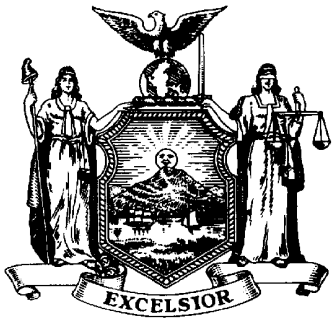

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

REPORT ON EXAMINATION

OF THE

AMERICAN MEDICAL AND LIFE INSURANCE COMPANY

CONDITION: DECEMBER 31, 2009

DATE OF REPORT: MAY 23, 2011

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EXAMINER: ANTHONY CHIAREL

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Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

July 3, 2012

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

Sir:

In accordance with instructions contained in Appointment No. 30514, dated April 28, 2010 and annexed hereto, an examination has been made into the condition and affairs of American Medical and Life Insurance Company, hereinafter referred to as "the Company" or "AMLI," at its home office located at 8 West 38th Street, New York, NY 10018.

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

On October 3, 2011, the Insurance Department merged with the Banking Department to create the New York State Department of Financial Services.

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

1. EXECUTIVE SUMMARY

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

- During the examination period, consumer complaints emerged about the Company's limited medical benefit product and the manner in which it was marketed, which led to an investigation by the Department. Regulatory actions, as a result of the investigation, included a $700,000 fine, termination of the Company's national television advertisements for the limited medical benefit product, and, effective July 28, 2009, an order to cease sales of its limited medical benefit policies in New York State for an undetermined time period. In addition, the Company had to withdraw its limited medical benefit policy forms filed with the Department and offer conversion to individual coverage to all New York resident certificate holders under terminated policies. (See item 3F of this report.)

- In response to a prior report on examination, the Company engaged the services of an outside audit firm to perform its internal audit function. However, as of January 2011, an audit of the Company's enterprise risk management process and internal operational controls had yet to take place. The lack of an effective risk management function led, and may further lead, to additional risk exposures going undetected and/or exposures not being quantified in a timely manner, thus limiting the Company's ability to manage its risks proactively. (See item 3F of this report.)

- The outside audit firm conducted five audits during the examination period. Although significant claims handling, cash management, regulatory compliance, and reporting weaknesses were noted in three of the audits, the Company neither furnished the examiners with documentation demonstrating that any of the outside auditor's recommendations were implemented, nor was written rationale given for not implementing the recommendations. Further, the Company did not conduct any follow-up audits of the three Third Party Administrators ("TPAs"). The examiner recommends that the Company implement the recommendations made by its outside external auditor

unless there is compelling justification for not applying the guidance, and by performing the required follow-up reviews in a timely manner. (See item 3F of this report)

- The prior report on examination documented numerous violations of law and regulatory non-compliance that the Company was directed to correct. However, this examination revealed that many of the prior examination report findings had not been corrected, as follows:
    - The Company again violated Section 4211(a) of the New York Insurance Law by failing to submit a copy of the notice of election of its board of directors to the office of the Superintendent at least ten days before the day of such election. (See item 3E of this report.)
    - The Company again failed to exercise greater care in the compilation of its data for reporting purposes and comply with the annual statement instructions in preparing its filed annual statements. (See item 8C of this report.)
    - The Company again violated Section 215.2(b) of Department Regulation No. 34 by failing to establish a system of control over the content, form, and method of dissemination of all advertisements of its policies. (See item 10A of this report.)
    - The Company again violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain at its home office a complete file containing a specimen copy of every printed, published, or prepared advertisement disseminated in this or any other state with a notation indicating the manner and extent of distribution, the form number of any policy advertised, and the approvals for the advertisements. (See item 10A of this report.)
    - The Company again violated Section 3224-a(a) of the New York Insurance Law by failing to pay limited benefit medical health and group hospital medical surgical expense claims within forty-five days of their receipt. (See item 10B of this report.)
    - The Company again violated Section 3214(c) of the New York Insurance Law by failing to pay the correct interest amount on its group life death claims from the date of death to the date of payment. (See item 10C of this report.)

- The Company again violated Section 243.2 of Department Regulation No. 152 by failing to maintain claim files and other policy records that were processed during the examination period. (See item 8E of this report.)

- The Company outsourced almost all of its core operational processes. Amongst the multitude of tasks handled by its agents and TPAs, and discussed herein, are the following: billing and premium collection (see item 8A of this report); maintenance and security of financial and market conduct records (see items 8C, 8E, and 9B of this report); advertising and sales activities (see item 10A of this report); underwriting and policy forms (see item 10B of this report); treatment of policyholders, which includes claims processing and complaint handling (see item 10C of this report); agency operations, which includes maintenance of an active and eligible agents' listing (see item 10D of this report); and statutory compliance disclosures (see items 11 and 12 of this report). The examination review revealed that the Company failed to properly oversee the operational functions performed by these agents and TPAs during the entire examination period. The Company's lack of supervision and control over its agents and TPAs indicates that its corporate governance function did not provide the necessary scrutiny required to ensure that the services provided to the Company by its agents and TPAs were compliant with New York Insurance Laws, Department Regulations, "best business practices," and in compliance with the respective service agreements between the Company and its agents and/or TPAs. These inadequate internal controls resulted in the prior New York regulatory action, the current examination findings noted throughout this report, and reputational harm to the Company. (See item 3F of this report.)

- The Company violated Section 310(a)(2) and (3) of the New York Insurance Law by not providing convenient access to the books, records, files, and other documents which were relevant to the examination, and by not facilitating the examination in a timely manner. The examiner was required to repeatedly and continuously remind the Company's designated examination liaison of the need for the outstanding materials and the need to facilitate the examination. The constant delay in the Company's response time to examination requests, examination memoranda, and Pre-Examination Letter items in

providing required documentation to support its financial and market conduct activities severely delayed the conduct of the examination. (See item 7 of this report.)

- The Company committed multiple violations of Section 3201(b)(1) of the New York Insurance Law. Listed below is a summarized version of the violations and recommended remedial actions. (See item 10B of this report.)
    - The Company violated Section 3201(b)(1) of the New York Insurance Law by issuing a policy form for its individual disability income business that had been significantly altered from the form filed with and approved by the Department. Further, had such altered form been filed, the Department would not have approved it because significant required disclosures had been removed. The examiner recommends that the Company provide the approved form to all policyholders that were issued disability income policies using the altered form.
    - The Company violated Section 3201(b)(1) of the New York Insurance Law by issuing a policy form for its individual disability income business that provided benefit amounts in excess of the filed benefits approved by the Department, as well as charging premiums in excess of the approved rates. The examiner recommends that the Company determine the excess premiums that were charged to its policyholders to support the additional benefits provided and refund those excess premiums.
    - The Company violated Section 3201(b)(1) of the New York Insurance Law by issuing a certificate/policy form for its vision business that had been altered from the approved certificate/policy form and included benefits and co-payments in excess of the benefits and co-payments filed with and approved by the Department. The examiner recommends that the Company reimburse affected policyholders for the co-payments charged in excess of the approved amounts.

- The Company violated Section 4235(h)(1) and (2) of the New York Insurance Law by failing to file rate increases for its limited medical benefit policies that were issued outside of New York. (See item 10B of this report.)

- During the first quarter of 2012 it was brought to the Department's attention that other states in which the Company actively writes limited medical benefit business were commencing investigations into, and, in certain instances, taking regulatory actions against the Company for engaging in misleading sales practices and other regulatory infractions, similar to the types of issues previously addressed in the New York stipulation (No. 2009-0256-S) AMLI signed in July, 2009, which resulted in a $700,000 fine and the cessation of limited medical benefit sales in New York State. Of particular significance, on March 29, 2012, the Office of Financial and Insurance Regulation ("OFIR"), the agency responsible for regulating Michigan's financial industries, suspended the insurance license of the Company. The OFIR also ordered the Company and 29 other organizations that sold the Company's limited benefit health plans to cease and desist from all activities in violation of Michigan's Insurance Code. (See item 14 of this report.)

2. SCOPE OF EXAMINATION

The examination of the Company was a full scope examination as defined in the *NAIC Financial Condition Examiners Handbook, 2009 Edition* (the "Handbook"). The examination covers the 3-year period from January 1, 2007 through December 31, 2009. The examination was conducted observing the guidelines and procedures in the Handbook and, where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2009, but prior to the date of this report (i.e., the completion date of the examination), were also reviewed.

In the course of the examination, a review was also made of the manner in which the Company conducts its business and fulfills its contractual obligations to policyholders and claimants. The results of this review are contained in item 10 of this report.

The examination was conducted on a risk focused basis in accordance with the provisions of the Handbook published by the National Association of Insurance Commissioners ("NAIC"). The Handbook guidance provides for the establishment of an examination plan based on the examiner's assessment of risk in the insurer's operations and utilizing that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the current financial condition as well as identify prospective risks that may threaten the future solvency of the insurer. The examiner identified key processes, assessed the risks within those processes, and evaluated the internal control systems and procedures used to mitigate those risks. The examination also included assessing the principles used and significant estimates made by management, evaluating the overall financial statement presentation, and determining management's compliance with Department statutes and guidelines, Statutory Accounting Principles as adopted by the Department and annual statement instructions.

Information about the Company's organizational structure, business approach, and control environment were utilized to develop the examination approach. The Company's risks and management activities were evaluated incorporating the NAIC's nine branded risk categories. These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Company was audited annually, for the years 2007 through 2009, by the accounting firm of BDO Seidman, LLP. The Company received an unqualified opinion in all years. Certain audit workpapers of the accounting firm were reviewed and relied upon in conjunction with this examination.

Since 2008, the Company's internal audit function was performed by an outside entity. The audit firm was engaged to review the Company's TPAs; managing general agents ("MGAs"); and to review and report on the Company's enterprise risk management process and the accompanying system of internal controls. Where applicable, internal audit workpapers and reports were reviewed and portions were relied upon for this examination. The Company is not subject to the Sarbanes-Oxley Act of 2002 ("SOX").

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 15 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 December 17, 1964, under the name Medical Accident and Health Company of New York. The Company was licensed on February 14, 1966, and commenced business on February 17, 1966.

