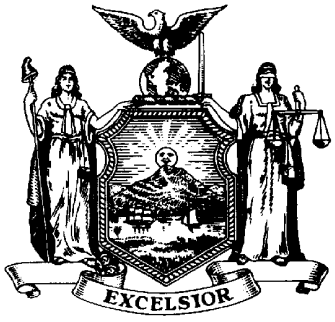

STATE OF NEW YORK INSURANCE DEPARTMENT

REPORT ON EXAMINATION

OF THE

FIRST UNITED AMERICAN LIFE INSURANCE COMPANY

CONDITION: DECEMBER 31, 2008

DATE OF REPORT: MARCH 5, 2010

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AS OF

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EXAMINER: EDEN M. SUNDERMAN

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January 17, 2013

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

Sir:

In accordance with instructions contained in Appointment No. 30332, dated May 7, 2010, and annexed hereto, an examination has been made into the condition and affairs of the First United American Life Insurance Company, hereinafter referred to as "the Company" at its home office located at 1020 Seventh North Street, Liverpool, NY, 13088.

On October 3, 2011, the Insurance Department merged with the Banking Department to create the New York State Department of Financial Services. 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 findings, violations and recommendations contained in this report are summarized below.

- The Company violated Section 325(a) of the New York Insurance Law by failing to maintain the minutes for all of its board of directors and board committee meetings at its principal office in this state. A similar violation appeared in the prior report on examination. (See item 3C of this report)
- The examiner recommends that the Company develop written procedures for the processing of both life and Medicare supplement claims to ensure consistent, fair and equitable claims handling among its policyholders in accordance with Section 2601(a)(3) of the New York Insurance Law. (See item 6C of this report)
- The Company violated Section 3211(b)(2) of the New York Insurance Law by failing to fully disclose to whole life and term life policyholders that unless payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the policyholder's right to any cash surrender value or nonforfeiture benefit or send a written notice to New York policyholders within six months after termination or lapse stating the type and amount of automatic nonforfeiture benefit in force. (See item 6C of this report)
- The Company violated Section 4221(a)(1) of the New York Insurance Law by failing to provide a paid-up nonforfeiture benefit as the default nonforfeiture option in cases where the premium was past due and the policyholder had not elected the reduced paid-up or extended term insurance paid-up nonforfeiture benefit options. (See item 6C of this report)
- The Company violated Section 3201(b)(1) of the New York Insurance Law by using a medical authorization release form without obtaining prior approval for the form. (See item 7 of this report)
- The Company violated Section 58.1(d)(1) of Department Regulation No. 193 by using a medical authorization release form that requires the disclosure of an applicant's entire medical record, in connection with the Medicare supplement insurance application process. (See item 7 of this report)

- The Company violated Section 58.1(b)(9) of Department Regulation No. 193 by failing to provide a copy of all advertisements for their Medicare supplement insurance to the superintendent, prior to their use. A similar violation appeared in the prior report on examination. (See item 7 of this report)
- The Company violated Section 4224(c) of the New York Insurance Law by tying the sale of the Reserve Fund Annuity to the Medicare Supplement High Deductible F+ policy without specifically mentioning the annuity in the Medicare supplement policy provisions. (See item 7 of this report)
- The examiner recommends that the Company enhance and revise their investment policies and procedures to better describe the functional and operational processes the Company has in place and have the revised policies and procedures approved by the board of directors and/or the investment committee. (See item 8 of this report)
- The examiner recommends that the Company establish a risk management function to manage investment and economic risks and that the investment risk management function provide regular reporting on the investment risks of the portfolio. (See item 8 of this report)
- The Company violated Section 4228(f)(1)(B) of the New York Insurance Law by continuing to sell agent written non-military business after receipt of the letter from the Department disapproving the compensation plan for such business. (See item 9 of this report)

2. SCOPE OF EXAMINATION

The prior examination was conducted as of December 31, 2005. This examination covers the period from January 1, 2006 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 verification of assets and liabilities as of December 31, 2008 to determine whether the Company's 2008 filed annual statement fairly presents its financial condition. The examiner reviewed the Company's income and disbursements necessary to accomplish such verification and utilized the National Association of Insurance Commissioners' Examiners Handbook or such other examination procedures, as deemed appropriate, in such review and in the review or audit of the following matters:

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

The examiner reviewed the corrective actions taken by the Company with respect to the violations and recommendations contained in the prior report on examination. The results of the examiner's review are contained in item 10 of this report.

