NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

REPORT ON MARKET CONDUCT EXAMINATION

OF

THE FIRST REHABILITATION LIFE INSURANCE COMPANY

OF AMERICA

CONDITION: DECEMBER 31, 2009

DATE OF REPORT: MAY 5, 2011

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

REPORT ON MARKET CONDUCT EXAMINATION

OF

THE FIRST REHABILITATION LIFE INSURANCE COMPANY

OF AMERICA

AS OF

DECEMBER 31, 2009

DATE OF REPORT: MAY 5, 2011

EXAMINER: MARK MCLEOD

TABLE OF CONTENTS

October 20, 2011

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

Sir:

In accordance with instructions contained in Appointment No. 30730, dated June 16, 2011 and annexed hereto, an examination has been made into the condition and affairs of The First Rehabilitation Life Insurance Company of America, hereinafter referred to as "the Company," at its home office located at 600 Northern Boulevard, Great Neck, New York, 11021.

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 violations contained in this report are summarized below.

- The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms that have not been filed with and approved by the superintendent. (See item 4B of this report)
- The Company violated Section 52.18(e)(2) of Department Regulation No. 62 by issuing a family policy that failed to provide coverage to stepchildren and adopted children dependent upon the insured on the same basis as natural children. (See item 4B of this report)
- The Company violated Section 3221(a)(14) of the New York Insurance Law by limiting the amount of time for bringing legal action against the Company to 12 months from the date of determination or 24 months from the date of service and by failing to inform the insured that no action in law or equity shall be brought after the expiration of two years following the time such proof of loss is required by the policy. (See item 4B of this report)

2. SCOPE OF EXAMINATION

The examination covers the period from January 1, 2007 through December 31, 2009. As necessary, the examiner reviewed matters occurring subsequent to December 31, 2009, but prior to the date of this report (i.e., the completion date of the examination).

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

The examiner reviewed the corrective actions taken by the Company with respect to the market conduct recommendation contained in the prior report on examination. The results of the examiner's review are contained in item 6 of this report.

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

3. DESCRIPTION OF COMPANY

A. History

The Company was incorporated in New York as a stock insurance company under the name of The First Rehabilitation Insurance Company of America on August 12, 1971. The Company was licensed on August 8, 1972 to write accident and health insurance as specified in paragraph 3 of Section 1113(a) of the New York Insurance Law and commenced business on November 1, 1972. In January 1997, the Company amended its charter to include the writing of life insurance and annuities as specified in paragraphs 1 and 2 of Section 1113(a) of the New York Insurance Law. The name of the Company was changed to The First Rehabilitation Life Insurance Company of America effective January 1, 1997. As of December 31, 2009, the Company had 20,000 shares of common stock outstanding and capital and paid in and contributed surplus of $2,000,000 and $6,006,228, respectively.

B. Territory and Plan of Operation

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

The Company is licensed to transact business in 15 states and the District of Columbia. In 2009, 94% of accident and health premiums and 93% of life premiums were received from New York. Policies are written on a non-participating basis.

The Company's primary product is the New York State Statutory Disability Benefit ("DBL"). The Company also offers group term life and group accident and health coverage including: long term disability, two excess major medical policies (an excess group major medical policy (XGMM) and an excess group medical reimbursement policy (GMRP)), stop loss, dental and vision plans. All policies are written on a group basis

The Company stopped accepting applications for its GMRP business in March 2010 and plans to exit the GMRP business in 2011.

4. MARKET CONDUCT ACTIVITIES

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

A. Advertising and Sales Activities

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

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

B. Underwriting and Policy Forms

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

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. . . ."

Section 3221 of the New York Insurance Law states, in part:

> "(a) No policy of group or blanket accident and health insurance shall, except as provided in subsection (d) hereof, be delivered or issued for delivery in this state unless it contains in substance the following provisions or provisions which in the opinion of the superintendent are more favorable to the holders of such certificates or not less favorable to the holders of such certificates and more favorable to policyholders, provided however, that the provisions set forth in paragraphs six and thirteen of this subsection shall not be applicable to any such policy which is issued to a policyholder in accordance with subparagraph (E) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter . . .
> (14) That no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy. . . ."