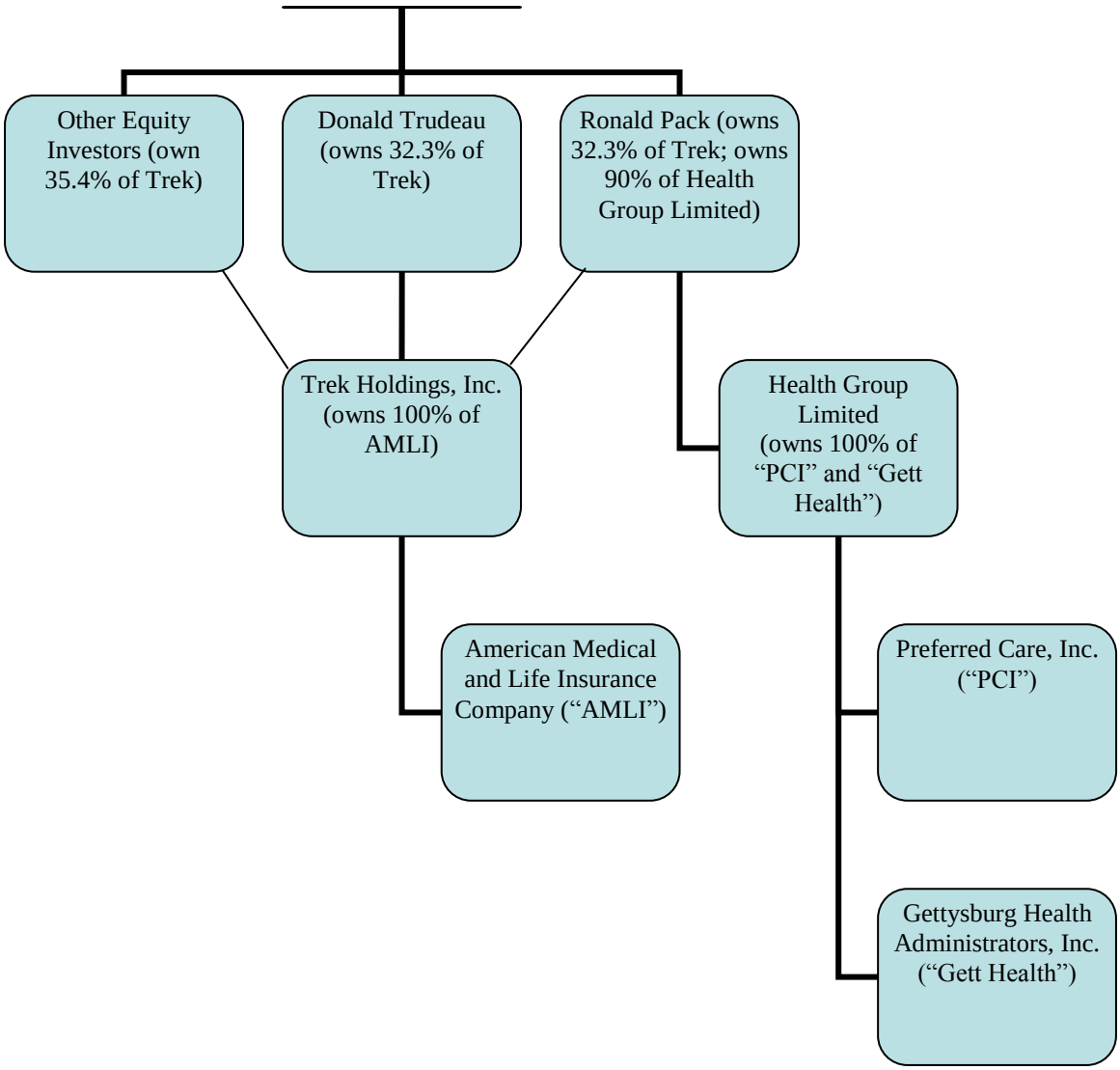
The Superintendent approved a charter amendment to change the Company's name to American Medical and Life Insurance Company ("AMLI") on November 22, 1988. The license to transact life insurance, annuities, and accident and health insurance was issued on January 3, 1989. To comply with the initial capital and surplus requirements for a stock company doing life insurance business in New York, the Company increased its capital to $2 million and increased its gross paid in and contributed surplus to $4 million, consisting of 100,000 shares with a par value of $20 per share. In 2006, there was an increase in the Company's surplus due to a $1 million capital contribution from its parent. In 2007, there was another increase in the Company's surplus due to a $4 million capital contribution from its parent.

B. Holding Company

The Company was originally owned by American Laboratories, Inc. (75%) and Dr. Jules V. Lane, D.D.S. (25%). On January 13, 2006, Trek Holdings, Inc. ("Trek"), a newly formed Company based in Delaware, acquired 100% of AMLI stock. In addition to cash consideration, Dr. Lane received shares of common stock, Class C, in Trek Holdings, Inc., which was equivalent to 10% of the fully diluted capital at the time. Ronald Pack and Donald Trudeau, both directors of the Company, each own 32.3% of Trek.

C. Organizational Chart

An organization chart reflecting the relationship between the Company and significant entities in its holding company system and other related parties as of December 31, 2009 follows:



D. Service Agreements

The Company had two 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
Claims administration 34988	10/1/06	Gettysburg Health Administrator Inc.	The Company	Claims and Claims customer services	2007 - $(459,041) 2008 - $(335,891)
Claims administration services 37799	5/1/08	Health Group LTD^	The Company	Claims/Premiums Administration	2008 - $(1,151,897) 2009 - $(3,617,302)

*Amount of income or (expense) incurred by the Company.

^Health Group LTD is the collective name for Gettysburg Health Administrator, Inc. ("Gett Health") and Preferred Care, Inc. ("PCI")

Since 2006, the Company has received claims administration and claims customer services from Gettysburg Health Administrator Inc. ("Gett Health") through its affiliate Preferred Care, Inc. ("PCI"). The administrative service agreement was filed with the Department pursuant to Section 1505(d) of the New York Insurance Law by letter dated February 9, 2006. The service agreement was approved on October 13, 2006, with the effective date of October 1, 2006. A revised administrative service agreement between the Company and Health Group, Ltd., the parent of Gett Health and PCI, was filed with the Department pursuant to Section 1505(d) of New York Insurance Law by letter dated June 8, 2007, with a final revised letter dated May 16, 2008. The service agreement was approved on May 23, 2008, with the effective date of May 1, 2008.

Health Group, Ltd. is 90% owned by Ronald Pack, a director of the Company and a shareholder who owns (32.3%) of Trek, the Company's parent.

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

E. Management

The Company's by-laws provide that the board of directors shall be comprised of not less than 9 and not more than 13 directors. As of December 31, 2009, the board of directors consisted of 11 members. Meetings of the board are held quarterly.

The 11 board members and their principal business affiliation, as of December 31, 2009, were as follows:

Name and Residence	Principal Business Affiliation	Year First Elected
Andrew A. Alberti* Tuckahoe, NY	President Cross River International, Capstan Equity Group	2006
John W. Green Centerport, NY	Partner Marcum and Kliegman, LLP	2006
Scott P. McGregor New York, NY	Chief Financial Officer American Medical and Life Insurance Company	2007
Edward F. McKernan* Duluth, GA	President Insurance Services, Inc.	2006
John F. Ollis New York, NY	President and Chief Executive Officer American Medical and Life Insurance Company	2006
Robert G. Ostrander Fairfield, CT	Executive Vice President American Medical and Life Insurance Company	2007
Ronald E. Pack Gettysburg, PA	President and Chief Marketing Officer Gettysburg Health Administrator, Inc. Director Trek Holdings, Inc. (32.3% Shareholder)	2006
Michael C. Szwajkowski* Rye Brook, NY	President, Managing Director Capital Source, Inc.	2006
Sydney T. Taylor Millbrook, NY	Executive Vice President CBCA, Inc.	2006
Douglas M. Thomas* Havertown, PA	President North Wind, LLC	2006
Donald J. Trudeau Stamford, CT	President Benistar Administrative Services	2006

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

In June, 2010, Scott P. McGregor resigned from the board and left the Company. He was replaced by Patrick Adamo, who subsequently left the Company effective August 31, 2011.

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

Section 4211(a) of the New York Insurance Law states, in part:

> "No election of directors of a domestic stock life insurance company shall be valid unless a copy of the notice of election shall have been filed in the office of the superintendent at least ten days before the day of such election…"

The Company failed to file the notice of election of directors with the Superintendent at least ten days before the day of such election. In 2007, the Company notified the Department of the election of its board members ten days after the election was held, not ten days before the day on which the meeting for the election was held.

The Company violated Section 4211(a) of the New York Insurance Law by failing to submit a copy of the notice of election to the office of the Superintendent at least ten days before the day of such election. This is a repeat violation from the prior report on examination.

Section 1 of Article IV of the Company's amended by-laws, dated October 17, 2007, states, in part:

> "Directors shall be elected at the annual meeting of shareholders by a plurality of the votes cast and shall hold office for not less than one year and not more than two years, the term of which shall be decided by Shareholders at either the Annual Meeting or a Special Meeting called by Shareholders for that purpose."

The examiner's review of the board of directors' minutes for the examination period indicated that none of the Company's directors were elected or re-elected in 2008, 2009, or 2010. The directors who were elected to the board in 2007 continued to serve as directors more than two years without an election and continued to serve during the examination period. Also, the directors' terms were not decided at the annual shareholders' meeting or any special meeting.

The examiner recommends that the Company comply with its by-laws by re-electing its board members within the two year maximum time period, or electing other directors to take the

place of the existing board members. The examiner also recommends that the Company decide the term of office for its directors at the annual or a special meeting of its shareholders.

The examiner's review of the board minutes indicated that the Company did not maintain copies of all presentations, reports, charts, etc., that were referred to in the board minutes and/or the committee minutes with or attached to said minutes.

The examiner recommends that the Company maintain copies of all presentations, reports, charts, etc. referred to in the board minutes and/or committee minutes with or attached to the minutes. A similar recommendation was included in the prior report on examination.

The Company's Investment Committee Charter states, in part:

> " . . . The committee will review and approve the investment transactions on an ongoing basis . . . The committee will meet on a quarterly basis."

A review of the investment committee minutes indicated that the committee met once in 2007, twice in 2008, and twice in 2009, in violation of its charter which requires that the committee meet quarterly.

The examiner recommends that the investment committee meet quarterly in accordance with its charter. This is a repeat recommendation from the prior report on examination.

The examiner recommends that the Company establish and maintain internal controls to ensure compliance with its charter and by-laws.

The following is a listing of the principal officers of the Company as of December 31, 2009:

Name	Title
John F. Ollis	President and Chief Executive Officer
Michael F. Murphy	Executive Vice President and Chief Operating Officer
Michael A. James	Executive Vice President and Chief Counsel
Robert G. Ostrander	Executive Vice President and Chief Underwriter
Scott P. McGregor	Chief Financial Officer and Treasurer
Steve G. Mellas*	Chief Compliance Officer
Lorraine Classi	Executive Vice President

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

In April 2010, Patrick Adamo became Chief Financial Officer and Treasurer replacing Scott McGregor, who relinquished those positions and left the Company at the end of June, 2010.

In December 2010, Michael Murphy was named President and Chief Operating Officer replacing John Ollis as President. John Ollis maintained the title of the Chief Executive Officer.

F. Corporate Governance

In accordance with the Company's charter and by-laws fiduciary responsibilities to manage, oversee, and monitor AMLI's corporate obligations rests with its board of directors and executive management. During the review of the Company's corporate governance policies and objectives, the following were noted:

1. Enterprise Risk Management

In the prior report on examination, the examiner recommended that the Company establish and maintain an independent, adequately resourced, and competently staffed internal audit function to provide management and the audit committee with ongoing assessments of the Company's risk management processes and the accompanying system of internal controls.

The Company engaged an outside audit firm, SMART & Associates LLP ("SMART"), to perform its internal audit function beginning in 2008. The outside audit firm was engaged to review the Company's TPAs; MGAs; and to review and report on the Company's enterprise risk management process and the accompanying system of internal controls. As of January 2011, the Company's Chief Financial Officer indicated that an audit of the Company's enterprise risk management process and internal operational controls had not yet commenced. The lack of an effective risk management function led, and may further lead, to additional risk exposures going undetected and/or exposures not being quantified in a timely manner, thus limiting the Company's ability to manage its risks proactively.

The examiner recommends that the Company immediately commence an audit of its enterprise risk management process and the accompanying system of internal controls. Furthermore, the examiner recommends that the results of such audit be forwarded to the Department upon completion.

2. Internal Audits

SMART conducted five audits during the examination period. Four of these audits were of TPAs and MGAs that marketed and/or serviced the Company's limited medical benefit business, and one audit was of the TPA that marketed and serviced the Company's dental business. The audit firm employed a grading system that consists of four ratings as follows:

1. Satisfactory
2. Satisfactory with Recommendations
3. Needs Improvement – This rating indicates that timely corrective action is required to reduce the likelihood of financial exposure and/or loss that might be material to the Company or threaten the operation's ability to achieve its long-term objectives, or when the weakness in controls results in a high risk of fraud. This rating requires a follow-up review **within one year** to verify that the original findings were corrected.
4. Unsatisfactory – This rating indicates that immediate corrective action must be taken to prevent further exposure and/or loss that may be material to the Company or threaten the operation's ability to achieve its long-term objectives, or where there is evidence of fraud, illegal acts, unreported conflicts of interest or significant waste and or inefficiency. This rating requires a follow-up review **within six months**.

