



NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES
MARKET CONDUCT REPORT ON EXAMINATION
OF THE
CIGNA LIFE INSURANCE COMPANY OF NEW YORK

CONDITION:

DECEMBER 31, 2013

DATE OF REPORT:

MAY 28, 2015

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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EXAMINER:

FLORA EGBUCHULAM

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

September 21, 2018

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

Madam:

In accordance with instructions contained in Appointment No. 31095, dated September 29, 2014, and annexed hereto, an examination has been made into the condition and affairs of Cigna Life Insurance Company of New York, hereinafter referred to as “the Company,” at its office located at 1601 Chestnut Street, Philadelphia, PA 19102. The Company’s home office is located at 140 East 45th Street, New York, NY 10017, but most functions are performed in Philadelphia, Pennsylvania.

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

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

1. EXECUTIVE SUMMARY

The material violations contained in this report are summarized below.

- The Company violated Section 310(a) of New York Insurance Law when it failed to facilitate the examination by making records and documents readily available and accessible to the examiner. (See item 5 of this report)
- The Company violated Section 3214(c) of the New York Insurance Law by failing to pay sufficient interest on death claims proceeds from the date of death to date of payment. (See item 4 of this report)
- The Company violated Section 226.3(a) of 11 NYCRR 226 (Insurance Regulation 200) by failing to conduct a multiple policy search for the insured or account holder for every policy or account to determine whether the insurer has any other policies or accounts for the deceased insured or account holder. (See item 4 of this report)
- The Company violated Section 216.4(e) of 11 NYCRR 216 (Insurance Regulation 64) by failing to register and monitor all the complaints that are logged against the Company. (See item 4 of this report)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2009, through December 31, 2013. As necessary, the examiner reviewed matters occurring subsequent to December 31, 2013, 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 Regulations Handbook* or such other examination procedures, as deemed appropriate, in such review.

The examiner reviewed the corrective actions taken by the Company with respect to the market conduct violations and recommendations contained in the prior report on examination. The results of the examiner's review are contained in item 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 as a stock life insurance company under the laws of the State of New York on June 29, 1965, was licensed and commenced business on December 28, 1965. In 1973, ownership of the Company was transferred from Life Insurance Company of North America to Insurance Company of North America (“INA”). In March of 1977, INA Financial Corporation, a wholly owned subsidiary of INA Corporation, purchased the Company from INA for cash and marketable securities valued at \$12,369,849.

On April 1, 1982, INA Corporation merged with Connecticut General Corporation. At that time, the resulting merged organization ranked as the second largest publicly-held insurance group in the United States. The new holding company was named CIGNA Corporation (“CIGNA”). On July 19, 1999, the Company changed its name from INA Life Insurance Company of New York to CIGNA Life Insurance Company of New York.

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 New York Insurance Law.

The Company is licensed to transact business in five states, namely Alabama, Missouri, New York, Pennsylvania and Tennessee, and in the District of Columbia. In 2013, 100% of life premiums and 99% of accident and health premiums were received from New York. Policies are written on a non-participating basis.

All premiums were generated from group term life, group long-term disability and group short-term disability products. The group long-term disability product provides a monetary benefit to active full-time employees who suffer a covered disability while insured under the plan. The plan covers disabling injuries or sickness that last beyond the benefit waiting period, whether they occur on or off the job. The group short-term disability plan provides a monetary benefit to active full-time employees who suffer a covered disability while insured under the plan, or suffer disabling injuries or sicknesses that are sustained off the job.

The Company’s agency operations are conducted on a general agency and branch office direct response basis. Internal sales representatives distribute the Company’s products through

independent agents, brokers and consultants, and through a limited number of general agents without underwriting authority. The Company has one sales office in New York State, with eight sales representatives and two sales managers.

4. MARKET CONDUCT ACTIVITIES

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

A. Advertising and Sales Activities

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

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

“To appoint a producer, the appointing insurer shall file, in a format approved by the superintendent, a notice of appointment within fifteen days from the date the agency contract is executed. . . .”

