NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

REPORT ON MARKET CONDUCT EXAMINATION

OF THE

UNITY MUTUAL LIFE INSURANCE COMPANY

CONDITION: DECEMBER 31, 2008

DATE OF REPORT: APRIL 14, 2010

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EXAMINER: EDEN M. SUNDERMAN

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May 24, 2017

Honorable Maria T. Vullo
Superintendent of Financial Services
New York, New York 10004

Madam:

In accordance with instructions contained in Appointment No. 30565, dated July 14, 2010, and annexed hereto, an examination has been made into the condition and affairs of the Unity Mutual Life Insurance Company, hereinafter referred to as "the Company", at its home office located at 507 Plum Street, Syracuse, New York 13250.

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

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

1. EXECUTIVE SUMMARY

The material violations contained in this report are summarized below.

- The Company violated several sections of Department Regulation No. 64 and Section 2601 of the New York Insurance Law by failing to: effectuate prompt, fair and equitable settlements of claims submitted in which liability had become reasonably clear; provide notification to claimants in a timely manner; maintain claim files so that they can be reconstructed; and attempt in good faith to settle claims. (See item 4C of this report)
- The Company violated Section 3209(b)(1)(A) of the New York Insurance Law by failing to provide prospective purchasers with a copy of the preliminary policy information. (See item 4B of this report)
- The Company violated Section 3227 of the New York Insurance law by failing to pay interest on surrender transactions that took more than ten business days to process. (See item 5 of this report)
- The Company violated Section 3214(c) of the New York Insurance Law by failing to pay interest on claims from the date of death to the date of payment. (See item 5 of this report)
- The Company violated Section 4228(f) of the New York Insurance Law by failing to file changes to compensation arrangements or plans with the Department in a timely manner. (See item 7 of this report)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2006 through December 31, 2008. As necessary, the examiner reviewed matters 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 9 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 organized as a fraternal benefit society in 1903 under the name of the Imperial Order of Tycoons and commenced business in 1905. The name of the Society was changed in 1908 to the Unity Insurance Society, in 1918 to The Unity Protective Insurance Association and in 1928 to The Unity Life and Accident Insurance Association.

Effective January 1, 1957, the Society was converted to a mutual life insurance company, pursuant to the provisions of Section 487 (now Section 7304) of the New York Insurance Law. At the time of conversion, the name of the Company was changed to The Unity Mutual Life Insurance Company of New York. The present name, Unity Mutual Life Insurance Company was adopted in September 1972.

Effective December 1983, Guarantee Mutual Life Insurance Company was merged with and into the Company. Effective December 31, 1985, Empire State Mutual Life Insurance Company was merged with and into the Company. Effective September 30, 1987, Volunteer Firemen's Mutual Life Insurance Company was merged with and into the Company.

Effective November 30, 1989, Progressive Life Insurance Company was merged with and into the Company. Effective May 31, 1993, Eastern Mutual Life Insurance Company of New Jersey was merged with and into the Company. Effective December 30, 1993, Empire State Life Insurance Company, a subsidiary of the Company, was merged with and into the Company.

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 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. In 2008, 71.5% of life premiums were received from New York (47.7%) and New Jersey (23.8%). Similarly, 79.1% of annuity considerations were received from New York.

The Company's products and marketing strategies are aimed at the low and middle-income market. The low-income market targets young to middle-aged prospects in urban areas that have been historically under served by the insurance industry. The low-income market also includes

senior citizens outside of urban areas, where pre-need products are sold to satisfy the desires of this group to pre-arrange their funerals.

During 2003, the Company began marketing its final expense products in New York State and it is now the Company's primary product. Final expense products are sold by personal producing general agents, independent general agencies and managing general agencies. Outside of New York, the Company's pre-need market continues to be served exclusively by Unity Financial Life Insurance Company ("UFLIC"), an indirect subsidiary of the Company. UFLIC is a Pennsylvania domiciled life insurer authorized to write life insurance, annuities and accident and health insurance in 40 states, but not in New York.

During the examination period, the Company offered the following four products: Horizon (Final Expense); Millennium (Regular Ordinary); Senior Whole Life Monthly Debit Ordinary ("MDO"); and Twenty Pay Life MDO. Effective December 31, 2008, the Company discontinued selling both MDO products.