Preferred Care Insurance, Inc. ("PCI"), the principal TPA that processed claims for the Company's limited medical benefit and student medical products during the examination period, received a rating of "Unsatisfactory" as a result of an audit of the limited medical benefit claims processing that was dated November 30, 2009. Claims handling, cash management, regulatory compliance, and reporting weaknesses were noted during SMART's review of PCI. The primary reasons for the unsatisfactory rating are as follows:

- Claims were not processed on a timely basis which created a large backlog.
- PCI incurred avoidable interest expenses of $340,000 related to delayed claims processing since January 2009.
- PCI's process resulted in 6,372 claims in inventory that were identified as duplicates, which represented 7.46% of all 82,429 claims. Besides overstating the claims inventory, these claim duplicates increased the risk of inappropriate payments for manual claims as adjusters are likely to process claims in sequential order without cross-referencing

previously processed claims. In fact, this data entry error was noted during SMART's testing of claim overpayments.

- SMART reviewed GettHealth's systems report of overpayments and concluded that GettHealth's report is unreliable and does not aid in the correct identification of overpayment amounts, counts, and other deviations noted. This report was deemed unreliable by SMART due to GettHealth's system incorrectly accumulating the number of hospital stays, ICU (Intensive Care Unit) days, and benefit amounts. DXL (Diagnosis Services) dates were also confused with office visit benefits causing the system to erroneously accumulate benefits paid. Further, this report included items that were not overpayments.
- There is a lack of segregation of duties in the receiving and processing of overpayment refunds and returned checks sent to PCI from providers and members. Based on the amount and volume of payments of returned checks handled, SMART identified that this weakness in the cash handling process can lead to a high risk of return checks being lost, stolen, or misappropriated. Further, these lack of segregation of duties results in deficient controls over the cash receipts function.
- SMART performed a walkthrough of PCI's overpayment refund request process and noted that PCI does not have a procedure in place to track and follow refund requests for overpayments made in error.
- SMART inquired about, and attempted to review, the escheatment of unclaimed property procedures followed by AMLI in accordance with New York State law. SMART learned that PCI does not currently have a process in place to track the un-cashed, returned, and voided check for escheatment purposes.

In its audit report SMART made numerous recommendations to cure the aforementioned deficiencies, some of which are listed below:

- SMART recommended that PCI immediately implement a detailed action plan with a timeline and attainable targets to alleviate the claims processing backlog. AMLI should ensure that all pressing compliance issues are immediately addressed.
- SMART recommended that as PCI and AMLI are working to address this issue, they develop a formal action plan, with target dates and accountabilities, to review these identified duplicate claims, and process denials to reduce the risk that overpayments are

made by paying claims twice. All potential duplicate claims in inventory that have been identified should be flagged and not processed further until verified as actual duplicates. Duplicates that have been verified should be removed from the claim inventory. A weekly process should be instituted to identify and remove potential duplicates in inventory.

- SMART recommended that PCI Claim Adjusters continue to work with the GettHealth Systems team to develop a more accurate overpayment identification report. This estimated overpayment amount and the related support should be reported to AMLI contemporaneously when performed on a monthly basis going forward.
- SMART strongly recommended an expedited remediation that entry log, data entry, and mailing duties should be segregated accordingly: one associate should receive the checks and create the log entry recording receipt of the check; the checks should then go to a different associate to be entered into the claims system. The entry log should be sent to the Fort Washington office by the associate who has control over the log. The physical checks should then be sent separately to the Fort Washington office by the data-entry associate. When received, Fort Washington personnel should compare the log entries to the physical checks received to ensure that all refunds, returned, and voided checks are properly accounted for. Finally, all checks received should be stored in a secure location with limited personnel access while being processed at PCI offices.
- During the review, SMART learned that PCI does not currently have a process in place to track the un-cashed, returned, and voided check for escheatment purposes. Non-compliance with this regulatory requirement is a direct violation of the in-force TPA Agreement between AMLI and PCI. SMART recommended that AMLI and PCI research the applicable regulations regarding escheatment procedures in New York State and other applicable states as required by law, and immediately implement the proper procedures to track un-cashed, returned, or voided checks, as well as any other unclaimed property in their possession for the purposes of escheatment to the State. AMLI should ensure that escheatment procedures are implemented and monitored as a compliance issue going forward.

PCI was terminated as the Company's limited medical benefit claims processor at year end 2009. However, PCI continued to service the Company's student medical line of business.

PCI is owned by Mr. Ronald Pack, who is a member of the Company's board of directors; a member of the board of directors of TREK, the Company's parent and sole shareholder; and a 32.3% share holder of TREK.

Group Plan Administrators ("GPA"), a program manager that serviced one of the Company's Associations that marketed the limited medical benefit product to its members, was given a "Needs Improvement" rating as a result of an audit that was dated April 28, 2009. The scope of SMART's audit was to review the Premium, Collections, Cash Management, and Agent Licensing processes for completeness, compliance with established guidelines, establishment of adequate procedures and controls, and accuracy of reporting to AMLI. However, GPA did not provide SMART with adequate documentation to test key areas and as such SMART was unable to conclude on the effectiveness of the controls within these processes. GPA's failure to furnish the information requested by SMART violated the TPA Agreement between GPA and AMLI.

Based on ratings criteria, at a minimum a follow-up review should have been conducted by April 28, 2010. However, as of the first quarter of 2011, no follow-up review had been performed.

Pro Benefits (f/k/a The Dental Shop) is the TPA that services the Company's dental business. Similarly, Pro Benefits was given a rating of "Needs Improvement" as a result of an audit that was dated February 14, 2008. Claims handling, cash management, regulatory compliance, and reporting weaknesses were noted during SMART's review. The primary reasons for the needs improvement rating are as follows:

- The Accounts Receivable Manager's tasks represent a segregation of duties conflict since they include responsibilities such as handling cash, maintaining the check log, recording cash receipts, endorsing checks, preparing and making bank deposits, and collection attempts.
- The Account Director's tasks and system capabilities represent a segregation of duties conflict since they include responsibilities such as maintaining the accounting system (general ledger), preparing the bank reconciliations, authorizing bank transfers, printing checks, processing invoices, and entering all journal entries which, in addition, do not require approval by a third party.

- Claims examiners are able to process payments for uncovered services without approval by using claims system overrides.
- The TPA does not have a written cancellation policy and, as a result, cancellation procedures are not consistently applied to all insureds.
- In accordance with the Agency Administration Agreement dated December 1, 2001, quarterly claim audits must be performed to confirm that claims are being processed in accordance with industry standards and best practices, and the results should be provided to AMLI. However, SMART determined that the TPA was not performing quarterly claims audits.
- The Agency Administration Agreements effective December 2001 and January 2007 have not been updated to reflect AMLI's revised reporting requirements relating to premium and claims.

The following are some of SMART's recommendations to cure the aforementioned deficiencies:

- The responsibilities for maintaining the check log and preparing/making the bank deposits should be reassigned to another individual. Further, someone other than the preparer should review and sign-off on the bank reconciliations, bank transfers and journal entries. Compensating controls should be implemented to review and monitor the deposits for completeness. In addition, management should review the financial statements on a monthly or quarterly basis to highlight and investigate any large or unusual transactions or fluctuations. An annual review or audit of the financial statements by a third party would provide additional assurance as to the accuracy of the company's financial records.
- A system change needs to be implemented to prevent unauthorized approval of overrides. A procedure needs to be established to ensure that any such claims are reviewed and approved by AMLI prior to payment.
- Cancellation policies and procedures should be documented to ensure more efficient and reliable processes and controls. In addition, procedures to identify and account for uncollectible debt should be developed to ensure that uncollectible debt is properly accounted for and the Accounts Receivable balance is accurately reflected.

- A process for completing quarterly claims audits to cover all examiners should be put into effect. This will confirm that claim guidelines, industry standards, and best practices are being followed by each examiner. SMART also recommended that an underwriting audit be completed quarterly to confirm that the system coding information corresponds to the underwriting file since the claim processing relies heavily on the system coding to generate claims payment rates.

Based upon the aforementioned rating, a follow-up review should have been conducted by February 14, 2009. However, as of the date of this report, a follow-up review had not been conducted on Pro Benefits.

Additionally, the Company neither furnished the examiners with documentation demonstrating that any of SMART's recommendations were implemented, nor was written rationale for not implementing the recommendations provided.

The examiner recommends that the Company implement the recommendations made by its outside external auditor unless there is compelling justification for not applying the guidance, and by performing the required follow-up reviews in a timely manner.

3. Regulatory Actions

The prior triennial examination report of the Company cited AMLI for various violations of the New York Insurance Law and Department regulations and directed the Company to implement a number of recommendations. In responding to the prior report on examination, the Company made various assurances to the Department indicating that steps would be taken to improve its operating environment. However, during the current examination, the examiner noted that several of the violations and recommendations made during the prior examination period were not corrected. (See item 14 of this report.)

Furthermore, prior to this examination, numerous consumer complaints regarding the Company's limited medical benefit product ("LM") and the manner in which it was marketed, led to an investigation by the Department which commenced in April of 2009. The investigation covered the time period from August 2006 through January 2009. The investigation resulted in regulatory actions that included a $700,000 fine for various violations of New York Insurance Law and Department regulations regarding the marketing and sales of the LM product, the termination of the Company's national television advertisements, and an order to cease sales of

its LM product in New York State as of July 28, 2009. Following the Department's investigation, several other States commenced actions against the Company for improper business practices.

As noted immediately above in this section (Corporate Governance, specifically items 2 and 3), and throughout this report on examination, the Company outsourced almost all of its core operational processes. Amongst the multitude of tasks handled by its agents and TPAs, and discussed herein, are the following: billing and premium collection (see item 8A of this report); maintenance and security of financial and market conduct records (see items 8C and E and 9B of this report); advertising and sales activities (see item 10A of this report); underwriting and policy forms (see item 10B of this report); treatment of policyholders, which includes claims processing and complaint handling (see item 10C of this report); agency operations, which includes maintenance of an active and eligible agents' listing (see item 10D of this report); and statutory compliance disclosures (see items 11 and 12 of this report).

The examination review revealed that the Company failed to properly oversee the operational functions performed by these agents and TPAs during the entire examination period. The Company's lack of supervision and control over its agents and TPAs ensured that its corporate governance function failed to guarantee that the services provided to the Company by its agents and TPAs were compliant with New York Insurance Laws, Department Regulations, "best business practices", and in compliance with the respective service agreements between the Company and its agents and/or TPAs. These inadequate internal controls resulted in the prior New York regulatory action, the current examination findings noted throughout this report, and significant reputational harm to the Company.

4. TERRITORY AND PLAN OF OPERATIONS

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.

During the examination period the Company was licensed to transact business in 39 states and the District of Columbia. As of December 31, 2009, approximately 99% of the Company's overall business consisted of accident and health products, with approximately 93% of accident and health premiums being generated from the sale of its LM products. The remaining 1% of its total premiums was generated from the sale of life insurance products which were sold predominantly to New York State residents. In 2009, 99% of life premiums and 18% of accident and health premiums were received from New York, and 12% of accident and health premiums were received from Florida. Policies are written on a non-participating basis.

The following tables show the percentage of direct premiums received, by state and by major lines of business, for the year 2009:

Life Insurance Premiums			Accident and Health Insurance Premiums	
New York	98.6%		New York	18.0%
New Jersey	1.0		Florida	12.1
Florida	0.4			
Subtotal	100.0%		Subtotal	30.1%
			All others	69.9
Total	100.0%		Total	100.0%

A. Statutory and Special Deposits

As of December 31, 2009, the Company had $1,920,000 (par value) of United States Treasury Notes on deposit with the State of New York, its domiciliary state, for the benefit of all policyholders, claimants, and creditors of the Company. The Company also had special deposit in the amount of $1,287,063 being held by the states of Arkansas, Florida, Nevada, North Carolina, and Oklahoma.

B. Direct Operations

The Company primarily markets group insurance products including dental, medical, and life insurance.

The medical line consists of limited medical benefit insurance, student accident and health insurance, and group hospital medical surgical expense insurance which together comprised more than one-half of the net premium revenue generated during the examination period.