The Company failed to provide the appointment notices sent to the Superintendent, or failed to provide other documents showing that the Superintendent was notified about the appointment of the 25 agents that were sampled for review.

The Company violated Section 2112(b) of the New York Insurance Law for failing to notify the Superintendent, or for failing to provide evidence to substantiate that it notified the Superintendent about the appointment of 25 producers.

B. Underwriting and Policy Forms

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

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.

1) Complaints

Section 216.4(e) of 11 NYCRR 216 (Insurance Regulation 64) states:

“As part of its complaint handling function, an insurer's consumer services department shall maintain an ongoing central log to register and monitor all complaint activity.”

The examiner compared the Company's Complaint Log to the Department's Complaint Log and noted that the Company's log contained six fewer complaints than the Department's log. The examiner then asked the Company for a revised complaint log that includes all complaints and inquiries for all lines of business, including long-term disability. The revised log and additional information provided to the examiner indicated that the six complaints occurred during the examination period but were not recorded by the Company, which indicates that the Company is not registering all complaints and/or monitoring all complaint activities as required by Section 216.4(e) of Insurance Regulation No. 64.

The Company violated Section 216.4(e) of 11 NYCRR 216 (Insurance Regulation 64) by failing to register and monitor all the complaints that are logged against the Company.

2) Claims - Retained Asset Account

Insurance Circular Letter No. 4 (2012) advises, in part:

“ . . . Where a life insurance policy or certificate is delivered or issued for delivery in New York prior to April 1, 2012 and only provides that payment will be made in a lump sum, a single sum, or its equivalent, an insurer should pay the full life insurance proceeds in the form of a single check to a beneficiary of a New York policy or to a New York beneficiary, unless there has been an affirmative election of another settlement option, including an RAA. . . .

. . . Where payment of life insurance proceeds may be made by settlement options other than a single check, an insurer should not place the proceeds of the policy or certificate in a settlement option, including an RAA, unless there has been an affirmative election of the settlement option. . . .

. . . In no event should the insurer establish an RAA unless there has been an affirmative election authorizing the insurer to do so. . . .

When an RAA is an option, in order to avoid any potential for misleading the beneficiary of a New York policy or a New York beneficiary, an insurer should, as of April 1, 2012, provide certain written disclosures to a beneficiary no later than the time when an option must be elected. The disclosures should be set forth in a clear and conspicuous manner. At a minimum, these disclosures should include:

- In addition to an option to establish an RAA, a list of other available options from which the beneficiary may choose. Unless the policy provides for

payment of the life insurance proceeds only in installments, one option should be for payment by a single check for the full proceeds. The option to receive the full life insurance proceeds as a single check should be offered as prominently as all other listed available options. . . .

- Services provided by the bank or other institution to an RAA holder and the fees associated with such services, including any costs or fees associated with the RAA. . . .”

The examiner’s review of the Company’s Retained Asset Account (“RAA”) program, namely the CIGNAssurance Program, and the examiner’s review of claim records revealed that death and accidental death and dismemberment proceeds of more than \$5,000 are automatically deposited into an RAA called CIGNAssurance Account. Claimants are then required to sign on the claim form that if they want a lump sum payment, they would then write a draft for the total balance in the CIGNAssurance Account. Based on the examiner’s review of the Company’s records and based on information obtained during discussions with management about CIGNAssurance Account, the examiner determined that no other payment option is disclosed in the claim forms, and that claimants are not given an option for a lump sum payment at the time a loss is reported.

The examiner recommends that the Company establish an RAA only upon the affirmative election by the beneficiary as prescribed by Circular Letter No. 4 (2012).

Furthermore, the CIGNAssurance Account operates in a similar vein as a checking account with potential checking account charges such as stop-payment fees, overdraft fees, and statement copy fees. The examiner noted that these fees are not disclosed to claimants at the time they sign up for the CIGNAssurance Account; the disclosures are provided with the claim payment letter, after the claimant had already signed up for the CIGNAssurance payment option. Such charges should be fully disclosed to claimants at the same time they sign up for the RAA.