Section 52.18(e)(2) of Department Regulation No. 62 states:

> "A family policy shall provide that adopted children and stepchildren dependent upon the insured be eligible for coverage on the same basis as natural children."

The Group Vision Policy Form (GV P 10/05) and Group Vision Certificate Policy Form (GV C 10/05) used by the Company to issue group vision policies during the examination period differed from the respective policy forms approved by the Department. The changes limited certain benefits of the certificateholder**.**

On Group Vision Policy Form (GV P 10/05) the Company added the following sentence to SECTION IX - STANDARD PROVISIONS on page 11 of the policy form, under "Legal Actions,"

> "Once a determination has been made, the insured has 12 months from the date of determination or 24 months from the date of service to bring a legal action against the Company."

The added language limits the amount of time for bringing legal action against the Company to 12 months from the date of determination or 24 months from the date of service instead of 24 months from the date that the proof of loss is required by the policy.

On Group Vision Certificate Policy Form (GV C 10/05) the Company added the following language to SECTION I – DEFINITIONS on page 3 of the certificate, under "Child", the words "living with the insured" were added to item 4, causing the sentence to read, "a stepchild of the insured living with the insured." The words "who resides with" were added to item 6, causing the to sentence read "any individual who is under testamentary or court-appointed guardianship of the insured, other than temporary guardianship of less than 12 months duration, who resides with and is a dependent of the insured."

These alterations place limitations on the benefits provided to stepchildren and adopted children under the group vision policy by requiring a stepchild or adopted child to live with the insured.

. In addition, the Company omitted the following sentence which complies with Section 3221(a)(14) of the New York listed above from SECTION IX - STANDARD

PROVISIONS on page 11 of the certificate, under “Legal Actions”, "No legal action may be brought by an insured under this policy after the expiration of 2 years following the time such proof of loss is required by the policy."

This language should be included in order to inform the insured of the two year limitation for taking legal action against the Company.

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

The Company violated Section 52.18(e)(2) of Department Regulation No. 62 by issuing a family policy that failed to provide coverage to stepchildren and adopted children dependent upon the insured on the same basis as natural children.

The Company violated Section 3221(a)(14) of the New York Insurance Law by limiting the amount of time for bringing legal action against the Company to 12 months from the date of determination or 24 months from the date of service and by failing to inform the insured that no action in law or equity shall be brought after the expiration of two years following the time such proof of loss is required by the policy.

It is noted that the Company filed a new vision policy form with the superintendent, which was approved, replacing Group Vision Policy Form (GV P 10/05).

It is also noted that, the examiner did not identify any cases where a vision claim was denied because a claimant was a stepchild or adopted child that did not live with the insured.

It is further noted that the examiner did not identify any cases where a legal action on a vision claim was denied because the legal action was brought more than 12 months after the date of determination or 24 months from the date of service.

2) The Company’s group statutory disability policy (“DBL”) applications, for groups with less than 50 lives, are submitted on-line, usually by the broker. The Company sends the completed application to the policyholder and requests that the application be signed and returned to the Company. A signed copy of the application was not located in 38 of the 69 (55%) group DBL application files reviewed by the examiner.

The examiner recommends that the Company obtain a signature for all completed DBL applications.

C. Treatment of Policyholders

The examiner reviewed a sample of various types of claims, 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.

The Office of General Counsel opinion dated January 4, 2002 advises:

> "An insurer may charge late payment fees, reinstatement fees, and premium installment fees provided that the insured was made aware of these fees prior to being charged such. These service fees, and any consequences an insured would experience for failure to pay such fees, must be clearly stated to the insured (i.e., by including this information in the insurance policy form or in the billing statement). To preclude discrimination, the amounts and condition of these service fees must be applied equally to all insureds of the same class that are subject to the fees. In addition, the service fee charged must be reasonable."

The Company's DBL Annual Premium Report past due notice states the following:

> "To avoid late fees and possible lapse in coverage, please remit payment by due date above. If your payment is not received by the end of our grace period, a late charge will be added."

