.35 for one policy/plan.

Upon inquiry, the Company stated that the degree of underwriting discretion varies based on group characteristics impacting risk that are not reflected in the manual rate calculation, such as health status or prior claims experience.

With respect to written underwriting guidelines, the Company stated that it was unable to provide a written basis/procedure documenting the use of underwriting discretion. Underwriting discretion was used as a factor in 4,612 of the 6,375 dental cases issued during the examination period and all 47 medical large group market cases issued during the examination period.

In addition, the examiner did not observe any evidence of filing and supporting documentation regarding the 19.4% Underwriting Discretionary discount that was used in determining the medical coverage monthly billed premium for policy/plan.

The Company violated Section 4235(h)(1) of the New York Insurance Law by failing to file its underwriting discretion factors used in connection with the issuance of its group accident and health insurance policy.

4. Section 2611 of the New York Insurance law states in part:

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

In 15 out of 63 (23.8%) underwriting files reviewed, the Company required the proposed insured to be subject to an HIV related test without receiving written informed consent prior to the test.

In four out of 63 (6.6%) underwriting files reviewed, the Company subjected the applicant to an HIV related test without receiving the written informed consent of such individual.

The Company violated Section 2611(a) of the New York Insurance Law by requesting or requiring the proposed insured to be subjected to an HIV related test without receiving prior written informed consent.

C. Treatment of Policyholders

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

1. The Company's individual disability claim correspondence and claim forms used during the examination period contains Berkshire Life Insurance Company letterhead and references Berkshire, as a subsidiary and administrator for Guardian. However, the Company is not identified as the insurer anywhere in the claim correspondence or claim form. Further, the disability claim instructions provided with the claim forms state that the forms are to be used with policies issued by Berkshire Life Insurance Company, Berkshire Life Insurance Company of America, or The Guardian Life Insurance Company of America, potentially confusing the claimant as to the true insurer of the policy.

The examiner recommends that the Company clearly identify Guardian Life Insurance Company as the insurer on the individual disability claim form and all individual disability claim correspondence pertaining to New York policies, where such is the case.

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

> "(d) All applications for commercial insurance, individual, group or blanket accident and health insurance and all claim forms…shall contain a notice in a form approved by the superintendent that clearly states in substance the following:
>
> "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

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

> "(a) . . . all claim forms for insurance, and all applications for commercial insurance and accident and health insurance, provided to any person residing or located in this State in connection with insurance policies for issuance or issuance for delivery in this State, shall contain the following statement:
> 'Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.' . . .
> (e) . . . insurers may use substantially similar warning statements provided such warning statements are submitted to the Insurance Frauds Bureau for prior approval."

In 11 out of 57 (19%) group long term disability cases reviewed, the Company used claim forms that did not contain the appropriate language required by Section 403 of the New York Insurance Law. The fraud language contained in the long term disability cases reviewed neither conforms to Section 86.4 of Department Regulation No. 95 nor was it submitted to the Department for prior approval.

In 3 out of 54 (5.5%) group short term disability cases reviewed, the Company used claim forms that did not contain the appropriate language required by Section 403 of the New York Insurance Law. The fraud language contained in the short term disability cases reviewed neither conforms to Section 86.4 of Department Regulation No. 95 nor was it submitted to the Department for prior approval.

In all 14 individual disability income cases reviewed, the Company used claim forms that did not contain the appropriate language required by Section 403 of the New York Insurance Law. The claim forms which all belong to the claims administrator, Berkshire Life Insurance Company of America, neither conforms with Section 86.4 of Department Regulation No. 95 nor were they submitted for prior approval.

The Company violated Section 403(d) of the New York Insurance Law and Sections 86.4(a) and (e) of Department Regulation No. 95 by utilizing claim forms that failed to contain the required fraud warning statement, and further, by using language that deviated from the required fraud warning statement without obtaining prior approval from the Department's Insurance Frauds Bureau.