The Company strongly emphasized the marketing of limited medical benefit insurance during the examination period. This business has been sold primarily through two associations, the National Congress of Employers ("NCE") and the Association of Independent Managers ("AIM"), to their members. As used elsewhere in this report, the term Associations refers to NCE and AIM. During the examination period, consumer complaints emerged about the limited medical benefit product and the manner in which it was marketed, which led to the aforementioned investigation and disciplinary measures imposed by the Department.

The student medical and accident business for the examination period consisted of coverage on seven colleges in New York State.

The group hospital medical surgical expense insurance, which is conventional medical coverage with deductibles and co-insurance with low maximum annual benefits, was marketed through trucking associations, but was discontinued in January 2009.

The Company offers insured dental programs primarily in the State of New York. In connection with the Company's group indemnity dental program, both on an insured and self-insured basis, the Company has a preferred provider network consisting of over 1,000 dentists. The Company has a small group dental program for groups of less than 50 lives that is being sold by brokers to the small group market.

The Company also markets group vision care insurance and prescription drug coverage which was offered as an add-on product to the limited medical benefit product. In addition, the Company marketed an individual disability product which offered hospital confinement and accidental death and dismemberment benefits.

Other insurance offered included term life and accidental death and dismemberment products marketed primarily to employers.

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

In 2009, agents for the NCE association produced approximately 87% of the Company's limited medical benefit insurance or $66,404,407 of premium.

As mentioned previously, the Company's business model utilizes TPAs for the production (marketing, sales, and underwriting) and administrative handling (premium billing and collection, claims processing, etc.) of the majority of its product lines. While this model is used to some extent by many New York insurers, AMLI relies on this model almost exclusively. This "soup to nuts" approach of outsourcing all major aspects of its insurance business places a heavier burden on company management, including its board of directors, to ensure that appropriate policies are established and adequate controls are in place and operating effectively in order to safeguard the Company's assets and ensure compliance with all Department rules and regulations, including assurances that its policyholders are treated fairly and reasonably. However, as will be noted throughout this report, the appropriate level of due diligence on the part of management and the board of directors was notably absent both during and subsequent to the examination period.

C. Reinsurance

As of December 31, 2009, the Company had reinsurance treaties in effect with eight companies, of which four were authorized or accredited. The Company's life business is reinsured on a yearly renewable term basis, while the accident and health business is reinsured on a coinsurance basis. Reinsurance is provided on an automatic and facultative basis.

The maximum retention limit for individual life contracts is $50,000. The total face amount of life insurance ceded as of December 31, 2009, was $203,470,500, which represents 56.6% of the total face amount of life insurance in force. As of December 31, 2009, the Company ceded $45,539,769 of accident and health premiums to non-affiliates. Reserve credit taken for reinsurance ceded to unauthorized companies totaling $3,698 was supported by funds deposited by and withheld from reinsurers.

5. SIGNIFICANT OPERATING RESULTS

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

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

	December 31, 2006	December 31, 2009	Increase (Decrease)
Admitted assets	$13,649,199	$27,083,551	$13,434,352
Liabilities	$ 5,921,850	$19,514,324	$13,592,474
Common capital stock	$ 2,000,000	$ 2,000,000	$ 0
Group contingency reserve	363,323	363,323	0
Gross paid in and contributed surplus	5,000,000	9,000,000	4,000,000
Unassigned funds (surplus)	364,026	(3,794,096)	(4,158,122)
Total capital and surplus	$ 7,727,349	$ 7,569,227	$ (158,122)
Total liabilities, capital and surplus	$13,649,199	$27,083,551	$13,434,352

The increase in gross paid in and contributed surplus is due to a $4 million capital contribution from its parent in 2007. The increase in liabilities and the decrease in surplus were a result of the increase in sales of the limited medical benefit business and the resulting claims associated with that business.

The Company's invested assets as of December 31, 2009, were mainly comprised of bonds (53%), and cash and short-term investments (47%).

The Company's entire bond portfolio, as of December 31, 2009, was comprised of investment grade obligations.

In 2007, the Company cashed out its stock portfolio and invested in U.S. Treasuries, Agencies and corporate bonds, all NAIC investment grade 1 and 2.

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

	Group Accident and Health		
	2007	2008	2009
Outstanding, end of previous year	361	339	36,837
Issued during the year	8	50,300	8,371
Other net changes During the year	(30)	(13,802)	0
Outstanding, end of current year	339	36,837	45,208

The large increase in the group accident and health business is due to the significant increase in the limited medical benefit insurance, which is the Company's major product line. As discussed above, this business is sold primarily through associations like NCE and the AIM, to their members.

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

	2007	2008	2009
Industrial Life	$ 0	$ 0	$ (272)
Ordinary:			
Life insurance	$ 1,897	$ 2,354	$ 4,123
Total ordinary	$ 1,897	$ 2,354	$ 4,123
Group:			
Life	$ 537,335	$ 388,392	$ 435,992
Total group	$ 537,335	$ 388,392	$ 435,992
Accident and health:			
Group	$ 916,064	$1,796,082	$(5,209,664)
Other	0	0	687
Total accident and health	$ 916,064	$1,796,082	$(5,208,977)
All other lines	$(670,197)	$ (859,954)	$(1,360,867)
Total	$ 785,099	$1,326,874	$(6,130,001)

The increase in the group accident and health line of business between 2007 and 2008 was primarily the result of the increase in underwriting income from the growth of the limited medical benefit business.

The large loss noted in the accident and health line of business in 2009 was mostly the result of the limited medical product not being priced appropriately at its inception, regarding expenses (i.e., regulatory matters and legal matters) related to the limited medical product, and adverse claims experience in that line of business.

Following an investigation by the Department which found numerous violations of the Insurance Law, the Company was required to cease writing limited medical benefit business in the state of New York, its domiciliary state and largest market. Other jurisdictions also initiated investigations during the examination period and further curtailed the sale of the limited medical

benefit business. These combined actions were a major factor in the group accident and health loss from operations reported for 2009 in the above chart.

The "all other lines" represents the portion of corporate expenses which are not allocated to actual lines of business. These expenses are offset by other income not generated specifically from other insurance lines of business.

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

	2007	2008	2009
Premiums earned	100.0%	100.0%	100.0%
Incurred losses	65.6%	62.7%	79.7%
Commissions	4.0	(1.2)	(4.8)
Expenses	28.4	29.7	38.6
Experience rating refund	0.0	0.0	(0.3)
	98.0%	91.2%	113.2%
Underwriting results	1.9%	8.8%	(13.2)%

The increase in the incurred losses and related expenses during 2008 and 2009 were mostly the result of the limited medical product as noted above. On October 1, 2009, January 1, 2010, and April 1, 2010, the Company increased its limited medical rates in an attempt to increase the profit margin on its limited medical benefit business.

The commission expense as presented in the 2008 and 2009 Schedule H was presented net of commissions and expense allowance on reinsurance ceded, which resulted in the negative ratios indicated in the above chart.

6. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital and surplus as of December 31, 2009, as contained in the Company's 2009 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, 2009 filed annual statement.

A. Independent Accountants

The firm of BDO Seidman, LLP was retained by the Company to audit the Company's combined statutory basis statements of financial position of the Company as of December 31st of each year in the examination period, and the related statutory-basis statements of operations, capital and surplus, and cash flows for the year then ended.

BDO Seidman, LLP concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Company at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no material discrepancies noted.

B. Net Admitted Assets

Bonds	$10,114,249
Cash, cash equivalents and short term investments	8,905,692
Investment income due and accrued	102,493
Premiums and considerations:	
Uncollected premiums and agents' balances in the course of collection	6,042,114
Reinsurance:	
Amounts recoverable from reinsurers	1,141,957
Funds held by or deposited with reinsured companies	385,982
Electronic data processing equipment and software	72,813
Receivables from parent, subsidiaries and affiliates	42,824
Due from third party administrators and others	143,482
Other receivables	130,370
Other asset	1,575
Total admitted assets	$27,083,551

C. Liabilities, Capital and Surplus

Aggregate reserve for life policies and contracts	$ 142,566
Aggregate reserve for accident and health contracts	207,499
Contract claims:	
Life	183,140
Accident and health	10,670,593
Contract liabilities not included elsewhere:	
Other amounts payable on reinsurance	3,126,179
Interest maintenance reserve	762,134
Commissions to agents due or accrued	10,732
General expenses due or accrued	417,544
Taxes, licenses and fees due or accrued, excluding federal income taxes	1,131,324
Miscellaneous liabilities:	
Asset valuation reserve	17,446
Reinsurance in unauthorized companies	328,603
Drafts outstanding	1,404,723
Payable for securities	973,828
Other amounts payable	138,013
Total liabilities	$19,514,324
Common capital stock	$ 2,000,000
Group contingency reserve	363,323
Gross paid in and contributed surplus	9,000,000
Unassigned funds (surplus)	(3,794,096)
Total capital and surplus	$ 7,569,227
Total liabilities, capital and surplus	$27,083,551

D. Condensed Summary of Operations

	2007	2008	2009
Premiums and considerations	$19,353,261	$28,500,270	$44,865,286
Investment income	574,968	675,817	572,444
Commissions and reserve adjustments on reinsurance ceded	1,237,642	4,725,962	11,985,514
Miscellaneous income	781,062	180,889	186,085
Total income	$21,946,933	$34,082,938	$57,609,329
Benefit payments	$12,384,392	$17,653,286	$35,371,119
Increase in reserves	(25,173)	95,818	(21,597)
Commissions	1,977,969	4,418,782	9,888,316
General expenses and taxes	6,824,646	9,914,851	18,501,492
Total deductions	$21,161,834	$32,082,737	$63,739,330
Net gain (loss)	$ 785,099	$ 2,000,201	$ (6,130,001)
Federal and foreign income taxes incurred	0	673,326	0
Net gain (loss) from operations before net realized capital gains	$ 785,099	$ 1,326,875	$ (6,130,001)
Net realized capital gains	196,521	0	0
Net income	$ 981,620	$ 1,326,875	$ (6,130,001)

E. Capital and Surplus Account

	2007	2008	2009
Capital and surplus, December 31, prior year	$ 7,727,349	$12,705,598	$12,099,585
Net income	$ 981,620	$ 1,326,875	$ (6,130,001)
Change in net unrealized capital gains (losses)	(142,393)	0	0
Change in non-admitted assets and related items	(38,246)	(1,930,749)	1,891,528
Change in liability for reinsurance in Unauthorized companies	0	0	(328,603)
Change in reserve valuation basis	0	0	40,388
Change in asset valuation reserve	177,268	(2,139)	(3,671)
Surplus adjustments: Paid in	4,000,000	0	0
Net change in capital and surplus for the year	$ 4,978,249	$ (606,013)	$ (4,530,359)
Capital and surplus, December 31, current year	$12,705,598	$12,099,585	$ 7,569,227

7. FACILITATION

Section 310(a) of the New York Insurance Law states, in part:

> "(2) Any examiner authorized by the superintendent shall be given convenient access at all reasonable hours to the books, records, files, securities and other documents of such insurer or other person, including those of any affiliate or subsidiary companies thereof… which are relevant to the examination . . . "
> (3) The officers and agents of such insurer or other person shall facilitate such examination and aid such examiners in conducting the same so far as it is in their power to do so . . . "

Throughout the course of the examination the Company failed to timely provide responses to examination requests for financial, technology, and market conduct information such that progress on the examination was severely delayed. The examiner was required to repeatedly and continuously remind the Company's designated examination liaison of the need for the outstanding materials and the need to facilitate the examination. This was expressed to the Company's liaison and to the Chief Financial Officer at the status meeting on August 12, 2010, and at all status meetings from that date forward.

Furthermore, of particular concern was the Company's inability to furnish timely responses to the Pre-Examination Letter ("PEL"). The information requested through this letter serves as the foundation for the entire examination. The PEL was sent to the Company's home office on March 19, 2010, and listed and outlined requests for eighty-one (81) various pieces of documentation and information, including electronic data files. The PEL indicated that the information and documentation could be provided on three separate dates - April 23rd, May 4th, and June 2nd of 2010. The three delivery dates were selected to allow sufficient time for AMLI to respond to the varied PEL items that were requested.