The examination review revealed that the Company charges a $35 administration fee to insureds that pay their premiums late; those premiums remitted after the mandatory 10-day cancellation notice is mailed to the insured. While the Company's DBL premium notice indicates that a late fee will be charged, it does not state the amount of the late fee or when the late fee will be charged. Further, the Company's Client Services Internal Audit Report states that there are cases when the DBL late fee is waived. For example, if the broker calls and requests that late fees be waived, although the Company attests that waivers are considered on a case-by-case basis, the Internal Audit report indicated that such fees are generally waived. The examiner attempted to gain an understanding of the process employed by the Company when waiving a late charge. However, during the examination period, there were no written procedures in place to ensure that determinations regarding the fee waivers were relevant or consistently applied.

Furthermore, as the Company failed to maintain records documenting the specific instances when late fees were waived, the examiner was unable to determine if certain insureds were granted the fee waiver in more instances than others.

Subsequent to the examination date, but prior to the date of this report, the Company developed specific criteria for the waiving of late fees to ensure that fee waivers would be granted in a systematic manner.

The examiner recommends that the Company clearly notify the insured of the actual late fee to be charged and when such fee will inure to the policy, preferably by including this information in the policy form or the premium notice.

The examiner also recommends that the Company take proactive steps to monitor late fee waivers to ensure that they are in compliance with established policies and do not unfairly favor any insured over another. Such monitoring should include the maintenance and regular review of documentation identifying the name of the insured and number of instances a fee waiver is requested and the reason such waiver was granted or denied.

5. DATA FILES

The Company was unable to reconcile the number of policies reported in the Accident and Health Exhibit in the Company's filed annual statements for examination period, to the data files provided to examiners to support those numbers.

The Company does not have a standard report which identifies the number of policies issued each month. As a result, in order to determine the number of issued policies listed in the Annual Statement the Company runs a query of polices in-force at the end of the year. The number of policies issued is the difference between the beginning and ending balances, less cancellations.

The examiner recommends that the Company implement procedures to maintain data files that reconcile to the number of issued policies reported in its filed annual statement.

6. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following is the market conduct recommendation contained in the prior report on examination and the subsequent action taken by the Company in response to the citation:

Item	Description
A	The examiner recommends that the Company comply with Section 216.4(e) of Department Regulation No. 64 and maintain a log of all consumer complaints including those that the Company receives directly from policyholders. The Company now maintains a log of all consumer complaints including those that the Company receives directly from policyholders.

7. SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in this report:

Item	Description	Page No(s).
A	The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms that have not been filed with and approved by the superintendent.	7
B	The Company violated Section 52.18(e)(2) of Department Regulation No. 62 by issuing a family policy that failed to provide coverage to stepchildren and adopted children dependent upon the insured on the same basis as natural children.	7
C	The Company violated Section 3221(a)(14) of the New York Insurance Law by limiting the amount of time for bringing legal action against the Company to 12 months from the date of determination or 24 months from the date of service and by failing to inform the insured that no action in law or equity shall be brought after the expiration of two years following the time such proof of loss is required by the policy.	7
D	The examiner recommends that the Company obtain a signature for all completed DBL applications.	7
E	The examiner recommends that the Company clearly notify the insured of the actual late fee to be charged and when such fee will inure to the policy, preferably by including this information in the policy form or the premium notice.	9
F	The examiner also recommends that the Company take proactive steps to monitor late fee waivers to ensure that they are in compliance with established policies and do not unfairly favor any insured over another. Such monitoring should include the maintenance and regular review of documentation identifying the name of the insured and number of instances a fee waiver is requested and the reason such waiver was granted or denied.	9
G	The examiner recommends that the Company implement procedures to maintain data files that reconcile to the number of issued policies reported in its filed annual statement.	10

Respectfully submitted,

/s/
Mark McLeod
Associate Insurance Examiner

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

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

/s/
Mark McLeod

Subscribed and sworn to before me

this_____ day of _____

APPOINTMENT NO. 30730

STATE OF NEW YORK

INSURANCE DEPARTMENT

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

MARK MCLEOD

as a proper person to examine into the affairs of the

FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA

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

COMPANY

with such other information as he shall deem requisite.

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

this 16th day of June, 2011

JAMES J. WRYNN
Superintendent of Insurance

Superintendent