The examiner recommends that an asterisk be affixed next to the check-off box where the claimant must sign for the CIGNAssurance Account to direct his or her attention to read the account’s features and charges explained in the CIGNAssurance Program Disclosure Notice before making his or her selection.

3) Claims - Interest on Death Claims for Non-Resident Beneficiaries

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

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

In 4 out of 10 (40%) group life paid claims reviewed, the Company did not pay sufficient interest on death proceeds, as interest was not paid from date of death to date of payment. The four policies refer to six non-resident beneficiaries. OGC Opinion No. 87-30 provides that “the residence of the beneficiary, in and of itself, has no bearing on the obligation to pay interest under Section 3214.” It also provides that “there is no exception in the statute that allows non-payment of interest to the beneficiary of a group life insurance policy delivered in New York to the policyholder simply because the beneficiary of that policy is a non-resident.” Therefore, interest on death claim proceeds for policies issued in New York is payable to beneficiaries pursuant to Section 3214(c) of the New York Insurance Law, regardless of their state of residence.

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

4) Claim Forms

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

“All applications for commercial insurance, individual, group or blanket accident and health insurance and all claim forms, except as provided for in subsection (e) of this section, shall contain a notice in a form approved by the superintendent that clearly states in substance the following:

‘Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.’”

In four out of ten (40%) short term disability denied claims reviewed, the Company’s short-term disability claim forms did not contain the required New York fraud warning statement.

The Company violated Section 403(d) of the New York Insurance Law by failing to include the required fraud warning statement in its short-term disability claim forms.

5) Policy Cross-Checks

Section 226.3(a) of 11 NYCRR 226 (Insurance Regulation 200) states:

“Upon receiving notification of the death of an insured or account holder or in the event of a match made by a death index cross-check pursuant to section 226.4 of this Part, an insurer shall search every policy or account...to determine whether the insurer has any other policies or accounts for the insured or account holder.”

In 6 out of 10 (60.0%) policy cross-checks reviewed, the Company failed to conduct a multiple policy search for a deceased insured or account holder for every policy or account to determine whether the insurer has any other policies or accounts for the deceased insured or account holder.

The Company violated Section 226.3(a) of 11 NYCRR 226 (Insurance Regulation 200) by failing to conduct a multiple policy search for the deceased insured or account holder for every policy or account to determine whether the insurer has any other policies or accounts for the deceased insured or account holder.

6) Disclosure Authorization in Claim Forms

The examiner reviewed the Company’s responses to examination’s requests related to the disclosure authorization in claim forms along with the claim form denoted as “LM613500 Group Association Proof of Loss LAD – pop.pdf.”

The second paragraph in page 4 of the claim form packet states:

“I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Insured’s agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of the deceased to give the Company or their employees and authorized agents, or authorized representatives, any information or records that they have concerning the deceased’s occupation, activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.”

The above paragraph requests that the claimant authorizes financial institutions, family members, friends, neighbors, and the Social Security Administration, among other parties, to provide information or records about the deceased insured's occupation, activities, prior claim files and claim history, work history and work-related activities to the Company. The Company indicated that this language is necessary to determine if benefits for group life and/or accidental death are payable. Generally, a claimant need only provide proof of death when filing a claim (for instance, a copy of the death certificate to the insurer). While the Department understands that in some instances a life insurance death claim or an accidental death benefit claim may require additional information, the language in this authorization is overly broad and is requesting information that the claimant may have no legal standing to authorize release of from a third party. For example, if the claimant is not related to the deceased insured, their authorization for release of information about the deceased from the Social Security Administration or a financial institution would be unlikely. Similarly, a claimant cannot authorize friends, neighbors or family members of the deceased insured to provide information to the Company. Accordingly, it would be unfair and potentially misleading to utilize such language in the authorization form.