Notwithstanding this flexible schedule, the Company did not provide timely responses. More than half of the PEL items were not received by June 2, 2010, the final date indicated by the PEL. On April 15, 2011, more than one year after the initial request was made, the last PEL response was provided by the Company. The average time for receipt of PEL responses from the Company that were past due was 57.8 business days. Additionally, many other examination memoranda and requests for information were slow to be provided or not provided at all.

The constant delay in the Company's response time to PEL requests, examination requests, and examination memoranda in providing required documentation to support its financial and market conduct activities severely delayed the conduct of the examination.

The Company violated Section 310(a)(2) and (3) of the New York Insurance Law by not providing convenient access to the books, records, files, and other documents which were relevant to the examination, and by not facilitating the examination in a timely manner.

8. ACCOUNTS AND RECORDS

A. Premium Receipts

The examiners requested the Company to provide a listing of all new business issued during the examination by year. The Company responded as follows:

> "The Company was not able to provide for the vision, dental, student medical and group life products. It had been the understanding of the Company that since these are employer group and student group policies that the Company would only record new business when a new group was added. As a result it would be extremely difficult to try to capture this data for the examination period of 2007 through 2009."

The TPAs for the Company's vision, dental, and short term disability lines of business billed the groups/individuals for the premiums due on a monthly basis. The TPAs for the Company's student medical line of business collect premiums biannually from the agents for the specific colleges. The TPAs did not provide the detail support to the Company for verification of premium receipts and aging of receivables, and the Company did not have procedures to verify the completeness and accuracy of the premium receipts reported by the TPAs. The Company simply relied on the aggregate amounts reported by the TPAs.

The examiner recommends that the Company establish procedures to obtain, on a monthly basis, the policy level detail supporting the amount of premiums collected by its TPAs and to verify the accuracy and completeness of the premium receipts reported by its TPAs and MGAs by conducting regularly scheduled premium audits.

B. Allocation of Expenses

Section 91.4(a) of Department Regulation No. 33 states, in part:

"(a) *General instructions.* (1) It is the responsibility of each life insurer to use only such methods of allocation as will produce a suitable and equitable distribution of … expenses by lines of business…

(2) Each life insurer shall maintain records with sufficient detail to show fully:

(i) the system actually used for allocation of … expenses;

(ii) the actual bases of allocation;…

(3) Such records shall be classified and indexed in such form as to permit ready identification between the item allocated and the basis upon which it was allocated, and shall be maintained in such a manner as to be readily accessible for examination. These records shall bear a date and shall identify the person responsible for the preparation thereof…"

The examiner requested the Company to provide the methodology used to derive the dollar amounts reported in Exhibit 2 of its annual statement. The Company's response follows:

"The methodology used to report expenses on Exhibit 2, is as follows:

Where possible direct allocation is used; each expense account is reviewed to determine if the expense is directly related to a specific product.

Expenses that cannot be directly allocated – percentages are used. To allocate

- The life business allocation is based on the percentage of time spent by Director of Customer Services and the Accountant (processes premium receipts, calculates and pays commissions, etc.) on life functions for the year.
- All Other Lines of Business is primarily Finance. The CFO determines each year what the allocation should be."

The allocation of expenses for "All Other Lines of Business" performed by the CFO each year does not describe the "actual bases" used for the allocation of expenses in Exhibit 2 nor could the Company provide the actual method used by the CFO to determine the amounts reported during the examination period. In addition, the Company did not maintain the records in such a manner as to be readily accessible for examination. It took the Company 57 business days (in excess of 11 weeks) to provide a response to the request to provide the methodology used to derive the dollar amounts reported in Exhibit 2 of its annual statement.

The Company violated Section 91.4(a)(1), (2)(i) and (ii), and (3) of Department Regulation No. 33 by not maintaining records with sufficient detail to show the system actually used for allocation of expenses and the actual bases of allocation.

The examiner recommends that the Company develop a suitable method of allocation for expenses that is compliant with Department Regulation No. 33, and have the records supporting such method readily accessible for examination.

C. Annual Statement Preparation

The Company's filed annual statements during the period under examination contained reporting errors and misclassification of accounts. The following list is comprised of some of the errors identified during the examination:

1. The Company did not report any "in course of settlement" claims in Exhibit 8 Part 1 of the annual statement for the years 2007, 2008, and 2009. The Company reported all the claims in course of settlement on the "incurred but not reported" line.

2. The Company was unable to reconcile the amounts reported in the "Exhibit of Number of Contracts in Force" for its Accident and Health business for 2007, 2008, and 2009. A similar comment was noted in the prior report on examination.

3. The Company was unable to provide accurate data for new certificates issued during each of the years of the examination period, for its vision, dental, student accident and health, major medical, and group life products.

4. The Company reported a reserve credit taken in the amount of $3,698 in Schedule S Part 4 of its 2009 annual statement as being supported by a trust agreement with American Labor Life Insurance Company. The examiners requested a copy of the trust agreement but were informed by the Company's Account Manager that there was no trust agreement with American Labor Life Insurance Company and that the reserve credit was supported by funds withheld.

The examiner recommends that the Company exercise greater care in the compilation of its data for reporting purposes and comply with the annual statement instructions in preparing its filed annual statements. This is a repeat recommendation from the prior report on examination.

D. Outstanding Checks

1. The Company reported outstanding drafts in the amount of $1,404,723 in its 2009 annual statement. The examiner requested a detailed listing of all outstanding checks for the examination period. The Company was unable to provide a complete list of the outstanding checks.

In the prior report on examination the examiner recommended, and the Company agreed, that the Company would establish a procedure whereby it would segregate checks which remained outstanding for more than six months into a separate liability control account. A review of the outstanding checks procedure indicated that the Company did not comply with this process during the examination period.

The examiner recommends that the Company adhere to the agreed upon procedures to segregate checks which remain outstanding for more than six months. This is a repeat recommendation from the prior report on examination.

2. The examiner's review of the information that was provided by the Company and its external auditor indicated that there were outstanding checks (unclaimed funds) that were issued prior to January 1, 2007. The New York funds, which remained unclaimed for more than three years, should have been escheated to the New York State Comptroller, Office of Unclaimed Funds. In addition, the Company failed to file an abandoned property report for the years 2007, 2008, and 2009, and did not remit the unclaimed funds to the New York State Comptroller's Office during the examination period. The Company did escheat $21,981.03 to the New York State Comptroller on June 1, 2010, for unclaimed funds from 2004, 2005, and 2006.

The examiner recommends that the Company escheat abandoned property to the New York State Comptroller as required. The prior report on examination contained a similar recommendation.

Further, the Company failed to publish notices of unclaimed property by May 1st of each year during the examination period as required by the New York Abandoned Property Law.

The examiner recommends that the Company publish notices of unclaimed funds in accordance with the New York Abandoned Property Law. The prior report on examination contained a similar recommendation.

E. Record Retention

Section 216.11 of Department Regulation No. 64 states in part:

"…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…Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners…"

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

. . .

"(b) Except as otherwise required by law or regulation, an insurer shall maintain:

(1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer . . . A policy record shall include . . .
(ii) The application, including any application form or enrollment form for coverage under any insurance contract or policy;
(iii) The contract or policy forms issued including the declaration pages, endorsements, riders, and termination notices of the contract or policy . . .
(iv) Other information necessary for reconstructing the solicitation, rating, and underwriting of the contract or policy . . .
(4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received . . ."

1. The Company could not provide a number of claim records requested during the examination, as follows:

The examiner requested a sample of 120 limited medical benefit claim files for review. The Company was unable to provide 16, or approximately 13.3%, of the limited medical benefit claim files requested.

The Company provided two data files that it indicated was comprised exclusively of student accident and health claims filed during the examination period. However, upon review the examiner determined that one of the two files also included major medical claims from the Westbury Union Free School District. The examiner requested a sample of 79 claims to review from the two data files provided by the Company; 29 student accident and health claims and 50 major medical claims. The Company was unable to provide 5 of the 29, or 17%, of the student accident and health claim files requested and 4 of the 50, or 8%, of the major medical claim files requested in the sample.

The examiner also selected a sample of 33 of the Company's group hospital medical surgical expense claim files for review. The Company could not provide 7 of the 33, or 21%, of the files requested.

The Company violated Section 243.2(b)(4) of Department Regulation No. 152 by failing to maintain claim files in a manner that would permit the examiner to reconstruct all events relating to a claim. A similar violation was cited in the prior report on examination.

2. The Company provided the examiner with data indicating that 111,001 dental claims were paid during the examination period. The examiner selected and reviewed a sample of 82 of the claims, which were processed by a TPA. The TPA used a usual, reasonable, and customary ("URC") methodology to process the out-of-network claims.

The Company could not provide all the information needed to reconstruct the claims, and could not determine which claims were paid using the URC methodology. The explanation provided by the Company is that URC charges are uploaded into the TPA's system on January 1st of each year by the TPA's actuaries and used during that year, but are automatically overwritten on the next January 1st when the new URC charges are uploaded, without making a back-up of the previous year's URC charges.

As a result, there was no information available to reconstruct benefits that were paid using the URC method for the entire examination period. Of the 82 dental claims reviewed, 9 or approximately 11% were processed using the URC method.

The Company violated Section 216.11 of Department Regulation No. 64 by failing to maintain all events relating to each claim so that the claim could be reconstructed by the examiners.

The Company also violated Section 243.2(b)(4) of Department Regulation No. 152 by failing to maintain sufficient documentation to readily determine which claims were processed using the URC charges and the year specific methodology that was used to determine the URC charges for each year of the examination period.

3. The Company could not provide a number of policy application forms requested during the examination, as follows:

The examiner reviewed 100 policy application files for the Company's limited medical benefit business and noted that the Company did not maintain 93 of the enrollment forms and 5 of the application forms for its limited medical benefit business as required by Section 243.2(b)(1)(ii) of Department Regulation No. 152.

The examiner requested the policy application files for each of the 33 group hospital medical surgical expense claim files referenced above. The 33 claim files consisted of 15 insureds. The Company did not maintain the application forms for any of the 15 insureds or 100% of the sample requested.

The examiner requested the policy application forms for each of the 29 student accident and health claim files and the 50 major medical claim files referenced above. The Company did not maintain 5 of the 29, or 17%, student accident and health policy application forms requested, and 48 of the 50, or 96%, of the major medical application forms requested. Further, when the examiner inquired about the missing policy application forms for the major medical policy, the Company stated that it "has not kept copies of the applications. We are in the process of trying to gather this information."

The Company violated Section 243.2(b)(1)(ii) of Department Regulation No. 152 by not maintaining enrollment forms and/or policy application forms. A similar violation was cited in the prior report on examination.

4. The examiner requested copies of the group policies, certificates, and schedule of benefits issued in connection with the 100 limited medical benefit application files referenced above. The Company did not maintain five of the group policies, two of the certificates, and two of the schedule of benefit forms.

The Company violated Section 243.2(b)(1)(iii) of Department Regulation No. 152 by not maintaining policy records. This is a repeat violation from the prior report on examination.

9. INFORMATION TECHNOLOGY

A. Security of Information Technology Resources

In its management letter of April 2009, issued for the year ended December 31, 2008, the Company's external auditor, BDO Seidman, LLP, cited the following:

> "Currently the server area is used as the Company's supply room and allows unrestricted access to proprietary servers. Access to the server room should be restricted to IT and upper management."

Management's response at that time was:

> "Management believes that physical security controls over the server are appropriate in light of the size of the organization."

This situation has not changed as of April 22, 2011, and at this time it appears that it will not be resolved in the near future. During the on-site examination, the examiners noted that deliveries by non-Company personnel were received in the computer server room.