3. Department Circular Letter No. 14 (2007) states, in part:

> "…To ensure that affected insureds are treated fairly and in the manner required by Insurance Law Section 3234, every insurer that has issued group or blanket disability income policies should undertake the following remedial actions:
>
> (1) By February 29, 2008, the insurer should make a good faith effort to identify and review all claim denials for disability benefits based upon pre-existing conditions going back two years from the date of the Court of Appeals' decision (June 27, 2007). If the insurer's policy form provides for a period of time to bring legal action to recover on the policy greater than the two years specified in Insurance Law Section 3221(a)(14), then the insurer should go back and review all such claim denials based upon pre-existing conditions for such greater period, measured from the date of the Court of Appeals' decision…
>
> (2) By April 30, 2008, insurers should make a good faith effort to notify all affected insureds in writing of the results of such review, and retroactively pay all benefits due with interest from the commencement of the period for which the insurer would have been liable had the insurer applied the Benesowitz interpretation of Insurance Law Section 3234 to the claim at the time the proof of loss was first submitted to the insurer. If additional information is required to determine whether benefits are payable, the insurer should attempt to request the information on or before this date. No later than 60 days from the receipt of all information necessary to complete the re-examination of the claim, the insurer should reach a determination and pay retroactively any benefits owed, with interest…"

The Company conducted a review pursuant to the remediation prescribed in Department Circular Letter No. 14 (2007). Although each of the 36 short term disability and 31 long term disability claims identified by the Company contained a letter from the Company to the insured requesting information to complete the re-examination of the claim, the examiner was unable to

determine from the claim file that a review was done by the Company for each claim affected by the judicial decision referenced in Department Circular Letter No. 14. Additionally, the Company's letter to the insureds failed to indicate that a review was being performed by the Company and failed to include the results of the review, as requested by Department Circular Letter No. 14 (2007).

The examiner recommends that the Company review all identified short term and long term disability claims and notify all affected insureds, in writing, of the results of such review.

4. Section 4900 of the New York Insurance Law defines the following as a health care plan and utilization review agent:

> (d-5)""Health care plan" means an insurer subject to article thirty-two or forty-three of this chapter, or any organization licensed under article forty-three of this chapter."
>
> (i) ""Utilization review agent" means any insurer subject to article thirty-two or forty-three of this chapter and any municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter performing utilization review and any independent utilization review agent performing utilization review under contract with such insurer or municipal cooperative health benefit plan."
>
> Section 4901 of the New York Insurance Law states, in part:
>
> "Reporting requirements for utilization review agents.
> (a) Every utilization review agent shall biennially report to the superintendent of insurance, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section.
>
> Section 410.9 of Department Regulation No. 166 states, in part:
>
> "Responsibilities of health care plans - Health care plans shall be responsible for compliance with all applicable requirements of Article 49 of the Insurance Law and with the following:…"

The Company failed to provide proof of filing the biennial reports with the Superintendent for the period under examination along with a copy of the biennial reports, related to the Company's medical utilization reviews.

The Company violated Section 4901(a) of the New York Insurance Law for failure to biennially report to the Superintendent, in a statement subscribed and affirmed as true under the penalties of perjury, the Company's medical utilization reviews.

5. THIRD PARTY ADMINISTRATOR

Section 2101(g)(1) of the New York Insurance Law states, in part:

> "(g) In this article, "adjuster" means any "independent adjuster" or "public adjuster" as defined below:
> (1) The term "independent adjuster" means any person, firm, association or corporation who, or which, for money, commission or any other thing of value, acts in this state on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer and who performs such duties required by such insurer as are incidental to such claims…"

Section 2108(a) of the New York Insurance Law states, in part:

> "(3) No adjuster shall act on behalf of an insurer unless licensed as an independent adjuster, and no adjuster shall act on behalf of an insured unless licensed as a public adjuster.
> (4) No insurer, agent or other representative of an insurer shall pay any fees or other compensation to any person, firm, association or corporation for acting as an independent adjuster except to a licensed independent adjuster or to a person excepted from the licensing requirement pursuant to subsection (g) of section two thousand one hundred one of this article…"

A review of the Company's agreements with third party administrators ("TPAs") revealed that one of its TPAs performed adjudication services during the period under examination on behalf of the Company without obtaining an independent adjuster's license. The Company paid the third party administrator $1,722,526 during the examination period for dental and medical claims adjudication services.