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

3. DESCRIPTION OF COMPANY

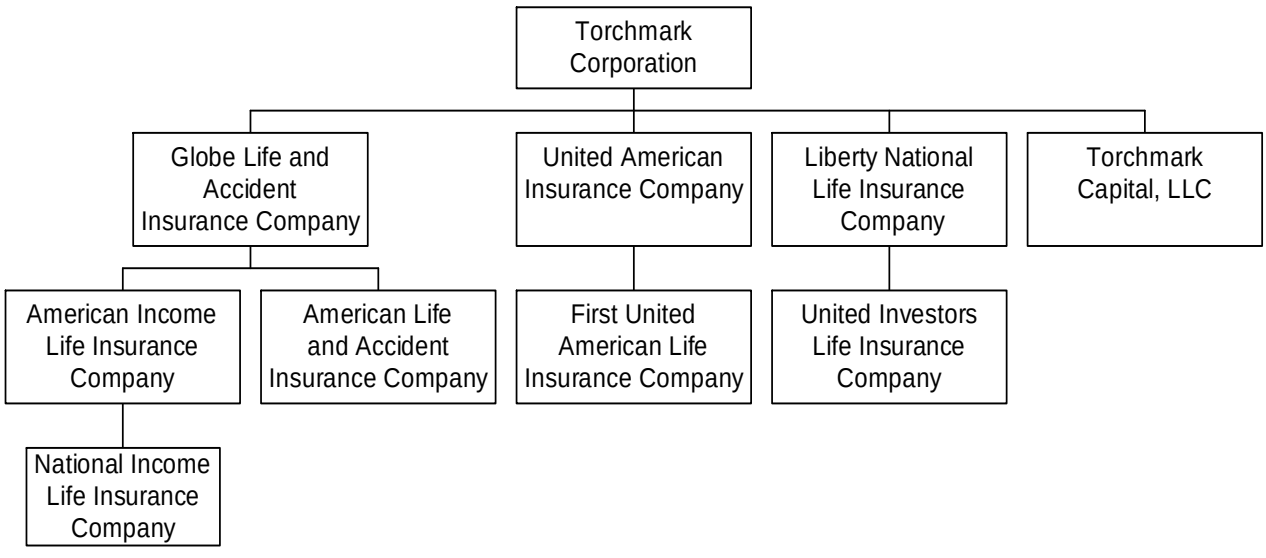
A. History

The Company was incorporated as a stock life insurance company under the laws of New York on June 16, 1981 under the name of Globe International Life Insurance Company. The Company was licensed and commenced business on December 10, 1984. The name of the Company was changed to First United American Life Insurance Company effective October 1, 1985. Initial resources of $6,428,480 consisting of common capital stock of $2,000,000 and paid in and contributed surplus of $4,428,480 were provided through the sale of 100 shares of common stock (with a par value of $20,000 each) for $64,284.80 per share. As of December 31, 2008, the Company's capital and paid in and contributed surplus were $2,000,000 and $4,428,480 respectively.

B. Holding Company

The Company is a wholly owned subsidiary of United American Insurance Company ("UAIC"), a Delaware insurance company. UAIC is in turn a wholly owned subsidiary of Torchmark Corporation ("TMK"), the ultimate parent of the Company. TMK is a publicly traded Delaware investment advisory company. National Income Life Insurance Company ("NILIC") is an affiliate company which is also domiciled in the State of New York.

An organization chart reflecting the relationship between the Company and significant entities in its holding company system as of December 31, 2008 follows:



The Company had five service agreements in effect with affiliates during the examination period.

Type of Agreement and Department File Number	Effective Date	Provider(s) of Service(s)	Recipient(s) of Service(s)	Specific Service(s) Covered	Income/ (Expense)* For Each Year of the Examination
Service Agreement File No. 28815	8/1/2000	UAIC	The Company	Underwriting, claims and administrative support for certain health insurance and military business. Data processing, accounting, record retention, telephone switchboard, legal, and actuarial services.	2006 $(1,030,086) 2007 $(1,035,988) 2008 $(977,274)
Addendum #1 Replaces Sections 6 & 7 File No. 32816	7/1/2004			Amended provisions including maintenance of books of account and ownership and custody of records.	
Service Agreement File No. 27016	4/1/2001	Globe Life and Accident Insurance Company	The Company	Billing, underwriting, claims, marketing and advertising for direct response business.	2006 $(4,642,958) 2007 $(5,286,607) 2008 $(4,774,374)
Amended File No. 31378	6/1/2003			Amended provisions regarding the billing services, maintenance of books and ownership and custody of records.	
Service Agreement File No. 31541	11/1/2003	The Company	NILIC	Supervisory, oversight, support and managerial services.	2006 $4,163 2007 $4,305 2008 $4,445
Investment Agreement File No. 024005	1/1/1994	TMK and UAIC	The Company	Manage all monies, stocks, bonds and securities.	2006 $(12,000) 2007 $(12,000) 2008 $(12,000)
Sublease File No. 31377	5/1/2002	The Company	NILIC	Sublease of office space.	2006 $1,947 2007 $2,496 2008 $2,009

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

C. Management

The Company's by-laws provide that the board of directors shall be comprised of not less than nine and not more than 21 directors. The number of directors, however, shall be increased to not less than 13 within one year following the end of the calendar year in which the corporation exceeds $1.5 billion in admitted assets. Directors are elected for a period of one year at the annual meeting of the stockholders held at the time and on the date determined by the board of directors. As of December 31, 2008, the board of directors consisted of nine members. Most meetings of the board of directors were held by means of unanimous written consent.

The nine board members and their principal business affiliation, as of December 31, 2008, were as follows:

Name and Residence	Principal Business Affiliation	Year First Elected
Gary L. Coleman Plano, TX	Executive Vice President and Chief Financial Officer Torchmark Corporation	1994
Terry Cummings* Montclair, NJ	Attorney at Law Hitchcock and Cummings, LLP	1989
Jerry Greenspan* Harrison, NY	Founder New Democracy Project	2007
Vern D. Herbel McKinney, TX	Chief Executive Officer First United American Life Insurance Company	2004
Larry M. Hutchison Duncanville, TX	Vice President, General Counsel, and Secretary First United American Life Insurance Company	1993
Dirk Marschhausen* Garden City, NY	Attorney at Law Marschhausen and Fitzpatrick PC	1997
Rosemary J. Montgomery Parker, TX	Executive Vice President and Chief Actuary First United American Life Insurance Company	1994
James A. Savo Liverpool, NY	Vice President, Operations and General Manager First United American Life Insurance Company	2000
Stephen W. Still* Mountain Brook, AL	Attorney at Law Maynard, Cooper and Gale, PC	2003

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

In December, 2009, Terry Cummings resigned from the board and was replaced by Jules Pagano, an unaffiliated director.

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

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

The Company did not maintain, at its principal office in this state, the minutes for its board of directors and board committee meetings for its November 11, 2008 meeting and for all meetings that took place in the years 2009 and 2010.

The Company violated Section 325(a) of the New York Insurance Law by failing to maintain the minutes for all of its board of directors and board committee meetings at its principal office in this state. A similar violation appeared in the prior report on examination.

The following is a listing of the principal officers of the Company as of December 31, 2008:

Name	Title
Andrew W. King	President
Vern D. Herbel	Chief Executive Officer
Larry M. Hutchison	Vice President, General Counsel and Secretary
Danny H. Almond	Executive Vice President, Chief Financial Officer and Treasurer
Rosemary J. Montgomery	Executive Vice President and Chief Actuary
Ben W. Lutek	Senior Vice President and Appointed Actuary
James A. Savo*	Vice President, Operations and General Manager

* Designated consumer services officer per Section 216.4(c) of Department Regulation No. 64

D. Territory and Plan of Operation

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

The Company is only licensed to write business in New York. In 2008, all life premiums, accident and health premiums and annuity considerations were received from New York. Policies are written on a non-participating basis.

Prior to 1994, the Company wrote, almost exclusively, individual Medicare supplement insurance. In 1994, the Company began writing individual life insurance. In 1995, the Company began writing group Medicare supplement insurance and individual annuities.