In 2007, the Company realized that the increase in sales in 2006 of the final expense products and the forecasted sales for 2007 would cause a significant strain on available surplus of the Company. In order to curtail this situation, the Company implemented a suspension of new sales from the majority of the Company's Atlantic and Eastern region agents and suspended all sales of the Horizon series nationally. As the year progressed, it was apparent that sales would continue to exceed the sales goals and therefore, the Company suspended sales from all agencies except its largest producer. The 2008 marketing plan continued the sales suspension with an annual goal of $5 million in total sales. In April 2008, the Company decided to re-open sales from select agencies that had good mortality experience and persistency.

The Company has not sold annuity products since 2003. Crediting rates on its annuity products have also been lowered throughout the portfolio to meet spread targets. The Company's products include both qualified and non-qualified annuity contracts.

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

4. MARKET CONDUCT ACTIVITIES

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

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.

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

B. Underwriting and Policy Forms

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

Section 3209 of the New York Insurance law states, in part:

" . . . (b)(1) No policy of life insurance shall be delivered or issued for delivery in this state after the applicable effective date, as set forth in subsection (n) of this section, unless the prospective purchaser has been provided with the following:
(A) a copy of the most recent buyer's guide and the preliminary information required by subsection (d) of this section, at or prior to the time an application is taken. . . .
(d) The preliminary information shall be in writing and include, to the extent applicable, the following:
(1) the name and address of the insurance agent or broker or, if no agent or broker is involved, a statement of the procedure to be followed in order to receive responses to inquiries concerning the preliminary information;
(2) the full name and home office, administrative office or branch or agency office address of the company in whose name the life insurance policy is to be written;
(3) the date of the preliminary information and the generic name, the initial amount of insurance and the initial annual premium for the basic policy;
(4) the total guaranteed cash surrender values for the basic policy, at the end of the tenth and twentieth policy years or at the end of the premium-paying period if earlier. These values may be shown on a per thousand or per unit basis;
(5) the effective policy loan annual percentage interest rate, if the policy would contain this provision, and whether this rate is applied in advance or in arrears, adjustable or fixed;
(6) for the life insurance policies described in paragraph one of subsection (n) of this section, life insurance cost indexes and the equivalent level annual dividend for the basic policy for ten and twenty years, but in no case beyond the premium-paying period;

> (7) in addition, the applicant shall be advised that, when the policy is issued, a complete policy summary, including cost data, based on the benefits, premiums and dividends of the policy as issued, will be furnished; and that, following the receipt of the policy and policy summary, there will be a period of not less than ten days within which the applicant may return the policy for an unconditional refund of the premiums paid; and
> (8) notwithstanding the foregoing, no applicant for life insurance shall be prevented or delayed in effecting or applying for coverage by the requirements of this section. In such cases where prior to application it is impractical to provide any items prescribed by this section, such items may be estimated in good faith or furnished as soon thereafter as practical prior to delivery of policy . . .”

The Company was unable to provide any evidence that agents provided prospective applicants with a copy of the preliminary information required by Section 3209(d) of the New York Insurance Law during the examination period. The Company’s written procedures call for agents to secure a Preliminary Statement of Policy Cost and Benefit Information (“Form”) signed by the applicant. However, the Company was unable to supply copies of the signed form for a sample of policies selected.

In addition, the examiner’s review of the standardized Form indicated the following:

- The Form does not contain the home office address as required by Section 3209(d)(2) of the New York Insurance Law.
- The Form contains variable language regarding the effective policy loan annual percentage interest rate and whether this rate is applied in advance or in arrears, adjustable or fixed. The variable language may be confusing to the prospective applicant with regard to the policy loan provisions under the policy being applied for.

The Company violated Section 3209(b)(1)(A) of the New York Insurance Law by failing to provide the prospective purchaser with a copy of the preliminary policy information.

When brought to the Company’s attention, the Company implemented revised procedures and issued a field release to all agents explaining the requirements of Section 3209 of the New York Insurance Law. The Company has also produced revised preliminary information forms by product that contain all of the information required by Section 3209(d) of the New York Insurance Law.