The Company violated Section 2108(a)(3) of the New York Insurance Law by allowing an unlicensed third party to adjust claims on behalf of the Company.

The Company violated Section 2108(a)(4) of the New York Insurance Law by paying fees or other compensation to a TPA acting as an independent adjuster that is not licensed as such.

The Company terminated its agreement with this TPA on April 30, 2009.

6. RECORD RETENTION

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

"…(b) Except as otherwise required by law or regulation, an insurer shall maintain:
(1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer . . .
(4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received.
(5) A licensing record for six calendar years after the relationship is terminated for each Insurance Law licensee with which the insurer establishes a relationship. Licensing records shall be maintained so as to show clearly the dates of appointment and termination of each licensee . . .
(8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review.
(e) The records shall be readily available and easily accessible to the superintendent…"

The examiner requested a sample of policy records (application, claim, and policyholder benefit) for review. The Company was unable to provide some of the requested items and was missing information in the policy records:

1) In 7 out of 100 (7%) group life death claims reviewed, the Company did not maintain the application, including the application form or enrollment form for coverage under the insurance contract or policy.
2) In 6 out of 100 (6%) group life death claims reviewed, the Company did not maintain the death certificates and the proof of death claim forms.
3) In 7 out of 110 (5.54%) policy loans reviewed, the Company did not maintain a copy of the loan request in the policy records.
4) The Company was unable to provide 2 out of 20 (10.0%) denied group life death claims requested.
5) The Company was unable to provide 6 out of 60 (10.0%) paid group short term disability claims requested.
6) The Company was unable to provide 4 out of 27 (14.8%) denied group short term disability claim files requested.

7) The Company was unable to provide 3 out of 36 (8.33%) group short term disability claim files requested for the purpose of reviewing compliance with Department Circular Letter No. 14 (2007).
8) In 23 out of 69 (33%) declined applications reviewed, the Company did not maintain in the policy records, a notice to the applicants advising them of the specific reasons for the adverse decision.

The Company violated Section 243.2(e) of Department Regulation No. 152 by failing to maintain its policy records in a manner that allows ready and easy access.

7. POLICY DATA FILES

The Company provided reconciliations between summary policy information contained in data files provided to the examiner and the corresponding policy count information reported in the Company's filed annual statements. Upon review of the information provided, the Company was requested to furnish an explanation for certain identified material differences between the data file information and the corresponding reported annual statement amount. In its response the Company indicated that the material differences were due to an inadvertent omission of data during annual statement preparation.

The examiner recommends that the Company implement enhanced controls, for those annual statement exhibits and schedules identified during the examination, to ensure the accuracy of the data reported.

The examiner was unable to reconcile the group accident and health claims amount reported in the Company's filed annual statements (Exhibit 8, Part 2) for the examination period to the data files provided.

The examiner recommends that the Company implement procedures to ensure that its summary group accident and health claim information reconciles to the information reported in its filed annual statement, and that all pertinent summary policy information be readily available upon request for future examinations.