The Company's individual Medicare supplement insurance and individual annuities are solicited through the Company's agency force, which operates on a general agency basis. Approximately 99% of the ordinary life business was sold through direct response marketing; the other 1%, mostly senior life products, was sold through the Company's agency force. All life insurance sold during the examination period was written on a simplified issue basis.

The Company's group Medicare supplement insurance is primarily solicited to employer and union groups through licensed brokers or agents; direct response marketing is also used but to a lesser extent. The group Medicare supplement business may be issued as mandatory or voluntary coverage depending upon the group. For mandatory business, the employer or union bears the cost of the insurance and all retirees are covered. For voluntary business, the group policyholder provides a list of retirees eligible for coverage and the Company sends direct response packages with enrollment forms to the retirees.

In 2006, the Company contracted with Centers for Medicare and Medicaid Services ("CMS") to be an insurer under the government's new Medicare Part D stand-alone prescription drug plan for Medicare beneficiaries. Unlike the Company's Medicare supplement plans, insurers participating in Medicare Part D are the primary insurers for plans regulated and funded in part by CMS. The Medicare Part D program generally calls for CMS to pay two-thirds of the premium with the insured Medicare beneficiary paying one-third of the premium. The Company's Medicare Part D product is primarily sold through direct response methods, but it is also sold by general agents.

E. Reinsurance

As of December 31, 2008, the Company had no reinsurance treaties in effect for new business. The Company reported total accident and health unearned premium and other than unearned premium reserve credits of $1,038,761. The accident and health reserve credit is related to a reinsurance treaty that was terminated on July 1, 1993 and covers the Company's long-term care business, which is currently in run-off.

The Company did not assume any business during the examination period.

4. SIGNIFICANT OPERATING RESULTS

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

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

	December 31, 2005	December 31, 2008	Increase
Admitted assets	$101,880,147	$125,418,007	$23,537,860
Liabilities	$ 70,256,099	$ 87,612,094	$17,355,995
Common capital stock	$ 2,000,000	$ 2,000,000	$ 0
Gross paid in and contributed surplus	4,428,480	4,428,480	0
Unassigned funds (surplus)	25,195,568	31,377,433	6,181,865
Total capital and surplus	$ 31,624,048	$ 37,805,913	$ 6,181,865
Total liabilities, capital and surplus	$101,880,147	$125,418,007	$23,537,860

The Company's invested assets as of December 31, 2008 were mainly comprised of bonds (90.3%) and stocks (5.3%).

The majority (88.7%) of the Company's bond portfolio, as of December 31, 2008, was comprised of investment grade obligations.

The ordinary lapse ratio was 55.7% in 2006, 54.5% in 2007 and 37.0% in 2008. The observed lapse ratios are normal for the direct response business that the Company writes and were fully anticipated in the pricing and approval of the product. The products pass the self-support test of Section 4228(h) of the New York Insurance Law.

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

	2006	2007	2008
Ordinary:			
Life insurance	$1,479,784	$1,805,481	$2,165,166
Individual annuities	413,340	416,326	299,566
Total ordinary	$1,893,124	$2,221,807	$2,464,732
Accident and health:			
Group	$ 126,368	$ 177,278	$ 16,226
Other	6,506,065	6,223,548	4,831,525
Total accident and health	$6,632,433	$6,400,826	$4,847,751
Total	$8,525,557	$8,622,633	$7,312,483

5. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital and surplus as of December 31, 2008, as contained in the Company's 2008 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Company's financial condition as presented in its financial statements contained in the December 31, 2008 filed annual statement.

A. ASSETS, LIABILITIES, CAPITAL AND SURPLUS AS OF DECEMBER 31, 2008

Admitted Assets

Bonds	$ 99,642,460
Stocks:	
Preferred stocks	5,876,719
Cash, cash equivalents and short term investments	2,071,429
Contract loans	2,775,945
Investment income due and accrued	1,641,228
Premiums and considerations:	
Uncollected premiums and agents' balances in the course of collection	1,411,162
Deferred premiums, agents' balances and installments booked but deferred and not yet due	5,365,458
Current federal and foreign income tax recoverable and interest thereon	912,569
Net deferred tax asset	3,968,000
Health care and other amounts receivable	1,422,486
New York Department adjustments	330,551
Total admitted assets	$125,418,007

Liabilities, Capital and Surplus

Aggregate reserve for life policies and contracts	$ 62,925,061
Aggregate reserve for accident and health contracts	10,807,632
Contract claims:	
Life	1,258,000
Accident and health	5,335,000
Premiums and annuity considerations for life and accident and health contracts received in advance	1,060,338
Contract liabilities not included elsewhere:	
Interest maintenance reserve	42,266
General expenses due or accrued	254,000
Taxes, licenses and fees due or accrued, excluding federal income taxes	(188,905)
Amounts withheld or retained by company as agent or trustee	121,806
Amounts held for agents' account	246,516
Dividends to stockholders declared and unpaid	3,954,047
Asset valuation reserve	680,108
Payable to parent, subsidiaries and affiliates	1,110,522
Adjustment for nursing home business	5,703
Total liabilities	$ 87,612,094
Common capital stock	$ 2,000,000
Gross paid in and contributed surplus	4,428,480
Unassigned funds (surplus)	31,377,433
Total capital and surplus	$ 37,805,913
Total liabilities, capital and surplus	$125,418,007

The Company reported a health care receivable equal to $1,422,486 in 2008. This receivable is for a claims reimbursement due from the federal government for its share of Medicare Part D claims paid.

The Company closes its ledger on December 24th each year instead of December 31st. The 1990 report on examination contained a recommendation that the Company establish an accrual for the period between December 24th and December 31st in order to comply with Section 307 of the New York Insurance Law. The New York Department adjustments line in the annual statement represents an estimate of cash transactions for premiums, claims, commissions, investment income, etc., during the period between December 24th and December 31st of the current year.