C. Treatment of Policyholders

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

Section 2601(a) of the New York Insurance Law states, in part:

> "No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:
> (1) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;
> (2) failing to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies . . .
> (4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear . . . "

Section 216.3(b) of Department Regulation No. 64 states:

> "No insurer shall deny any element of a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is made in writing."

Section 216.6(d) of Department Regulation No. 64 states:

> "The company shall inform the claimant in writing as soon as it is determined that there was no policy in force or that it is disclaiming liability because of a breach of policy provisions by the policyholder. The insurer must also explain its specific reasons for disclaiming coverage."

The examiner selected a sample of 29 claims out of a population of 173 claims that were processed by the Company and closed without payment during the examination period. In all 29 cases reviewed, the Company did not advise the claimant, informant, or beneficiary in writing that the claim was being closed without payment or denied. The Company closed the claim on its Claims Administration System ("CAS") and no further communications were made with the informant or claimant. With regard to claims, where the death of the insured was reported by someone other than the beneficiary, the examiner's review of the claim files revealed that there was no evidence in the files that a good faith attempt was made to locate the beneficiary through a credit reporting agency or other means.

In nine out of the 29 claims reviewed, the claim was filed within the policy's contestable period and the Company closed the claim without payment because it was unable to obtain medical records. In these instances, there was no medical evidence to support that the insured materially misrepresented themselves on the application for insurance or reinstatement, or that there was a breach of policy provisions. An additional claim involved an accidental death benefit that was not paid because the police department did not cooperate with the Company by providing information on the homicide of the insured and provide evidence that the insured was not involved in the commission of a crime at the time of death. For the ten claims, the claimant provided the required proofs of death, including a certified death certificate. However, the Company closed the claim without payment and placed the policy back in in-force status and allowed the policy to lapse with no value.

The Company violated Sections 216.3(b) and 216.6(d) of Department Regulation No. 64 by failing to make reference in writing to a specific policy provision, condition or exclusion in the policy that were the grounds for denial of the claim or failing to provide the specific reasons for disclaiming coverage.

The Company violated Sections 2601(a)(1), (2), and (4) of the New York Insurance Law by misrepresenting facts and policy provisions relating to coverage; failing to acknowledge pertinent communications regarding claims arising under its policies; and failing to attempt in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability had become reasonably clear.

The examiner recommends that the Company demonstrate a good faith effort to locate the beneficiary of the policy when the death of the insured is reported by someone other than the beneficiary.

The examiner also recommends that the Company conduct a study of all claims that were denied or closed without payment from January 1, 2006 until the date this report is filed. In cases where the Company cannot prove material misrepresentation by the insured, the Company shall pay the claim, and in cases where the Company can prove material misrepresentation by the insured, the Company shall rescind the policy with a full return of premiums.

5. THIRD PARTY ADMINISTRATORS

The Company has three administrative service agreements in place with third parties.

1) Effective May 1997, the Company entered into a claims administration agreement with Maurice W. Pomfrey & Associates, Ltd. ("POMCO") whereby POMCO provides the Company with claims adjudication services related to a closed block of accident and health policies.
2) Effective February 2008, the Company entered into an administrative services agreement with Madison. The agreement covers policies reinsured with Madison Life Insurance Company ("Madison") under a coinsurance agreement that was also effective February 2008. However, Madison did not commence providing administrative services under the agreement until November 1, 2008.
3) Effective January 2009, the Company entered into an administrative services agreement with Actuarial Management Resources, Inc. ("AMR") whereby AMR provides administrative services for closed blocks of universal life, interest sensitive life and accident and health policies. Claims adjudication services for the accident and health policies are provided by POMCO, all other administrative services such as billing, premium collection, and actuarial are provided by AMR.

The Company's internal audit plan for 2009 does include the review of services that have been outsourced to third parties. The establishment and implementation of adequate controls over third party servicing entities and the review of these controls are the responsibility of the Company's management, including the board of directors and specifically the audit committee.

The examiner recommends that management determine through periodic review of controls whether control procedures continue to be effective and relevant by addressing risks associated with the outsourcing of work to TPAs or whether these controls need to be adapted to accommodate changes in the operating environment and regulatory requirements. This includes the control system in place to ensure compliance with New York Insurance Law and Department Regulation.