8. PRIOR REPORT SUMMARY AND CONCLUSIONS

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

Item	Description
A	The Company violated Section 51.6(b)(3) of Department Regulation No. 60 by failing to examine and ascertain that Disclosure Statements completed by its agents and submitted with applications during the examination period were accurate and complete with respect to the information on such Disclosure Statements pertaining to the existing coverage. Due to the timing of the stipulation between the Company and the Department arising from the findings contained in the prior report on examination, the examiner did not review the Company's remedial actions with respect to this item, for the purposes of the current report.
B	The Company violated Section 243.2(b)(1) and (8) of Department Regulation No. 152 by failing to maintain the documentation obtained from the original insurer. Due to the timing of the stipulation between the Company and the Department arising from the findings contained in the prior report on examination, the examiner did not review the Company's remedial actions with respect to this item, for the purposes of the current report.
C	The Company violated Section 51.6(b)(4) of Department Regulation No. 60 by failing to furnish, within ten days of receipt of the application, a copy of any proposal including the sales material used in the sale of the proposed life insurance policy and the completed "Disclosure Statement" to the insurer whose coverage was being replaced. Due to the timing of the stipulation between the Company and the Department arising from the findings contained in the prior report on examination, the examiner did not review the Company's remedial actions with respect to this item, for the purposes of the current report.

Item	Description
D	The examiner recommends that the Company date stamp the application and all Department Regulation No. 60 forms. Due to the timing of the stipulation between the Company and the Department arising from the findings contained in the prior report on examination, the examiner did not review the Company's remedial actions with respect to this item, for the purposes of the current report.
E	The examiner recommends that the Company implement controls and procedures to comply with the above cited sections of Department Regulation No. 60. Due to the timing of the stipulation between the Company and the Department arising from the findings contained in the prior report on examination, the examiner did not review the Company's remedial actions with respect to this item, for the purposes of the current report.
F	The Company violated Section 3221(l)(11-a)(A) of the New York Insurance Law by failing to include the requisite policy language in its group health contracts providing for the availability of a prostate screening benefit. The Company included the requisite policy language in its group health contracts providing for the availability of a prostate screening benefit.
G	The examiner recommends that the Company advise all policyholders and certificateholders of the availability of the prostate screening benefit and provide the opportunity for certificateholders to submit previously unreported claims for prostate screening. The Company advised all policyholders and certificateholders of the availability of the prostate screening benefit and provided the opportunity for certificateholders to submit previously unreported claims for prostate screening.
H	The Company violated Section 3201(b) of the New York Insurance Law by utilizing unapproved applications. Due to the timing of the stipulation between the Company and the Department arising from the findings contained in the prior report on examination, the examiner did not review the Company's remedial actions with respect to the specific findings in this item, for the purposes of the current report.

Item	Description
I	The Company violated Section 403(d) of the New York Insurance Law and Section 86.4(a) and (e) of Department Regulation No. 95 by utilizing policy forms that failed to contain the required fraud warning statement and by using policy forms with altered fraud warning statements without obtaining prior approval from the Department's Insurance Frauds Bureau. Due to the timing of the stipulation between the Company and the Department arising from the findings contained in the prior report on examination, the examiner did not review the Company's remedial actions with respect to this item, for the purposes of the current report.
J	The Company violated Section 4904(d) of the New York Insurance Law by allowing the same clinical peer reviewer to render both the initial adverse and subsequent appeals determinations. The Company did not allow the same clinical peer reviewer to render both the initial adverse and subsequent appeals determinations during the examination period.
K	The examiner recommends that the Company re-open all appeals cases whereby the same clinical peer reviewer rendered both the initial adverse and subsequent appeals determinations and have such cases reviewed by a different clinical peer reviewer. The Company re-opened all appeals cases whereby the same clinical peer reviewer rendered both the initial adverse and subsequent appeals determinations and had such cases reviewed by a different clinical peer reviewer.
L	The examiner recommends that the Company add a lump sum option on the claim form for the convenience of its claimants. The Company added a lump sum option on the claim form for the convenience of its claimants.
M	The examiner recommends that the Company improve its record retention policies and procedures such that requested files and the underlying documentation supporting such files can be furnished in a timely manner. A similar violation is contained in the current report on examination. (See item 6 of this report)