B. CONDENSED SUMMARY OF OPERATIONS

	2006	2007	2008
Premiums and considerations	$68,148,625	$69,264,214	$65,079,020
Investment income	6,477,076	6,974,805	7,295,908
Commissions and reserve adjustments on reinsurance ceded	14,381	11,893	10,791
Miscellaneous income	117,272	152,013	(94,787)
Total income	$74,757,354	$76,402,925	$72,290,932
Benefit payments	$40,986,569	$42,481,387	$40,515,184
Increase in reserves	4,884,484	4,467,847	5,816,832
Commissions	6,108,415	5,706,688	5,266,071
General expenses and taxes	9,093,307	9,649,189	9,094,352
Increase in loading on deferred and uncollected premium	(664,689)	833,921	295,082
Total deductions	$60,408,086	$63,139,032	$60,987,521
Net gain (loss)	$14,349,268	$13,263,893	$11,303,411
Federal and foreign income taxes incurred	5,823,711	4,641,260	3,990,928
Net gain (loss) from operations Before net realized capital gains	$ 8,525,557	$ 8,622,633	$ 7,312,483
Net realized capital gains (losses)	(56,273)	0	(807,339)
Net income	$ 8,469,284	$ 8,622,633	$ 6,505,144

In 2005, the Company reported premiums and considerations equal to $59,331,607. The increase in premium considerations between 2005 and 2006 is primarily due to the introduction of the Medicare Part D business. The Company issued over 11,000 new policies in its first year of inception accounting for over $9 million in new premium collections. There were only modest increases in life premiums during the same period. The decrease in premiums and considerations between 2007 and 2008 is due to a decrease in Medicare Part D premiums of approximately $2.2 million, consistent with the Company's decision not to aggressively market the Medicare Part D business. In addition, the Company experienced a decrease in other health and Medicare supplement premiums of approximately $2.8 million which the Company attributes to a cautious market due to a worsening economy.

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C. CAPITAL AND SURPLUS ACCOUNT

	2006	2007	2008
Capital and surplus, December 31, prior year	$31,624,048	$37,439,414	$42,459,526
Net income	$ 8,469,284	$ 8,622,633	$ 6,505,144
Change in net deferred income tax	828,000	(59,000)	904,000
Change in non-admitted assets and related items	(431,251)	137,696	(272,648)
Change in asset valuation reserve	(100,667)	(181,217)	209,891
Dividends to stockholders	(2,950,000)	(3,500,000)	(12,000,000)
Net change in capital and surplus for the year	$ 5,815,366	$ 5,020,112	$ (4,653,613)
Capital and surplus, December 31, current year	$37,439,414	$42,459,526	$37,805,913

6. 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.

Section 3209(b)(1) of the New York Insurance Law states:

> "No policy of life insurance shall be delivered or issued for delivery in this state . . . 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. When sales solicitations are made by mail, without the involvement of an agent or broker, each initial solicitation must include a copy of the buyer's guide unless the policy for which application is made provides for a period of at least thirty days within which the applicant may return the policy for an unconditional refund of the premiums paid, in which event the buyer's guide must be delivered with the policy or prior to delivery of the policy; in addition, such solicitation must alert the prospective purchaser of the right to receive, upon request, a buyer's guide and a policy summary prior to delivery of the policy; and
> (B) a policy summary upon delivery of the policy. . . ."

The examiner reviewed the direct mail advertisements that were used by the Company during the period under examination. For a number of direct mail advertisements, the Company did not inform prospective applicants of their right to receive, upon request, a buyer's guide and a policy summary prior to delivery of the policy and provide a policy summary upon delivery of the policy.

The Company violated Section 3209(b)(1)(A) of the New York Insurance Law by failing to disclose in its direct mail solicitation that the prospective purchaser has the right to receive, upon request, a buyer's guide and a policy summary prior to delivery of the policy; and provide a policy summary upon delivery of the policy.

Section 2112 of the New York Insurance Law states, in part:

> " . . . (c) Certificates of appointment shall be valid until (i) terminated by the appointing insurer after a termination in accordance with the provisions of the agency contract; (ii) the license is suspended or revoked by the superintendent; or (iii) the license expires and is not renewed.
>
> (d) Every insurer . . . doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent licensed in this state . . . file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. . . ."

The examiner selected a sample of agents that had been terminated by the Company during the examination period. The Company was asked to provide a copy of the termination notice furnished to the Superintendent at the time of the agent's appointment termination with the Company.

In 20 out of 48 (42%) instances reviewed, the Company failed to notify the Superintendent of the agent's termination of appointment with the Company within thirty days of such termination.

The Company violated Section 2112(d) of the New York Insurance Law by failing to notify the Superintendent of the agent's termination of appointment with the Company within thirty days of the effective date of such termination.

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

> "Except as otherwise required by law or regulation, an insurer shall maintain . . .
>
> (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. . . ."

The examiner selected a sample of agents that were appointed with the Company during the examination period. The examiner also selected a sample of agents that were terminated by the Company during the examination period. For appointed agents, the Company was asked to

provide a copy of the certificate of appointment filed with the superintendent. For terminated agents, the Company was asked to provide a copy of the notice to the Superintendent advising of the agent's termination of appointment with the Company.

In 37 out of 68 (54%) instances, the Company was unable to provide either a copy of the certificate of appointment or a copy of the notice of termination to the Superintendent.

The Company violated Section 243.2(b)(5) of Department Regulation No. 152 by failing to maintain all licensing records, clearly showing the dates of appointment and termination of each licensee.

B. Underwriting and Policy Forms

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

Section II.D of Department Circular Letter No. 4 (1963) states, in part:

> "Juvenile Plans
> 1. Limitation of Benefits Provision
> Plans to which Section 147 of the Insurance Law is applicable must contain a provision, by rider or otherwise, which will substantially reflect the requirements of that section.
> 2. Payor Benefit Age Adjustment
> Any provision for age adjustment must include both the ages of the insured and the payor and must be based upon the aggregate premium paid for all benefits."

Section III.B of Department Circular Letter No. 4 (1963) states, in part:

> "Juvenile Insurance Limitations
> 1. The policy must contain a limitation of benefits provision, by rider or otherwise, reflecting the requirements and prohibitions of Section 147 of the Insurance Law. Any statement in relation to refund of excess premiums may specify a dollar amount or an amount as provided in a schedule filed with the Superintendent, and such schedule shall accompany the submission letter."