POMCO Claims Processing

Section 216.6(c) of the Department Regulation No. 64 states, in part:

"Within 15 business days after receipt by the insurer of a properly executed proof of loss and/or receipt of all items, statements and forms which the insurer requested from the claimant, the claimant, or the claimant's authorized representative, shall be advised in writing of the acceptance or rejection of the claim by the insurer . . ."

Section 216.11 of Department Regulation No. 64 states:

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

The examiner selected a sample of 15 accident and health claims that were processed by POMCO during the examination period to determine whether the claims were processed in compliance with Department Regulation No. 64.

In addition to reviewing the sample of accident and health claims, the examiner performed an on-site review at the POMCO business office located in Syracuse, New York and interviewed the claims examiner responsible for processing the Company's accident and health claims. The following information was obtained as a result of the on-site visit:

- Company incoming mail is reviewed by a POMCO claims examiner every two weeks. Company claims are not processed by POMCO upon receipt.
- The date printed on claim checks is not the date that the benefit check is mailed to the claimant. POMCO holds the printed claim check at their office until POMCO has received a wire transfer into their bank account from the Company for the claims paid for that daily cycle. POMCO maintains a "POMCO Check Run Release Log" that indicates the date that POMCO mailed or released the claim checks that were run on a given date.

- During the examination period, it was not POMCO's procedure to date stamp all claim material upon receipt. Some of the POMCO claims examiners date stamped claim documentation upon receipt, but it was not required. Some POMCO claims examiners maintained the envelope that the claim material was received in and used the postmark date on the envelope instead. However, in cases where there may have been more than one submission of claim documents, the examiner was not able to determine which claim documents were received on a given date because the envelopes were placed at the very end of the file.

In five out of 15 claims reviewed, the Company took more than 15 business days to pay the claim once all of the required proofs were received at POMCO.

The Company violated Section 216.6(c) of Department Regulation No. 64 by failing to provide notice of acceptance or rejection of accident and health claims within 15 business days of receipt of a properly executed proof of loss and all information required to pay the claim.

In five out of 15 claim files reviewed, the claim documentation was not date stamped upon receipt by POMCO and the examiner was unable to determine compliance with Section 216.6(c) of Department Regulation No. 64 with regard to the number of days that it took POMCO to process the claim.

The Company violated Section 216.11 of Department Regulation No. 64 by failing to date all claim file communications and transactions, whether written or oral, emanating from or received by the insurer so as to allow the examiner to reconstruct the events relating to the claim.

The examiner recommends that the Company monitor the activities of POMCO on a regular basis to ensure that the TPA is complying with New York Insurance Law and Department Regulations with regard to the claims administration services POMCO provides, specifically the timely payment of claims and the maintenance of claim files.

The examiner also recommends that the Company evaluate whether POMCO's practice of processing Company claims twice a month enables the Company to comply with the timeframes set forth in Section 216.6(c) of Department Regulation No. 64.

Madison Claim and Surrender Processing

Section 216.6 (c) of Department Regulation No. 64 states, in part:

"Within 15 business days after receipt by the insurer of a properly executed proof of loss and/or receipt of all items, statements and forms which the insurer requested from the claimant, the claimant, or the claimant's authorized representative, shall be advised in writing of the acceptance or rejection of the claim by the insurer . . ."

The examiner reviewed a sample of 16 death claims processed by Madison. In six out of the 16 claims reviewed, the Company took more than 15 business days to process the claim after receipt of a properly executed proof of loss and receipt of all documentation requested from the claimant.

The Company violated Section 216.6(c) of Department Regulation No. 64 by failing to provide notice of acceptance or rejection of claims within 15 business days of receipt of a properly executed proof of loss and all information required to pay the claim.

Section 3227 of the New York Insurance Law states:

"(a) Interest, at the rate provided for in section three thousand two hundred fourteen of this article, shall be payable by life insurers, fraternal benefit societies, and life insurance departments of savings banks upon: (1) the value of policies surrendered by policyholders for cash values, including the rollover of annuity funds to other entities, and (2) the funds disbursed as policy loans. Such interest payment shall be added to and be a part of the total sum paid or be paid separately at the option of the insurer.
(b) The interest calculated on amounts described in paragraphs one and two of subsection (a) hereof shall be calculated from the date the documentation necessary to complete the transaction is received by the insurer and shall be payable if the funds are not mailed or delivered by the insurer within ten working days of said receipt.
(c) No interest need be payable pursuant to this section unless the amount of such interest is at least twenty-five dollars or if the payment of benefits by the insurer has been deferred pursuant to other provisions of this chapter.
(d) Irrespective of the payment of interest in accordance with the above provisions, such life insurers, fraternal benefit societies and life insurance departments of savings banks shall make disbursements under paragraphs one and two of subsection (a) hereof as expeditiously as possible."