Item	Description
N	The Company violated Section 216.4(e) of Department Regulation No. 64 by failing to register all of its complaint activity in its central log. Due to the timing of the stipulation between the Company and the Department arising from the findings contained in the prior report on examination, the examiner did not review the Company's remedial actions with respect to this item.
O	The Company violated Section 3234(b)(3) of the New York Insurance Law by failing to provide on the EOBs an identification of the service for which a claim is made. The Company provided on the EOBs an identification of the service for which a claim is made.
P	The Company violated Section 3234(b)(7) of the New York Insurance Law by failing to provide on the EOBs the information regarding the insured’s or subscriber’s right of appeal. The Company provided on the EOBs the information regarding the insured’s or subscriber’s right of appeal.
Q	The examiner recommends that the EOBs be modified to clearly indicate that the claims are processed pursuant to the Company’s coverage under its Solutions product. The EOBs were modified to clearly indicate that the claims are processed pursuant to the Company’s coverage under its Solutions product.

9. SUMMARY AND CONCLUSIONS

Following are the violations, recommendations and comments contained in this report:

Item	Description	Page No(s).
A	The Company violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain, within its accident and health advertising files, the form numbers of the policies advertised.	5
B	The examiner recommends that the Company integrate its GEAR system with the information contained in its advertising log maintained by the business units to enhance its ability to determine the manner and extent of distribution for its accident and health advertising files.	6
C	The Company violated Section 219.4(e) of Department Regulation No. 34-A by using the words "at no additional cost" to describe additional or guaranteed coverage, with respect to advertisements for its Flexible Solutions VUL product.	6
D	The Company violated Section 219.5(a) of Department Regulation No. 34-A by failing to maintain, within its life insurance advertising files, the form numbers of the policies advertised.	7
E	The examiner recommends that the Company integrate its GEAR system with the information contained in its advertising log maintained by the business units to enhance its ability to determine the manner and extent of distribution for its life insurance advertising files.	8
F	The Company violated Section 51.6(b)(5) of Department Regulation No. 60 by failing to submit a complete report to the Superintendent, indicating which insurers failed to provide the information required by Section 51.6(c)(2) of Department Regulation No. 60.	8
G	The Company violated Section 51.6(b)(9) of Department Regulation No. 60 by failing to provide the applicant with a revised Disclosure Statement where the insurance policy issued differed from the life insurance policy for which the applicant applied.	9
H	The Company violated Section 51.6(b)(9) of Department Regulation No. 60 by failing to provide the existing insurer with a revised Disclosure Statement.	9
I	The examiner recommends that the Company indicate on its replacement notification letter to the company being replaced whether sales materials and/or illustrations were used along with the notification.	10

Item	Description	Page No(s).
T	The Company violated Section 2108(a)(4) of the New York Insurance Law by paying fees or other compensation to a third party administrator acting as an independent adjuster that is not licensed as such.	17
U	The Company violated Section 243.2(e) of Department Regulation No. 152 by failing to maintain its policy records in a manner that allows ready and easy access.	19
V	The examiner recommends that the Company implement enhanced controls, for those annual statement exhibits and schedules identified during the examination, to ensure the accuracy of the data reported.	19
W	The examiner recommends that the Company implement procedures to ensure that its summary group accident and health claim information reconciles to the information reported in its filed annual statement, and that all pertinent summary policy information be readily available upon request for future examinations.	19

Respectfully submitted,

/s/
Mark McLeod
Principal Insurance Examiner

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

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

/s/
Mark McLeod

Subscribed and sworn to before me

this_____ day of _____

APPOINTMENT NO. 30499

STATE OF NEW YORK

INSURANCE DEPARTMENT

I, JAMES J. WRYNN, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

MARK MCLEOD

as a proper person to examine into the affairs of the

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

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

COMPANY

with such other information as he shall deem requisite.

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

this 12th day of March, 2010

JAMES J. WRYNN
Superintendent of Insurance

Superintendent