The examiner reviewed a sample of 30 policies that were issued on the lives of minors (insured between 0 and 14 ½ years of age) during the examination period. In 20 of the 30 (67%) cases selected, the policies were marketed via the "direct response" marketing channel. While the review of the sample that was directly marketed indicates that the Company complied with the monetary limitations of Section 3207 of the New York Insurance Law, due to a system error, the riders that disclose the monetary limitations of Section 3207 of the New York Insurance Law

were not printed for all juvenile policies issued during the examination period and through October 30, 2009.

The Company failed to comply with Department Circular Letter No. 4 (1963) by not setting out the monetary limitations of Section 3207 of the New York Insurance Law in the policy provisions, an endorsement, or a rider for the policies that were issued through direct mail marketing.

The examiner recommends that the Company issue an endorsement explaining the monetary limitations set forth in Section 3207 of the New York Insurance Law to all policyholders with an in force policy that was issued between January 1, 2006 and October 30, 2009 on the life of a minor.

The Company implemented programming changes in October, 2009 which call for the rider for all juvenile polices to disclose the monetary limitations of Section 3207 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 of the New York Insurance Law states, in part:

> "(a) 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 . . .
>
> (3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies . . ."

The examiner found that the Company does not have written claims procedures for the processing of life or Medicare supplement claims. The Company informed the examiner that it has claim specialists that specialize in various areas but that the Company does not maintain written claims procedures.

The examiner recommends that the Company develop written procedures for the processing of both life and Medicare supplement claims to ensure consistent, fair and equitable

claims handling among its policyholders in accordance with Section 2601(a)(3) of the New York Insurance Law.

Section 216.5 of Department Regulation No. 64 states, in part:

> "(a) Every insurer shall establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant's authorized representative, within 15 business days of receipt of notice of claim. An insurer shall furnish to every claimant, or claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving notice of the claim. . . ."

The examiner reviewed 32 life claims that were closed without payment during the examination period. The review revealed that upon notice of the death of an insured the Company sets up a claim file. The Company maintains a claim file in an open status for 60 days from the date of notice to allow the claimant to submit any required proofs. After the 60 days, the Company closes the claim.

When a claim is incontestable and the claim is reported by phone, the informant is notified that the death certificate must be submitted in order for the Company to pay the claim. A written communication specifying all of the items, statements and forms required by the Company is not sent to the informant or beneficiary. If the death certificate has not been submitted to the Company within 30 days of notice of the claim, the Company sends a written request specifying all the proofs that are required to process and pay the death claim. It is the Company's practice to close the claim if it has not received any correspondence or proofs from the claimant after 60 days of the initial notice.

The examiner recommends that the Company furnish claimants with a notification indicating all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving notice of the claim by way of a telephone call.

For a contestable claim, a written communication which specifies all of the items, statements and forms that the Company reasonably believes will be required of the claimant in order to pay the claim is sent to the informant. The written acknowledgement is sent immediately upon notice of the claim. There is one written follow up request mailed 30 days

after the initial communication. In some instances, when follow up letters were sent to the claimants, the examiner noted that the Company referred the claimant to the earlier communication rather than listing the proof requirements in the subsequent communication. If the requested proofs are not received within 60 days of notice, the Company closes the claim.

The examiner recommends that all second request letters or any follow up letters to a claimant specify what proofs are outstanding and required of the claimant in order to pay the claim.

In 20 of the 32 (59%) cases reviewed, the Company closed the claim because the Company never received any proof of death from the informant. In 10 of these 20 (50%) cases where the Company closed the claim, the death of the insured was reported by someone other than the beneficiary. The examiner's review of the claim record revealed that there was no evidence that the Company's claim examiners made a good faith effort to locate the beneficiary through a credit reporting agency or other means, prior to closing the claim without payment.

The examiner recommends that the Company demonstrate a good faith effort to locate the beneficiary of the policy before closing the claim. In the event that, after a diligent effort, the Company is not able to locate the beneficiary of the policy, the Company should perform a search of the Death Master File maintained by the United States Social Security Administration to verify the death of the insured and escheat the proceeds of the policy to the State of New York in accordance with the provisions of the New York Abandoned Property Law.

Section 3211 of the New York Insurance Law states, in part:

> "(a)(1) No policy of life insurance or non-cancellable disability insurance delivered or issued for delivery in this state . . . shall terminate or lapse by reason of default in payment of any premium, installment, or interest on any policy loan in less than one year after such default, unless, for scheduled premium policies, a notice shall have been duly mailed at least fifteen and not more than forty-five days prior to the day when such payment becomes due . . .
>
> (b) The notice required by paragraph one of subsection (a) hereof shall . . .
>
> (2) state the amount of such payment, the date when due, the place where and the person to whom it is payable; and shall also state that unless such payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or nonforfeiture benefit."

The Company sends premium notices to their whole life and term life insurance policyholders on a direct bill monthly basis. The examiner reviewed a sample of these premium notices. The premium notices reviewed did not contain a disclosure stating that unless such payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or nonforfeiture benefit. The Company does not send a written notice to New York policyholders within six months after termination or lapse stating the type and amount of automatic nonforfeiture benefit in force.

The Company violated Section 3211(b)(2) of the New York Insurance Law by failing to fully disclose to whole life and term life policyholders that unless payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the policyholder's right to any cash surrender value or nonforfeiture benefit or send a written notice to New York policyholders within six months after termination or lapse stating the type and amount of automatic nonforfeiture benefit in force.

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

> "In the case of policies issued on or after the operative date of this section as defined in subsection (p) hereof, no policy of life insurance, except as stated in subsection (o) hereof, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the superintendent are at least as favorable to the defaulting or surrendering policyholder as are minimum requirements hereinafter specified and are essentially in compliance with subsection (n) hereof:
>
> (1) That, in the event of default in any premium payment, the company will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such value as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty days after the due date of the premium in default, a more favorable alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits. . . .
>
> (3) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default. . . . "

Section II(E)(2) of Department Circular Letter No. 4 (1963) states:

"Automatic Premium Loans

(a) The automatic premium loan provision included in the policy shall indicate that it is effective only if elected and that such election is subject to revocation. Any such provision shall be clear as to the right to resume premium payments as specified in the policy at any time.

(b) If any limitations are imposed upon the number or amount of premiums which may be subject to the provision, the fact of such limitations shall be referred to in a proper caption.

(c) In connection with any such provision, the policy shall clearly indicate how the provision will apply in the event that the loan value is insufficient to pay the stated premium due and the disposition of any sums not used to pay premiums.