The examiner recommends that the Company comply with its external auditor's recommendation and restrict access to its computer server room to information technology ("IT") personnel and upper management to ensure a more secure environment for its IT resources.

B. Disaster Recovery

The Company's TPAs/MGAs process premium income, perform underwriting functions and administer claims on all lines of business other than its group life business. Item number seven of the Company's disaster recovery plan, entitled "External Operations," requires each TPA/MGA to provide a copy of its written disaster recovery plan to the Company. It also requires that each TPA/MGA conduct an annual audit of its own disaster recovery plan and provide the results of that audit to the Company.

The examiner requested documentation from the Company to verify the existence of a disaster recovery plan for each of its TPAs/MGAs that provided services during the examination period. In addition, the Company was asked to provide the audit results of the disaster recovery plan that each of the TPAs/MGAs had performed on their own disaster recovery plan during the examination period.

The Company advised the examiner that disaster recovery plans were initially reviewed during the vetting process of the TPAs/MGAs; however, such reviews were not formally documented in writing. The Company also indicated that it did not collect and review the annual test results performed by its TPAs/MGAs, as required pursuant to the Company's own disaster recover plan.

The examiner recommends that the Company formally document, in writing, its initial review of disaster recovery plans for each of its TPAs/MGAs, and implement procedures to annually obtain, review and document the results of the disaster recovery test for each of its TPAs/MGAs.. Such reviews and documentation would help to mitigate the possibility that changes made by those entities to their respective disaster recovery plans and IT systems would not negatively impact the Company's operations and or the security of its electronic records.

10. 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, and solicitation of insurance policies.

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

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

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

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

The examiner requested a copy of the Company's advertising index and files. The Company provided the examiner with an index and related files, and indicated that, other than its limited medical benefit business, no advertisements were distributed during the examination period for any other lines of business. The examiner then selected a sample of seven brochures (one from each of the seven colleges insured by the Company) that were received with the student accident and health claim files. The Company lacked knowledge of the existence of the student accident and health advertisements. The examiner also selected an individual disability brochure provided by the Company's Chief Underwriting Officer. This disability brochure was

distributed by Tower Insurance Services, Inc, the administrator for the Company's disability income business.

The examiner tested the completeness of the Company's advertising file by tracing the eight advertisements to the advertising index obtained from the Company. None of the eight documents reviewed appeared on the Company's advertising index nor were copies maintained in the Company's advertising files. When presented with this finding the Company's General Counsel and Chief Compliance Officer, who are responsible for the approval of all advertisements, indicated that they were unaware that these advertisements were being used in the marketing of these products. In addition, the advertising index and advertising files did not contain any control numbers assigned to the advertisements, dates of production associated with the advertisements, description of who produced the advertisements, any dates indicating the length of time the advertisements were in use, or any approvals for the advertisements.

The Company violated Section 215.2(b) of Department Regulation No. 34 by failing to establish a system of control over the content, form, and method of dissemination of all advertisements of its policies. This is a repeat violation from the prior report on examination.

The Company also violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain at its home office a complete file containing a specimen copy of every printed, published, or prepared advertisement disseminated in this or any other state with a notation indicating the manner and extent of distribution, the form number of any policy advertised, and the approvals for the advertisements. This is a repeat violation from the prior report on examination.

B. Underwriting and Policy Forms

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

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

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

(a) During the examination period, the Company issued 186 individual disability income insurance policies in New York State. The individual disability income policy form, AMLI-DI-03 NY, was approved by the Department for use in New York on March 21, 2005. A review of the forms issued by the Company during the examination period indicated that page 3 of the form had been altered to eliminate segments of the required verbiage from the "Policy Schedule" of the form being used. Among the items eliminated from the policy form were the following: initial premium amount; premium modes and amounts; name of beneficiary and relationship; policy number; name and contact information for the Plan Administrator; the fact that the policy was nonparticipating; and the fact that the policy provided disability income insurance and did not provide basic hospital, basic medical, or major medical insurance. The examination review revealed that the alterations were made by the TPA handling the marketing efforts of this product for the Company.

The Company violated Section 3201(b)(1) of the New York Insurance Law by issuing a policy form that had not been filed with and approved by the Department.

The examiner directed the Company to provide the approved form to all policyholders that were issued disability income policies using the aforementioned altered form. The Company provided all active policyholders with the approved policy form as directed.

The examiner recommends that the Company ensure that all new policies are issued with the filed and approved page three of the policy form.

(b) The approved policy form AMLI-DI-03 NY referenced above indicated that the "Monthly Benefit For Total Disability Benefit," was a variable amount [100-1,000]. The Company provided an inventory consisting of the 186 policies that were issued during the examination period. The monthly benefit amounts provided to the insureds in 104 (56%) of the policies were in excess of the approved variable amount of [$100-$1,000]. Benefit amounts being paid were: $1,100; $1,200; $1,500, and $1,800.

The examiner recalculated the premium, using the Company's rate manual, for two of the individual policies selected from the sample and noted that the amounts recalculated did not match the premium rate the Company charged for the coverage provided. One of the two policies recalculated was higher than the amount charged, and the other one was lower than the amount charged. Upon investigating the inconsistencies, the Company's underwriter responded

that the differences in the premium amounts calculated by the examiner and charged by the TPA were due to a rounding issue. The Company further indicated that the difference in the calculated premium and the premium actually paid could be negligible or as much as $15 annually in excess of the calculated premium.

It appears that a formulaic error was inputted into the programming system utilized by the TPA handling the billing process for this product. Had the Company fulfilled its corporate responsibility to ensure that its agents acted in the best interests of its policyholders by auditing the information generated by this system, the inconsistent results would likely had been identified and corrected prior to the Department's examination.

The Company violated Section 3201(b)(1) of the New York Insurance Law by issuing a policy form for its individual disability income business that provided benefit amounts in excess of the filed benefits approved by the Department as well as charging premiums in excess of the approved rates.

The examiner recommends that the Company determine the excess premiums that were charged to its policyholders to support the additional benefits provided and refund those excess premiums.

(c) The examiner selected a sample of 11 paid claims from the Company's vision business which, as of December 31, 2009, consisted of 30 groups with 3,073 certificate holders. During the review of the 11 claims, the examiner compared the Benefits Summary on the certificates given to the claimants to the Benefits Summary on file with the Department and noted several discrepancies. The benefit amounts for in-network and out-of-network providers that were reported on the certificate given to the insureds were higher than those amounts on the approved certificate filed with the Department. In addition, the co-payments for in-network and out-of-network providers on the certificates given to the claimants were higher than those amounts on the approved certificate filed with the Department. The two largest groups that were reviewed, Bronx Lebanon Hospital Center and Auburn Memorial Hospital, charged co-payments of $15 per Eye Exam and $30 for Eyewear and $15 per Eye Exam and $25 for Eyewear, respectively. The co-payments for this coverage filed with the Department were $10.

In addition, the number of new issues during the examination period could not be provided by the Company even though the policy and certificate states in part, "the Policyholder

shall submit to the Administrator on a monthly basis, a list of all Insureds." The Company then requested the TPA, Block Vision, Inc., to provide the information. The total population reported by the TPA to the Company as of December 31, 2009 was 3,073 yet the policy level detail count provided by the TPA was 2,979. The Company stated that the differences could not be reconciled.

The Company violated Section 3201(b)(1) of the New York Insurance Law by issuing a certificate/policy form for its vision business that had been altered from the approved certificate/policy form and included benefits and co-payments in excess of the benefits and co-payments filed with and approved by the Department.

The examiner recommends that the Company reimburse affected policyholders for the co-payments charged in excess of the approved amounts.

The examiner further recommends that the Company obtain the monthly policy level detail and verify the number of insureds as reported by its TPA, Block Vision. The Company should also perform scheduled audits of the TPA to ensure that the information provided is accurate.

2. Section 4235(h)(1) and (2) of New York Insurance Law states in part:

> "(1) Each domestic insurer . . . doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of . . . group accident and health insurance . . . whether transacted within or without the state.
>
> (2) An insurer may revise such schedules from time to time, and shall file such revised schedules with the superintendent."

On October 1, 2009, January 1, 2010, and April 1, 2010, the Company increased its rates for limited medical benefit plans issued outside of New York State, but did not file those increases with the Superintendent as required by Sections 4235(h)(1) and (2) of the New York Insurance Law.

The Company violated Section 4235(h)(1) and (2) of the New York Insurance Law by failing to file rate increases for its limited medical benefit policies that were issued outside of New York.

C. Treatment of Policyholders

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

1. Section 216.4(a) of Department Regulation No. 64 states, in part:

> "Every insurer, upon notification of a claim, shall, within 15 business days, acknowledge the receipt of such notice . . ."

The examiner's review of a sample of 24 student blanket accident and sickness claim files revealed that the Company failed to notify 8 claimants, or 33.3% of the sample, of receipt of their claims within 15 business days. The time frames for the 8 responses ranged from 17 to 31 business days.

The Company violated Section 216.4(a) of Department Regulation No. 64 by failing to notify claimants of receipt of their claims within 15 business days.

2. Section 216.4(b) of Department Regulation No. 64 states, in part:

> "An appropriate reply shall be made within 15 business days on all other pertinent communications."

The examiner reviewed a sample of 82 non-Department initiated complaint files provided by the Company for the period January 1, 2007 through December 31, 2009. In 8 of the 82 complaints, or 9.8% of the sample, the Company did not respond to the complainant in the required 15 business days. The time frames for the 8 responses ranged from 19 to 93 business days.

The examiner reviewed an additional sample of 52 non-Department initiated complaint files provided by the Company for the subsequent time period January 1, 2010 through June 1, 2010. In 10 of the 52 complaints, or 19.2% of the sample, the Company did not respond to the complainant within the required 15 business days. The time frames for the 10 responses ranged from 21 to 130 business days.

The Company violated Section 216.4(b) of Department Regulation No. 64 by failing to appropriately reply to the complainants within the required 15 business days.

3. Section 308(a) of the New York Insurance Law states, in part:

> "The superintendent may also address to any …authorized insurer…or officers thereof, any inquiry in relation to its transactions or condition or any matter connected therewith. Every corporation or person so addressed shall reply in writing to such inquiry promptly and truthfully,….In the event any corporation or person does not provide a good faith response to an inquiry from the superintendent pursuant to this section relating to accident insurance, health insurance, accident and health insurance…within a time period specified by the superintendent of not less than fifteen business days, the superintendent is authorized to levy a civil penalty…against such corporation or person not to exceed five hundred dollars per day for each day beyond the date specified by the superintendent for response…. "

The examiner reviewed a sample of 25 Department-initiated complaint files provided by the Company. In 11 of the 25 complaints, or 44% of the sample, the Company did not respond to the Department within the required 15 business day time period. The time frames for 5 of the 11 responses ranged from 19 to 57 business days.

The examiner reviewed an additional sample of 34 Department-initiated complaint files provided by the Company for the time period January 1, 2010 through June 1, 2010. In 17 of the 34 complaints, or 50% of the sample, the Company did not respond to the Department with in the 15 business day time period. The time frames for 2 of the 17 responses ranged from 18 to 21 business days.

The Company violated Section 308(a) of the New York Insurance Law by failing to respond to the Department regarding complaints within the required 15 business days.

4. Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" (Prompt Pay Law), requires all insurers to pay undisputed ("clean") claims within forty-five days of receipt.

Section 3224-a (a) of the New York Insurance Law states, in part:

> "Except in a case where the obligation of an insurer . . . to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer . . . shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

A statistical sample of claims was reviewed to determine whether the claims were processed in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law. The examiner reviewed a sample of 104 clean limited medical claims processed during the examination period. Accordingly, all claims that were adjudicated after 45 days of receipt were segregated. The examiner identified 23 out of the 104, or 22.1% of the sample, where the Company failed to settle the claim within 45 days of its receipt. All 23 identified claim payments were paid in excess of 50 days after receipt. The examiner also reviewed the 23 claims to determine whether interest was properly calculated and found that the Company paid the requisite amount of interest on the 23 sampled claims.