The examiner reviewed a sample of 21 surrender transactions processed by Madison. In 15 out of the 21 transactions reviewed, the Company took more than ten business days to process

the surrender once all of the necessary forms were received. Madison did not pay interest in accordance with Section 3227 of the New York Insurance Law.

The Company violated Section 3227 of the New York Insurance Law by failing to pay interest on surrender transactions that took more than ten business days to process from the date the documentation necessary to complete the transaction was received to the date of payment.

The Company has completed a study of all surrender transactions, including outgoing replacements that were processed by Madison since it took over administration of the Company's policies, and identified all transactions where Madison took more than ten business days to process the surrender and the amount of interest due to the policyholder exceeded $25. The Company made restitution to 139 affected policyholders for a total amount of $37,630.

AMR Claim Processing

Section 3214(c) of the New York Insurance Law states:

> "If no action has been commenced, interest upon the principal sum paid to the beneficiary or policyholder shall be computed daily at the rate of interest currently paid by the insurer on proceeds left under the interest settlement option, from the date of the death of an insured or annuitant in connection with a death claim on such a policy of life insurance or contract of annuity and from the date of maturity of an endowment contract to the date of payment and shall be added to and be a part of the total sum paid."

The examiner reviewed a sample of ten life claims out of a total population of 19 claims that were processed by AMR. The examiner's review indicated that in five of the ten claims, AMR did not pay the proper number of days of interest resulting in an amount of interest due to the claimant, and in an additional three cases the Company did not pay any interest at all.

The Company violated Section 3214(c) of the New York Insurance Law by failing to pay interest on claims from the date of death to the date of payment.

The examiner recommends that the Company perform a study of all claims processed by AMR since it took over administration of the Company's universal life and interest sensitive life policies and pay any amounts due to claimants, including interest to the date of payment, because AMR did not pay the proper amount of interest when the claim was initially processed.

6. DIVIDENDS

Section 4231(a) of the New York Insurance Law states, in part:

"(1) Except as herein otherwise provided, every domestic life insurance company shall ascertain and distribute annually, and not otherwise, the proportion of any surplus accruing upon every participating insurance policy and annuity or pure endowment contract entitled as hereinafter provided to share therein, issued on or after the first day of January, nineteen hundred seven . . .
(3) After setting aside from such surplus such sums as may be required for the payment of authorized dividends upon the capital stock, if any, such sums as may properly be held for account of outstanding deferred dividend policies, if any, and such sums as may be deemed advisable for the accumulation of a surplus not in excess of the maximum prescribed in this chapter, every such company shall thereupon apportion the remainder of such earnings, if any, derived from participating policies and contracts, equitably to all policies or contracts entitled to share therein during the full dividend year adopted by the company for such purpose. Such apportionment shall not after the first policy year be made contingent upon the payment of the whole or any part of the premium for any subsequent policy year . . ."

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

"Except as otherwise required by law or regulation, an insurer shall maintain: . . .
(7) A financial record necessary to verify the financial condition of an insurer, including ledgers, journals, trial balances, annual and quarterly statement workpapers, evidence of asset ownership, and source documents, for six calendar years from its creation or until after the filing of the report on examination in which the record was subject to review, whichever is longer.
(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."

The examiner reviewed the Company's dividend formula and related documentation. The following was noted as a result of that review:

1. The Company did not maintain any experience studies to demonstrate mortality, expenses or interest.
2. The Company did not provide a dividend formula for its MDO or ordinary policies. The factors used in these formulas were provided, but there was no formula made available to the Department Actuary to determine if the dividends were in fact calculated correctly.