(d) Any automatic premium loan provision should be separately captioned and not included under or with the nonforfeiture provisions."

The policy provisions for Company policy forms NYWL4000 and NYWL5000 state that the Automatic Premium Loan ("APL") is the automatic nonforfeiture provision under the policy. This is contrary to Section 4221 of the New York Insurance Law and Department Circular Letter 4 (1963). Policy forms NYWL4000 and NYWL5000 were filed with the Department in accordance with Circular Letter No. 6 (2004).

The Company violated Section 4221(a)(1) of the New York Insurance Law by failing to provide a paid-up nonforfeiture benefit as the default nonforfeiture option in cases where the premium was past due and the policyholder had not elected the reduced paid-up or extended term insurance paid-up nonforfeiture benefit options.

In 2011, the Company received approval of NYWL4000-R and NYWL5000-R which replaced policy forms NYWL4000 and NYWL5000, respectively, and removed the APL as a nonforfeiture option in accordance with Section 4221(a)(1) and Section 4221(a)(3) of the New York Insurance Law and Section II(E)(2) of Department Circular Letter No. 4 (1963). The Department instructed the Company to provide NYWL4000-R to in-force issues of NYWL4000 by May 7, 2011 and to provide NYWL5000-R to in-force issues of NYWL5000 by June 24, 2010. Additionally, NYWL4000-R replaces the use of NYWL4000 for any new issues going forward from April 7, 2011 and NYWL5000-R replaces the use of NYWL5000 for any new issues going forward from May 24, 2011.

The examiner recommends that the Company review all other policy forms to see if they provide the APL as an automatic or optional nonforfeiture benefit, and file the revised forms with the Department as necessary.

Section 403(d) of the New York Insurance Law states:

> "All applications for commercial insurance, individual, group or blanket accident and health insurance and all claim forms, except as provided for in subsection (e) of this section, 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.'"

Section 86.4 of Department Regulation No. 95 states, in part:

> "(a) Except with respect to automobile insurance, 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) Notwithstanding the provisions of subdivisions (a) and (b) of this section, insurers may use substantially similar warning statements provided such warning statements are submitted to the Insurance Frauds Bureau for prior approval."

The examiner reviewed the claim form used by the Company for processing life claims during the examination period. The fraud warning language contained on the claim form used for life claims is not consistent with the language required by Section 403(d) of the New York Insurance Law. The Company did not obtain prior approval from the Insurance Frauds Bureau to use alternate fraud warning language as required by Section 86.4(e) of Department Regulation No. 95.

The Company violated Section 403(d) of the New York Insurance Law by using a claim form that does not contain fraud warning language conforming to the New York Insurance Law.

7. MEDICARE SUPPLEMENT INSURANCE

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. . . ."

Section 58.1(d) of Department Regulation No. 193 states, in part:

"Applications for Medicare supplement insurance. In addition to the requirements set forth in section 52.51 of this Title, the following provisions shall apply to applications for Medicare supplement insurance:

(1) Applications may not contain any questions dealing with the health or health history of the applicant and no physical examination may be requested. . . ."

Section 58.1(i) of Department Regulation No. 193 states, in part:

"Open enrollment.

(1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant. Applicants must be accepted at all times throughout the year for any Medicare supplement insurance benefit plan available from an issuer. . . ."

The examiner reviewed a sample of applications for Medicare supplement insurance taken during the examination period. In all cases, the applicant was required to sign a medical authorization release form, Form No. N3979. The form was not submitted to the Department for approval prior to use. The form indicates that the Company may seek out information about an individual's health status and that the information may be used for underwriting purposes. The form also states that the Company may not be able to process an application for Medicare supplement coverage without the signed medical authorization release.

The Company violated Section 3201(b)(1) of the New York Insurance Law by using a medical authorization release form without obtaining prior approval for the form.

The Company violated Section 58.1(d)(1) of Department Regulation No. 193 by using a medical authorization release form that requires the disclosure of an applicant's entire medical record, in connection with the Medicare supplement insurance application process.

The Company violated Section 58.1(i)(1) of Department Regulation No. 193 by requiring applicants to authorize the disclosure of their entire medical history as part of the application process, which is contrary to New York open enrollment rules for any Medicare supplement policy or certificate.

The examiner recommends that the Company cease the use of Form No. N3979 in connection with the processing of its Medicare supplement new business.

Section 58.1(b) of Department Regulation No. 193 states, in part:

> "Policy practices and provisions . . .
>
> (9) An issuer shall provide, prior to its use, a copy of any advertisement for a Medicare supplement insurance policy or certificate intended for use in this state whether through written, radio or television medium to the superintendent for review. Such advertisement shall comply with all applicable regulations and laws of this state. . . ."

The Company was not able to provide evidence that it filed eleven advertisements for Medicare supplement insurance with the Department, prior to the use of such advertisements.

The Company violated Section 58.1(b)(9) of Department Regulation No. 193 by failing to provide a copy of all advertisements for their Medicare supplement insurance to the superintendent, prior to their use. A similar violation appeared in the prior report on examination.

Section 4224(c) of the New York Insurance Law states:

> "Except as permitted by section three thousand two hundred thirty-nine of this chapter, no such life insurance company . . . and no employee or other representative of any such insurer, agent or broker, shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to any person to insure, or shall give, sell or purchase, or offer to give, sell or purchase, as such inducement, or interdependent with any policy of life insurance or annuity contract or policy of accident and health insurance, any stocks, bonds, or other securities, or any dividends or profits accruing or to accrue thereon, or any valuable consideration or inducement whatever not specified in such policy or contract; nor shall any person in this state knowingly receive as such inducement,

> any rebate of premium or policy fee or any special favor or advantage in the dividends or other benefits to accrue on any such policy or contract, or knowingly receive any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever which is not specified in such policy or contract."

During the examination period, the Company submitted advertising materials to the Department (Health Bureau) that describe a Medicare Supplement High Deductible F+ policy ("HDF"). The same materials also describe a Reserve Fund Annuity ("RFA") product that could be purchased separately from the HDF product. While the RFA is a stand-alone individual fixed annuity, consumers who have purchased an HDF policy from the Company may use the RFA to fund the annual deductible of the HDF. The Company admitted that it markets the RFA solely to those insureds that also purchase the HDF policy. The RFA is an Individual Flexible Premium Deferred Annuity Contract which was approved by the Department (Life Bureau) pursuant to Department Circular Letter No. 6 (2004). There is no mention of the HDF product in the RFA contract. Likewise, there is no mention of the RFA in the HDF policy. The RFA does not impose any surrender charges and the Company does not pay its agents a commission for the sale of the RFA.