Additionally, the examiner reviewed a sample of 28 group hospital medical surgical expense insurance policy claim files. In 6 out of the 28 claim files, or 21.4% of the sample, the Company did not make a payment within forty-five days of receipt of a claim. All 6 claim payments were paid in excess of 50 days.

The Company violated Section 3224-a(a) of the New York Insurance Law by failing to pay limited benefit medical health and group hospital medical surgical expense claims within forty-five days of their receipt. This is a repeat violation from the prior report on examination.

5. During the examination review of claims it was revealed that the Company implemented guidelines for pursuing pre-existing condition investigations related to its limited medical benefit claims. The investigation process dictating whether or not a pre-existing condition would be considered in making a claims settlement determination is based solely on the amount of a submitted claim. During the examination period this process was applied in two tiers. Prior to April 9, 2008, if the claim was less than $1,500, no investigation was made for a pre-existing

condition. From April 9, 2008, and thereafter, if the claim was less than $500 no investigation was made for a pre-existing condition.

Placing a dollar limit ($1,500 before April 9, 2008, and $500 after that date) on the initiation of the investigation process for a pre-existing condition, rather than basing the decision on a medical diagnosis or treatment, could result in an unequal distribution of benefits among the Company's certificate holders.

The examiner recommends that the Company implement procedures to ensure uniform claims settlement practices are applied to all claim submissions and predicated on a medical diagnosis or treatment rather than a numerical benchmark.

6. Section 3214(c) of the New York Insurance Law states, in part:

> "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 . . . in connection with a death claim on such a policy of life insurance . . . to the date of payment and shall be added to and be a part of the total sum paid."

The examiner inquired about the board resolution relating to the rate of interest paid on death claims during the examination period. The Company provided the examiner with a resolution dated September 19, 1995, and indicated that the resolution was still in effect. The resolution indicated that the Company would pay a rate of two percent (2%) below the commercial money market rate in effect at National Westminster Bank U.S.A. on the last day of the fiscal quarter last preceding the death of the insured.

The examiner reviewed 167 death claims that were processed during the examination period and found that interest was not being paid in accordance with Section 3214(c) of the New York Insurance Law. Further, the Company did not pay interest pursuant to the aforementioned board resolution; instead, the Company paid a flat 2% interest rate on the death proceeds.

The Company violated Section 3214(c) of the New York Insurance Law by not paying the correct interest amount on its group life death claims from the date of death to the date of payment. This is a repeat violation from the prior report on examination.

The Company agreed to recalculate the interest due the beneficiaries during the examination period and made payments where the additional amount owed to claimants

exceeded $5.00. The Company further indicated that its current board of directors has amended the procedures for the payment of interest on death claims whereby it will utilize the rate in effect on the 90-day T-Bill as its benchmark rate rather than the National Westminster rate, but the rate will not be less than 1%.

The examiner also recommends that the Company pay all group life death claims using the interest rate approved pursuant to its board resolution.

D. Agency Operations

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

> "Every insurer,…or insurance producer or the authorized representative of the insurer,…or insurance producer 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, or upon termination for cause…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…"

During the examination period the TPAs for the various product lines supplied the Company with agent licensing and termination information. A review of a sample of producer/agent licenses revealed that termination notices for 7 producers/agents were not filed with the Superintendent within 30 days of such termination.

The Company violated Section 2112(d) of the New York Insurance Law by failing to file a termination notice with the Superintendent within the 30 days following such termination.

The examiner notes that during the second half of 2009 and 2010, the Company developed a "core processing system" ("CPS") to centralize its agent licensing and agent appointment information. The CPS also incorporates the recording of premium billing and receipts, and updates the member records. The CPS did not become operational until late November 2010, approximately one year after the "As of Date" of the current examination. The CPS was specifically designed to manage the Company's limited medical business only. As of the date of this report, the CPS does not service the Company's other lines of business (i.e., student accident and health insurance, dental insurance, vision insurance, disability insurance,

etc.). The Company indicated that, in the future, the other lines of business may be included in the CPS.

11. FRAUD WARNING STATEMENTS

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 examiners reviewed a sample of claim forms for the individual disability and group life lines of business provided by the Company.

Five of the 74 individual disability claim forms filed with the Company during the examination period did not contain the required fraud warning language required by Section 86.4(a) of Department Regulation No. 95. The Company also did not submit the fraud warning statement that was contained in its disability claim forms to the Insurance Frauds Bureau for approval prior to its use, as required by Section 86.4(e) of Department Regulation No. 95.

The examiners reviewed 30 of the 167 group life death claims filed with and paid by the Company during the examination period. It was noted that 2 of the 30 claims forms reviewed did not contain the required fraud warning language pursuant to Section 86.4(a) of Department Regulation No. 95. The statement used by the Company omitted the words, "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."

The Company violated Section 86.4(a) of Department Regulation No. 95 by using claims forms that did not contain the required fraud warning statement.

The Company also violated Section 86.4(e) of Department Regulation No. 95 by not submitting the alternate fraud warning language used on its claims forms to the Insurance Frauds Bureau for approval prior to use.

The examiner recommends that the Company either use the required fraud warning statement on its claims forms, or submit its alternate fraud warning statement to the Insurance Frauds Bureau for approval prior to its use.

12. PRIVACY

Section 420.5(a)(1) of Department Regulation No. 169 states:

> "General rule. A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of 12 consecutive months during which that relationship exists. A licensee may define the 12-consecutive-month period, but the licensee must apply it to the customer on a consistent basis."

The examiner reviewed the Company's privacy questionnaire and noted that the Company did not respond to question number 3. The examiner followed up with a request to the Company, dated February 10, 2011, regarding the annual privacy notice which it was required to send to its customers. The Company's response was as follows.

> "The Company sends a privacy notice to each certificate holder as part of the AMLI's Welcome Package. Additionally, our privacy notice is on our corporate website. Effective April 1, 2011, the Company will commence mailing privacy notices to each certificate holder annually on the certificate anniversary date."

The Company's response related to its limited medical benefit business. The response did not address whether or not an initial privacy notice or an annual privacy notice was sent to

any of its customers for the other lines of business (student accident and health insurance, dental insurance, vision insurance, disability insurance, etc.). A second inquiry was sent to the Company on February 18, 2011, and a third inquiry was sent on March 2, 2011. The Company did not respond to either of the subsequent inquiries.

The Company violated Section 420.5(a)(1) of Department Regulation No. 169 by not providing annual privacy notices to its customers that accurately reflected its privacy policies and practices during the continuation of the customer relationship for any of its lines of business during the examination period and subsequent to the examination period.

The examiner recommends that the Company provide a clear and conspicuous notice to its customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship as required by Section 420.5(a)(1) of Department Regulation No. 169.

13. ASSESSMENT OF OPERATIONAL ENHANCEMENTS

The Company does not have adequate control over the lines of business (student accident and health insurance, dental insurance, vision insurance, disability insurance, etc.) it currently writes or has in force. In addition, the Company has not corrected all the violations and/or complied with all the recommendations from the prior report on examination regarding its internal audit function, claims processing, record retention, advertising requirements, and compliance with its by-laws. Further, item 7 of this report details the Company's inability to provide the examiners convenient access to the books, records, files, and other documents and information, which were relevant and necessary to conduct the examination. In certain instances the Company could not provide any requested documentation regarding specific records, files, and other requested information.

The examiner recommends that the Company develop and implement procedures to significantly enhance its operational environment to gain control over the methods used by its TPAs to market and administer the Company's products. Such procedures should be submitted to the Department for review and comment.

The examiner further recommends that any TPA reluctant to abide with the new procedures, upon turning over all records associated with the business they handled for the Company, be terminated immediately.

14. SUBSEQUENT EVENTS

During the first quarter of 2012 it was brought to the Department's attention that other states in which the Company actively writes limited medical business were commencing investigations into, and, in certain instances, taking regulatory actions against the Company for engaging in misleading sales practices and other regulatory infractions similar to the issues previously addressed in the New York stipulation (No. 2009-0256-S) AMLI signed in July, 2009, which resulted in a $700,000 fine and the cessation of limited medical sales in New York State. Of particular significance, on March 29, 2012, the Office of Financial and Insurance Regulation ("OFIR"), the agency responsible for regulating Michigan's financial industries, suspended the insurance license of the Company. The OFIR also ordered the Company and 29 other organizations that sold the Company's limited benefit health plans to cease and desist from all activities in violation of Michigan's Insurance Code.

15. 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 examiner recommended that, in the future, the Company await the Department's non-disapproval before operating under a Section 1505(d)(3) service agreement. The Company did not enter into any Section 1505(d)(3) service agreements during the examination period.
B	The Company violated Section 4211(a) of the New York Insurance Law by failing to file a copy of the notice of the election of directors in the office of the Superintendent at least ten days prior to the election. The Company did not comply with Section 4211(a) of New York Insurance Law. (See item 3E of this report.)
C	The examiner recommended that the Investment Committee meet quarterly in accordance with its Charter. The Investment Committee did not meet quarterly during the exam period. A similar recommendation is included in this report on examination. (See item 3E of this report.)
D	The examiner recommended that the Company amend its by-laws to reflect the change in the composition of the Investment Committee or increase the number of directors to five. The Company amended its by-laws whereby the composition of the Investment Committee now consists of three directors, one of which is a non-affiliated director.
E	The examiner recommended that the Company maintain copies of all presentations, reports, charts, etc., of securities approved by the board in its minutes. The Company did maintain copies of all presentations, reports, charts, etc., of securities approved by the board in its minutes. (See item 3E of this report.)

Item	Description
F	The examiner recommended that the Company exercise greater care in the compilation of its data for reporting purposes and comply with the annual statement instructions in preparing its filed annual statements. The Company did not exercise greater care in the compilation of its data for reporting purposes and comply with the annual statement instructions in preparing its filed annual statements. (See item 8C of this report.)
G	The Company violated Section 219.2(b) of Department Regulation No. 34-A and Section 215.2(b) of Department Regulation No. 34 by failing to establish a system of control over the content, form and method of dissemination of all advertisements of its policies. The Company did not comply with Section 215.2(b) of Department Regulation No. 34 during the examination period. This is a repeat violation from the prior report. (See item 10A of this report.)
H	The Company violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain at its home office a complete file containing a specimen copy of every printed, published, or prepared advertisement hereafter disseminated in this state with a notation indicating the manner and extent of distribution and the form number of any policy advertised. The Company did not comply with Section 215.17(a) of Department Regulation No. 34 during the examination period. This is a repeat violation from the prior report (See item 10A of this report.)
I	The examiner recommended that the Company comply with its advertising policy and procedures by obtaining the written approval of its General Counsel for all its advertising materials. The Company has not yet implemented a procedure whereby all advertising for all its lines of business (dental insurance, vision insurance, student accident and health insurance, etc.) is reviewed by its compliance officer and by its General Council. This is a repeat recommendation from the prior report (See item 10A of this report.)
J	The Company violated Section 216.5(a) and Section 216.6(c) of Department Regulation No. 64 by failing to notify the claimants of additional information required within 15 business days of receiving notice of the claims and by failing to notify claimants of the acceptance or rejection in writing within fifteen days after receipt of all items, statements, and forms which the insurer requested from the claimants.