3. The Company used an eight-factor formula to generate rates that were then "smoothed" to become the unit factors that were utilized to calculate dividend payments. When the Company's system was upgraded and subsequent to the upgrade, the Company did not maintain documentation to support the dividend calculations.
4. The Department requested detail calculation of dividends paid to certain policyholders and the Company was only able to provide the unit rate used to calculate the dividends. Components of the unit rate should have been maintained and readily accessible for review.

The Company violated Section 4231(a)(3) of the New York Insurance Law by failing to demonstrate that the amount set aside for dividends was apportioned equitably.

The Company violated Section 243.2(b)(7) of Department Regulation No. 152 by failing to maintain sufficient documentation that would allow the examiner to make a determination as to whether or not the Company's calculation of dividends payable to policyholders was fair and equitable.

The examiner recommends that the Company conduct and maintain timely experience studies of the factors used in its dividend formula that are readily available upon request by the Department.

The examiner recommends that the Company maintain the formulas that are programmed in their system as well as documentation to support that dividends are apportioned on an equitable basis.

7. AGENT COMPENSATION

Section 4228(f)(1) of the New York Insurance Law states, in part:

> "Filing requirements for agent and broker compensation plans are as follows:
> (A) A company shall make annual information filings with respect to any newly-introduced plans or changes under which the company makes payments to agents or brokers . . . shall be made not later than the last day of February next following the year in which such plans were placed in use or changed . . . "

In December 2006, the Company submitted an annual information filing of changes in the Company's agent compensation plans for its Millennium individual life product that were effective January 1, 2005.

In July 2009, the Company filed its agent compensation plan for its Horizon individual life product that was effective October 1, 2006.

The Company violated Section 4228(f) of the New York Insurance Law by failing to file changes to compensation arrangements or plans with the Department in a timely manner.

8. BUSINESS CONTINUITY AND DISASTER RECOVERY PLANS

The objective of a disaster recovery plan ("DRP") is to provide reasonable assurance that data, systems and operations can be successfully recovered and be available to users in the event of a disaster. The objective of a business continuity plan ("BCP") is to reasonably ensure that the recovery of critical business processes could take place in the event of a disaster.

The review of the Company's response to the Information Systems Questionnaire ("ISQ") indicated that the Company has not tested its BCP and DRP since 2006.

The examiner recommends that management periodically review the BCP and DRP to ensure that the plans are relevant and continue to meet the needs of the business.

The examiner recommends that Company perform periodic testing of its BCP and DRP, at least annually. Documentation of the BCP and DRP test plan and results should be maintained and be readily accessible for examination purposes.

9. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following are the violations and recommendations 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 219.5(a) of Department Regulation No. 34-A by failing to indicate the extent of distribution of its advertisements. A review of the Company's advertising file indicated that the Company maintained information regarding the manner and extent of advertisements disseminated in New York for the examination period.
B	The Company violated Section 51.6(b)(3) of Department Regulation No. 60 by failing to maintain documentation that supports the good faith approximation used by its agent to complete the required disclosure statement or that the Company examined and ascertained that Disclosure Statements completed by its agents and submitted with applications were accurate and complete. The Company did not receive any applications to replace existing insurance, with another insurer, during the examination period.
C	The Company violated Section 51.6(b)(5) of Department Regulation No. 60 by failing to include the name of an insurer that did not provide the information required in Section 51.6(c)(2) of Department Regulation No. 60 in its quarterly reports submitted to the Department. A review of the quarterly reports filed with the Department during the examination period as required by Section 51.6(b)(5) of Department Regulation No. 60 revealed that the reports included the name of insurers that did not provide information required in Section 51.6(c)(2) of Department Regulation No. 60.
D	The examiner recommended that the Company undertake steps to identify the policies affected as a result of failing to pay interest at the guaranteed rate for the first policy year and that it modify its administrative system programs that control interest crediting methods and apply a payment to each policy to adjust for the change in the interest crediting method. As a result of the last exam, the Company identified all annuity contracts that had been effected and made the appropriate interest credits to the values of their contracts. The Company also re-coded the system in how the interest was to be calculated going forward.