In September 2007, the Department (Health Bureau) instructed the Company to remove the reference to the RFA from the advertising materials used for the HDF. The Company withdrew the advertisement. On November 30, 2007, the Company notified the Department that it had sold a total of 24 RFAs and had 2 pending applications at that time. Each of the 24 RFA contractholders also had an HDF policy. The Department directed the Company on November 30, 2007 to immediately cease the marketing and issuance of these products.

The Company violated Section 4224(c) of the New York Insurance Law by tying the sale of the Reserve Fund Annuity to the Medicare Supplement High Deductible F+ policy without specifically mentioning the annuity in the Medicare supplement policy provisions.

8. INVESTMENT POLICIES AND PROCEDURES

Investment management services are provided by TMK through a service agreement.

The examiner's review of documents related to the Company's investment policies and procedures revealed that the Company does not maintain robust written investment policies and procedures. The policies and procedures do not address many key functions normally associated with managing an investment portfolio such as investment limits, permitted asset classes and liquidity management. In addition, the Company does not have an integrated investment risk management function. Lack of an integrated investment risk management function may cause investment risk exposures to go undetected and/or exposures to not be quantified in a timely manner, leading to investment risk exposures that exceed the company's risk tolerance levels and inadequate data for making informed managerial decisions pertaining to the investment portfolio.

The examiner recommends that the Company enhance and revise their investment policies and procedures to better describe the functional and operational processes the Company has in place and have the revised policies and procedures approved by the board of directors and/or the investment committee.

The examiner recommends that the Company establish a risk management function to manage investment and economic risks and that the investment risk management function provide regular reporting on the investment risks of the portfolio.

9. 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 if such plans are commission plans for which the commission percentages are, in all policy or contract years, no greater than the commission percentages set forth in paragraphs one, two, three and four of subsection (d) of this section, expense allowance plans other than those meeting the definition of a compensation arrangement, plans subject to the provisions of paragraph one of subsection (e) of this section under which compensation is not in excess of two percent of the fund annually in any of the first four policy or contract years, or plans subject to the provisions of paragraph four of subsection (e) of this section. These filings shall consist of a summary of information in enough detail to generally describe the filing content, and 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. The first such filing shall be due not later than the last day of February following the end of the year which includes the effective date of this section.

(B) Filings are required on or before the effective date of any changes to compensation arrangements as defined in this section, or to plans described in paragraphs one and two of subsection (g) of this section. These filings shall consist of a summary of information in enough detail to generally describe the filing's contents. A company may implement such compensation arrangements immediately upon filing same. If the superintendent notifies the company within ninety days of the receipt of the filing, that in his opinion the compensation arrangement described in such filing is not permitted under the law, and if the company within sixty days of the superintendent's notice, is not able to satisfy the superintendent's concern, with or without modifying the plan, the superintendent may order the company to cease using the plan. The company may request a formal hearing, but the plan that is the subject of the hearing may not be used unless and until permitted as a result of the hearing. . . ."

The examiner also reviewed the Life Bureau's records with regard to filings received from the Company. The Company filed a plan of agent compensation in August, 2003 (Department File No. 31737) for non-military business. The Department disapproved the plan on September 10, 2003. The Company continued to sell the agent written non-military life business through December 31, 2006.

The Company violated Section 4228(f)(1)(B) of the New York Insurance Law by continuing to sell agent written non-military business after receipt of the letter from the Department disapproving the compensation plan for such business.

The examiner recommends that the Company correct the problems identified in the September 10, 2003 disapproval letter from the Department for the non-military life business compensation plan and file the plan with the Department. In the filing, the Company should attempt to show that although it paid compensation under a disapproved plan of compensation, the amounts paid under the plan did not exceed the limits in Section 4228(d) of the New York Insurance Law.

10. 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 325(a) of the New York Insurance Law by failing to maintain the minutes of the meetings of its Audit and Evaluation committee for the year 2005 at its principal office in this state. The Company failed to take corrective action in response to this prior report violation. (See Item 3C of this report)
B	The examiner recommends that the Company's Board of Directors meet in person at a minimum of once every calendar year and more frequently as necessary to promote open discussion and better communication among directors. During the examination period, the Company's board of directors met once a year via teleconference.
C	The Company violated Section 219.4(u) of Department Regulation No. 34-A by describing an enrollment period as "last chance" or "last time" when it used successive enrollment periods as its usual method of marketing its policies. The examiner's review of advertising materials disseminated in New York after September, 2008 revealed that the Company did not use the phrases "last chance" or "last time" to describe successive enrollment periods.
D	The Company violated Section 2114(a)(3) of the New York Insurance Law by paying commissions to the general agency on behalf of an unlicensed insurance agent. The examiner's review of commission payments did not reveal any instances where the Company paid commissions to the general agency on behalf of an unlicensed insurance agent.

Item	Description
E	The Company violated Section 52.22(b)(9) of Department Regulation No. 62 (Section 52.22(b)(9) of Department Regulation No. 62 was repealed and replaced by Section 58.1(b) of Department Regulation No. 193) by using Medicare supplement advertising material that was not submitted to the Department for review prior to its use. The Company failed to take corrective action in response to this prior report violation. (See Item 7 of this report)
F	The Company violated Section 215.2(b) and Section 215.17(a) of Department Regulation No. 34 by failing to maintain a system of control over the content, form and method of dissemination of its advertisements and by failing to maintain as part of its advertising file the "Weiss" rating utilized by its agents in the sale of its Medicare supplement insurance. The examiner's review of Medicare supplement advertising materials did not reveal any instances where the Company used advertisements that were not maintained as part of its advertising file.
G	The Company violated Section 52.22(i)(1) of Department Regulation No. 62 by failing to establish auditable procedures to assure that excess Medicare supplement insurance is not sold or issued. The Company established procedures to ensure that excess Medicare supplement insurance is not sold or issued in New York.
H	The examiner recommends that the Company establish auditable procedures to assure that excess Medicare supplement insurance is not sold or issued. It is further recommended that the Company implement a remediation plan, agreeable to the Department, to address whether any Medicare supplement policyholder has excess coverage and to make appropriate refunds to such policyholders. The Company mails a "non-duplication letter" with every Medicare supplement replacement policy; this procedure was implemented April 17, 2008. Another "non-duplication letter" is mailed to the insured approximately four weeks after the policy effective date; this procedure was implemented on April 29, 2009. The consent order related to the prior examination resulted in refunds to five policyholders because excess Medicare supplement insurance was issued.