Item	Description
	The examiners did not note any claims in which additional information was required by the Company and where the Company did not respond to the claimant within 15 business days regarding the acceptance or rejection of the claim, in writing.
K	The Company violated Section 3214(c) of the New York Insurance Law by failing to pay the correct interest amount on its group life death claims from the date of death to the date of payment. The Company did not comply with Section 3214(c) of the New York Insurance Law. (See item 10C of this report.)
L	The examiner recommended that the Company follow its claims procedures by including the additional 14 days in the interest calculation for all claimants. The Company is currently including an additional 14 days in its interest calculation of its group life death claims.
M	The Company violated Section 3224-a(a) of the New York Insurance Law by failing to pay health claims to the covered person or to the health care provider within forty-five days of receipt of the claim or bill for services rendered. The Company did not pay all the health claims to covered persons or to the health provider within forty-five days of receipt of the claim or bill for services rendered. This is a repeat from the prior report on examination. (See item 10C of this report.)
N	The examiner recommended that the Company maintain its complaint log in accordance with Department Circular Letter No. 11 (1978). The Company currently maintains its complaint log in accordance with department Circular Letter No. 11 (1978).
O	The Company violated Section 2112(a) of the New York Insurance Law by failing to file a certificate of appointment in such form as the Superintendent may prescribe in order to appoint insurance agents to represent it. This is a repeat violation from the last report on examination. The Company has employed an electronic connection to the National Insurance Producer Registry (NIPR) to process appointment certificates through an automated interface as prescribed. This was accomplished in November 2010 for the limited medical benefit business only. (See item 10D of this report.)

Item	Description
P	The examiner recommended that a procedure be established to segregate checks which remain outstanding for more than six months, into a separate liability control account such as unclaimed funds. If such funds remain unclaimed for three years, it should then be remitted to the New York State Comptroller, Office of Unclaimed Funds or other appropriate jurisdiction. The Company did not comply with the prior report recommendation. (See item 8D of this report.)
Q	The examiner recommends that the Company publish notices of unclaimed funds in accordance with the abandoned property law. The Company indicated in its response dated January 13, 2011, that it has not complied with the recommendation currently or in the past, but will add this procedure to its current unclaimed fund procedures and implement it during 2011. (See item 8D of this report.)
R	The Company violated Section 86.6(d) of Department Regulation No. 95 by failing to include in its annual report its modifications to the fraud plan to amend its operations, to improve performance or to remedy observed deficiencies. The Company's compliance officer submitted the fraud plan on December 30, 2009. The Department's Frauds Bureau's review of the Plan resulted in a letter dated May 5, 2010, which noted deficiencies and requested further clarification on some aspects of the Plan. The Company provided a partial response on March 15, 2011. In response to a request from the Frauds Bureau, a revised Plan was sent to the Frauds Bureau on January 18, 2012 and is under review.
S	The examiner recommended that the Company establish and maintain an independent, adequately resourced, and competently staffed internal audit function to provide management and the audit committee with ongoing assessments of the Company's risk management processes and the accompanying system of internal controls. An outside audit firm was engaged to aid the Company in its annual risk assessment, its audit functions for its TPAs and MGAs, and internal audit functions for its internal operations as well. The outside audit firm conducted 5 audits of the Company's TPAs/MGAs during the examination period. However, the Company did not make any of the recommendations suggested by the outside audit firm or cure any deficiencies noted in its review. Additionally, in January 2011, the Company's CFO advised the examiners that the outside audit firm had not yet commenced an audit of the Company's enterprise risk management process and internal operational controls. (See item 3F of this report.) This is a repeat recommendation from the prior report on examination.

Item	Description
T	The Company violated Section 243.2(b)(1) of Department Regulation No. 152 by failing to maintain a policy record for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination. This is a repeat violation from the last report on examination. (See item 8E of this report.)
U	The Company violated Section 243.2(b)(4) of Department Regulation No. 152 by failing to maintain a claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report in which the claim file was subject for review. This is a repeat violation from the last report on examination. (See item 8E of this report.)
V	The Company violated Section 243.2(b)(6) of Department Regulation No. 152 by failing to maintain the complaint records for six calendar years after all elements of the complaints are resolved and the file is closed. During the examiners review of the Company's complaint records, it appeared that the Company has maintained the complaint records as required since the filing of the prior report on examination.

16. SUMMARY AND CONCLUSIONS

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

Item	Description	Page No(s).
A	The Company violated Section 4211(a) of the New York Insurance Law by failing to submit a copy of the notice of election of its board of directors to the office of the Superintendent at least ten days before the day of such election. This is a repeat violation from the prior report on examination.	13
B	The examiner recommends that the Company comply with its by-laws by re-electing its board members within the two year maximum time period, or electing other directors to take the place of the existing board members. The examiner also recommends that the Company decide the term of office for its directors at the annual or a special meeting of its shareholders.	13-14
C	The examiner recommends that the Company maintain copies of all presentations, reports, charts, etc. referred to in the board minutes and/or committee minutes with or attached to the minutes. A similar recommendation was included in the prior report on examination.	14
D	The examiner recommends that the investment committee meet quarterly in accordance with its charter. This is a repeat recommendation from the prior report on examination.	14
E	The examiner recommends that the Company establish and maintain internal controls to ensure compliance with its charter and by-laws.	14
F	The examiner recommends that the Company immediately commence an audit of its enterprise risk management process and the accompanying system of internal controls. Furthermore, the examiner recommends that the results of such audit be forwarded to the Department upon completion.	15
G	The examiner recommends that the Company implement the recommendations made by its outside external auditor unless there is compelling justification for not applying the guidance, and by performing the required follow-up reviews in a timely manner.	21
H	The Company outsourced many of its core operational processes, including marketing and sales, claims handling, and premium collection, and failed to properly oversee such functions which were performed by agents and TPAs during the examination period.	22

Item	Description	Page No(s).
I	The Company's business model of almost exclusively relying on TPAs for the production and administrative handling of the majority of its product lines places a heavy burden on its management, including its board of directors, to ensure that appropriate policies are established and adequate controls are in place and operating effectively in order to safeguard the Company's assets and ensure compliance with all Department rules and regulations, including assurances that its policyholders are treated fairly and reasonably. However, as noted throughout this report, the appropriate level of due diligence on the part of management and the board of directors was notably absent both during and subsequent to the examination period.	25
J	The Company violated Section 310(a)(2) and (3) of the New York Insurance Law by not providing convenient access to the books, records, files, and other documents which were relevant to the examination, and by not facilitating the examination in a timely manner.	35
K	The examiner recommends that the Company establish procedures to obtain, on a monthly basis, the policy level detail supporting the amount of premiums collected by its TPAs and to verify the accuracy and completeness of the premium receipts reported by its TPAs and MGAs by conducting regularly scheduled premium audits.	35
L	The Company violated Section 91.4(a)(1), (2)(i) and (ii), and (3) of Department Regulation No. 33 by not maintaining records with sufficient detail to show the system actually used for allocation of expenses and the actual bases of allocation.	37
M	The examiner recommends that the Company develop a suitable method of allocation for expenses that is compliant with Department Regulation No. 33, and have the records supporting such method readily accessible for examination.	37
N	The examiner recommends that the Company exercise greater care in the compilation of its data for reporting purposes and comply with the annual statement instructions in preparing its filed annual statements. This is a repeat recommendation from the prior report on examination.	38
O	The examiner recommends that the Company adhere to the agreed upon procedures to segregate checks which remain outstanding for more than six months. This is a repeat recommendation from the prior report on examination.	38
P	The examiner recommends that the Company escheat abandoned property to the New York State Comptroller as required. The prior report on examination contained a similar recommendation.	38

Item	Description	Page No(s).
Q	The examiner recommends that the Company publish notices of unclaimed funds in accordance with the New York Abandoned Property Law. The prior report on examination contained a similar recommendation.	39
R	The Company violated Section 243.2(b)(4) of Department Regulation No. 152 by failing to maintain claim files in a manner that would permit the examiner to reconstruct all events relating to a claim. A similar violation was cited in the prior report on examination.	40
S	The Company violated Section 216.11 of Department Regulation No. 64 by failing to maintain all events relating to each claim so that the claim could be reconstructed by the examiners.	41
T	The Company violated Section 243.2(b)(4) of Department Regulation No. 152 by failing to maintain sufficient documentation to readily determine which claims were processed using the URC charges and the year specific methodology that was used to determine the URC charges for each year of the examination period.	41
U	The Company violated Section 243.2(b)(1)(ii) of Department Regulation No. 152 by not maintaining enrollment forms and/or policy application forms. A similar violation was cited in the prior report on examination.	41
V	The Company violated Section 243.2(b)(1)(iii) of Department Regulation No. 152 by not maintaining policy records. This is a repeat violation from the prior report on examination.	42
W	The examiner recommends that the Company comply with its external auditor's recommendation and restrict access to its computer server room to information technology ("IT") personnel and upper management to ensure a more secure environment for its IT resources.	42
X	The examiner recommends that the Company formally document, in writing, its initial review of disaster recovery plans for each of its TPAs/MGAs, and implement procedures to annually obtain, review and document the results of the disaster recovery test for each of its TPAs/MGAs. Such reviews and documentation would help to mitigate the possibility that changes made by those entities to their respective disaster recovery plans and IT systems would not negatively impact the Company's operations and or the security of its electronic records	43

Item	Description	Page No(s).
Y	The Company violated Section 215.2(b) of Department Regulation No. 34 by failing to establish a system of control over the content, form, and method of dissemination of all advertisements of its policies. This is a repeat violation from the prior report on examination.	45
Z	The Company violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain at its home office a complete file containing a specimen copy of every printed, published, or prepared advertisement disseminated in this or any other state with a notation indicating the manner and extent of distribution, the form number of any policy advertised and the approvals for the advertisements. This is a repeat violation from the prior report on examination.	45
AA	The Company violated Section 3201(b)(1) of the New York Insurance Law by issuing a policy form that had not been filed with and approved by the Department.	46
AB	The examiner recommends that the Company ensure that all new policies are issued with the filed and approved page three of the policy form.	46
AC	The Company violated Section 3201(b)(1) of the New York Insurance Law by issuing a policy form for its individual disability income business that provided benefits amounts in excess of the filed benefits approved by the Department as well as charging premiums in excess of the approved rates.	47
AD	The examiner recommends that the Company determine the excess premiums that were charged to its policyholders to support the additional benefits provided and refund those excess premiums.	47
AE	The Company violated Section 3201(b)(1) of the New York Insurance Law by issuing a certificate/policy form for its vision business that had been altered from the approved certificate/policy form and included benefits and co-payments in excess of the benefits and co-payments filed with and approved by the Department.	48
AF	The examiner recommends that the Company reimburse affected policyholders for the co-payments charged in excess of the approved amounts.	48
AG	The examiner further recommends that the Company obtain the monthly policy level detail and verify the number of insureds as reported by its TPA, Block Vision. The Company should also perform scheduled audits of the TPA to ensure that the information provided is accurate.	48

Item	Description	Page No(s).
AR	The Company violated Section 86.4(e) of Department Regulation No. 95 by not submitting the alternate fraud warning language used on its claims forms to the Insurance Frauds Bureau for approval prior to use.	55
AS	The examiner recommends that the Company either use the required fraud warning statement on its claims forms, or submit its alternate fraud warning statement to the Insurance Frauds Bureau for approval prior to its use.	55
AT	The Company violated Section 420.5(a)(1) of Department Regulation No. 169 by not providing annual privacy notices to its customers that accurately reflected its privacy policies and practices during the continuation of the customer relationship for any of its lines of business during and subsequent to the examination period.	56
AU	The examiner recommends that the Company provide a clear and conspicuous notice to its customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship as required by Section 420.5(a)(1) of Department Regulation No. 169.	56
AV	The examiner recommends that the Company develop and implement procedures to significantly enhance its operational environment to gain control over the methods used by its TPAs to market and administer the Company's products. Such procedures should be submitted to the Department for review and comment.	56
AW	The examiner further recommends that any TPA reluctant to abide with the new procedures, upon turning over all records associated with the business they handled for the Company, be terminated immediately.	57

Respectfully submitted,

/s/
Anthony Chiarel
Senior Insurance Examiner

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

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

/s/
Anthony Chiarel

Subscribed and sworn to before me

this_____ day of _____

APPOINTMENT NO. 30721

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:

ANTHONY CHIAREL

as a proper person to examine into the affairs of the

AMERICAN MEDICAL AND LIFE INSURANCE COMPANY

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

COMPANY

with such other information as he shall deem requisite.

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

this 31st day of May, 2011

JAMES J. WRYNN
Superintendent of Insurance

Superintendent