Item	Description
E	The Company violated Section 4228(d)(1) and Section 4228(d)(5) of the New York Insurance Law by paying 140 personal producing general agents a total of $84,936 in first year commission payments in excess of 55%, and first year commission and expense allowance payments that together exceeded 91%, during the three year examination period. The examiners review of a sample of commissions paid to personal producing general agents during the exam period did not reveal any instances where the Company is paying first year commission to personal producing agents in excess of 55%, or first year commissions and expense allowance payments that together exceed 91%.
F	The examiner recommended that the Company seek reimbursement of all excess commission payments made to personally producing general agents and notify the Department in writing of any instances in which it is unable to recover such excess payments as required by Section 4228(f)(5) of the New York Insurance Law. The Company recovered approximately $20,346.77 out of the $84,927.84 that was overpaid (23.95%). The Company does not plan to take any further action in seeking reimbursement of these overpaid commissions.
G	The examiner recommended that the Company submit its Anti-money Laundering Program to Senior Management and its Board of Directors for review. The Company submitted its Anti-money Laundering Program ("Plan") to Senior Management in August 2007 and the Plan was presented to and approved by the Board of Directors at the September 2007 meeting.

10. SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in this report:

Item	Description	Page No(s).
A	The Company violated Section 3209(b)(1)(A) of the New York Insurance Law by failing to provide the prospective purchaser with a copy of the preliminary policy information.	7
B	The Company violated Sections 216.3(b) and 216.6(d) of Department Regulation No. 64 by failing to make reference in writing to a specific policy provision, condition or exclusion in the policy that were the grounds for denial of the claim or failing to provide a specific reason for disclaiming coverage.	9
C	The Company violated Sections 2601(a)(1), (2) and (4) of the New York Insurance Law by misrepresenting facts and policy provisions relating to coverage; failing to acknowledge pertinent communications regarding claims arising under its policies; and failing to attempt in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability had become reasonably clear.	9
D	The examiner recommends that the Company demonstrate a good faith effort to locate the beneficiary of the policy when the death of the insured is reported by someone other than the beneficiary.	9
E	The examiner recommends that the Company conduct a study of all claims that were denied or closed without payment from January 1, 2006 until the date this report is filed. In cases where the Company cannot prove material misrepresentation by the insured, the Company shall pay the claim, and in cases where the Company can prove material misrepresentation by the insured, the Company shall rescind the policy with a full return of premiums.	9
F	The examiner recommends that management determine through periodic review of controls whether control procedures continue to be effective and relevant by addressing risks associated with the outsourcing of work to TPAs or whether these controls need to be adapted to accommodate changes in the operating environment and regulatory requirements. This includes the control system in place to ensure compliance with New York Law and Department Regulation.	10

Item	Description	Page No(s).
O	The Company violated Section 4231(a)(3) of the New York Insurance Law by failing to demonstrate that the amount set aside for dividends was apportioned equitably.	16
P	The Company violated Section 243.2(b)(7) of Department Regulation No. 152 by failing to maintain sufficient documentation that would allow the examiner to make a determination as to whether or not the Company's calculation of dividends payable to policyholders was fair and equitable.	16
Q	The examiner recommends that the Company conduct and maintain timely experience studies of the factors used in its dividend formula that are readily available upon request by the Department.	16
R	The examiner recommends that the Company maintain the formulas that are programmed in their system as well as documentation to support that dividends are apportioned on an equitable basis.	16
S	The Company violated Section 4228(f) of the New York Insurance Law by failing to file changes to compensation arrangements or plans with the Department in a timely manner.	17
T	The examiner recommends that management periodically review the BRP and DRP to ensure that the plans are relevant and continue to meet the needs of the business.	18
U	The examiner recommends that Company perform periodic testing of its BRP and DRP, at least annually. Documentation of the BCP and DRP test plan and results should be maintained and be readily accessible for examination purposes.	18

Respectfully submitted,

/s/
Eden M. Sunderman
Associate Insurance Examiner

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

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

/s/
Eden M. Sunderman

Subscribed and sworn to before me

this_____ day of _____

APPOINTMENT NO. 30565

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:

EDEN SUNDERMAN

as a proper person to examine into the affairs of the

UNITY MUTUAL LIFE INSURANCE COMPANY

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

COMPANY

with such other information as she shall deem requisite.

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

this 14th day of July, 2010

JAMES J. WRYNN
Superintendent of Insurance

Superintendent