11. SUMMARY AND CONCLUSIONS

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

Item	Description	Page No(s).
A	The Company violated Section 325(a) of the New York Insurance Law by failing to maintain the minutes for all of its board of directors and board committee meetings at its principal office in this state. A similar violation appeared in the prior report on examination.	8
B	The Company violated Section 3209(b)(1)(A) of the New York Insurance Law by failing to disclose in its direct mail solicitation that the prospective purchaser has the right to receive, upon request, a buyer's guide and a policy summary prior to delivery of the policy; and provide a policy summary upon delivery of the policy.	16
C	The Company violated Section 2112(d) of the New York Insurance Law by failing to notify the Superintendent of the agent's termination of appointment with the Company within thirty days of the effective date of such termination.	17
D	The Company violated Section 243.2(b)(5) of Department Regulation No. 152 by failing to maintain all licensing records, clearly showing the dates of appointment and termination of each licensee.	18
E	The Company failed to comply with Department Circular Letter No. 4 (1963) by not setting out the monetary limitations of Section 3207 of the New York Insurance Law in the policy provisions, an endorsement, or a rider for the policies that were issued through direct mail marketing.	19
F	The examiner recommends that the Company issue an endorsement explaining the monetary limitations set forth in Section 3207 of the New York Insurance Law to all policyholders with an in force policy that was issued between January 1, 2006 and October 30, 2009 on the life of a minor.	19
G	The examiner recommends that the Company develop written procedures for the processing of both life and Medicare supplement claims to ensure consistent, fair and equitable claims handling among its policyholders in accordance with Section 2601(a)(3) of the New York Insurance Law.	19

Item	Description	Page No(s).
H	The examiner recommends that the Company furnish claimants with a notification indicating all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving notice of the claim by way of a telephone call.	20
I	The examiner recommends that all second request letters or any follow up letters to a claimant specify what proofs are outstanding and required of the claimant in order to pay the claim.	21
J	The examiner recommends that the Company demonstrate a good faith effort to locate the beneficiary of the policy before closing the claim. In the event that, after a diligent effort, the Company is not able to locate the beneficiary of the policy, the Company should perform a search of the Death Master File maintained by the United States Social Security Administration to verify the death of the insured and escheat the proceeds of the policy to the State of New York in accordance with the provisions of the New York Abandoned Property Law.	21
K	The Company violated Section 3211(b)(2) of the New York Insurance Law by failing to fully disclose to whole life and term life policyholders that unless payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the policyholder's right to any cash surrender value or nonforfeiture benefit or send a written notice to New York policyholders within six months after termination or lapse stating the type and amount of automatic nonforfeiture benefit in force.	22
L	The Company violated Section 4221(a)(1) of the New York Insurance Law by failing to provide a paid-up nonforfeiture benefit as the default nonforfeiture option in cases where the premium was past due and the policyholder had not elected the reduced paid-up or extended term insurance paid-up nonforfeiture benefit options.	23
M	The examiner recommends that the Company review all other policy forms to see if they provide the APL as an automatic or optional nonforfeiture benefit, and file the revised forms with the Department as necessary.	24

Item	Description	Page No(s).
N	The Company violated Section 403(d) of the New York Insurance Law by using a claim form that does not contain fraud warning language conforming to the New York Insurance Law.	25
O	The Company violated Section 3201(b)(1) of the New York Insurance Law by using a medical authorization release form without obtaining prior approval for the form.	26
P	The Company violated Section 58.1(d)(1) of Department Regulation No. 193 by using a medical authorization release form that requires the disclosure of an applicant's entire medical record, in connection with the Medicare supplement insurance application process.	27
Q	The Company violated Section 58.1(i)(1) of Department Regulation No. 193 by requiring applicants to authorize the disclosure of their entire medical history as part of the application process, which is contrary to New York open enrollment rules for any Medicare supplement policy or certificate.	27
R	The examiner recommends that the Company cease the use of Form No. N3979 in connection with the processing of its Medicare supplement new business.	27
S	The Company violated Section 58.1(b)(9) of Department Regulation No. 193 by failing to provide a copy of all advertisements for their Medicare supplement insurance to the superintendent, prior to their use. A similar violation appeared in the prior report on examination.	27
T	The Company violated Section 4224(c) of the New York Insurance Law by tying the sale of the Reserve Fund Annuity to the Medicare Supplement High Deductible F+ policy without specifically mentioning the annuity in the Medicare supplement policy provisions.	28
U	The examiner recommends that the Company enhance and revise their investment policies and procedures to better describe the functional and operational processes the Company has in place and have the revised policies and procedures approved by the board of directors and/or the investment committee.	29
V	The examiner recommends that the Company establish a risk management function to manage investment and economic risks and that the investment risk management function provide regular reporting on the investment risks of the portfolio.	29

Item	Description	Page No(s).
W	The Company violated Section 4228(f)(1)(B) of the New York Insurance Law by continuing to sell agent written non-military business after receipt of the letter from the Department disapproving the compensation plan for such business.	31
X	The examiner recommends that the Company correct the problems identified in the September 10, 2003 disapproval letter from the Department for the non-military life business compensation plan and file the plan with the Department. In the filing, the Company should attempt to show that although it paid compensation under a disapproved plan of compensation, the amounts paid under the plan did not exceed the limits in Section 4228(d) of the New York Insurance Law.	31

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 _____2010.

APPOINTMENT NO. 30331

STATE OF NEW YORK

INSURANCE DEPARTMENT

I, ERIC R. DINALLO, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

EDEN SUNDERMAN

as a proper person to examine into the affairs of the

FIRST UNITED AMERICAN 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 7th day of May, 2009

ERIC R. DINALLO
Superintendent of Insurance

Superintendent