The examiner recommends that the Company remove the language in the second paragraph in page four of the claim form that does not conform to the Department's observation referenced above.

On May 5, 2015, upon discussion with the examiner regarding the language of the disclosure authorization in the claim form, the Company provided a proposed revision to the fourth paragraph in page 4 of the claim form, as referenced below.

"I understand that I can refuse to sign this disclosure authorization; however, if I do so, the Company may delay my claim for benefits. I also understand that the Company may not need this form while reviewing my claim. If the disclosure authorization is needed and I haven't signed it in advance, then the Company may request that I sign it at a later date; this may delay my claim. If I continue to refuse to sign this disclosure authorization, the Company may not be able to approve my claim until the necessary information is obtained to support approval of my claim."

The Department determined the Company's proposed revision to this section of the claim form acceptable.

The examiner recommends that the Company use the above proposed language in all claim forms in which the Company had used the previous language in the fourth paragraph of page four of the claim form.

The examiner further recommends that the Company adhere to the above proposed revision in all instances wherein the Company uses disclosure authorization language in its claim forms.

5. FACILITATION OF EXAMINATION PROCESS AND CORPORATE RECORDS

A. Non-Facilitation of Examination Process

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 affiliated or subsidiary companies thereof, which are relevant to the examination, and shall have power to administer oaths and to examine under oath any officer or agent of such insurer or other person, and any other person having custody or control of such documents, regarding any matter 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.”

Section 243.2(e) of 11 NYCRR 243 (Insurance Regulation 152) states, in part:

“The records shall be readily available and easily accessible to the superintendent in accordance with Insurance Law, Section 310. . . . Upon request of the superintendent, the insurer shall provide a hard copy of the record, or, if the record is maintained in a medium which is used by the superintendent, the insurer may provide the record in that medium. Failure to produce and provide a record within a reasonable time frame shall be deemed a violation of Insurance Law, Section 308 unless the insurer can demonstrate that there is a reasonable justification for that delay.”

The Pre-Examination Letter (“PEL”) was sent to the Company on December 16, 2013, and received by the Company on December 20, 2013. Per the PEL, the normal turnaround time is 30 days from the company’s receipt of the letter, as it contains requests for items that are required for planning the examination, the most important of which are the data files that must be reviewed and validated before market conduct examination samples can be taken.

The Company was first granted an extension to respond to the PEL after the filing of the annual statement on March 1, 2014. On March 7, 2014, the Company again requested and was granted an extension until April 1, 2014, to provide the responses. Four additional extensions were granted between April and September of 2014.

On September 8, 2014, the Market Conduct field work commenced on-site in Philadelphia, Pennsylvania and the examiner was advised that the Company would not be able to provide the data files as promised. Subsequently, the examiner met at various times with the Company’s staff

to answer questions, clarify issues and address any concerns the Company had about the PEL. At each meeting, the examiner continued to highly stress the need to have the data files available for review, validation, and sampling; and at the meetings and via other communications, the Company provided varying estimated dates of delivery. The examiner made reasonable efforts to work with the Company and to accommodate those delivery dates by granting the extensions whenever the Company requested them.

However, on October 21, 2014, the Company advised the examiner that the remaining PEL files would not be provided until the middle or the last week in November 2014, making it an 11-month turnaround and clearly indicating that the records are not being generated and retained regularly as they should by statutes, rules, and regulations, and as common business standards or practices. As previously noted, the market conduct examination procedures depend greatly on the validation and sampling of the various data files. The 11-month turnaround significantly impeded the examination progress and did not facilitate the examination process.

The Company violated Section 310(a) of New York Insurance Law by failing to facilitate the examination by making records and documents readily available and accessible to the examiner.

6. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following are the market conduct violation and comment contained in the prior report on examination and the subsequent actions taken by the Company in response to each citation:

<u>Item</u>	<u>Description</u>
A	<p>The Company violated Section 216.6(a) of Department Regulation No. 64 by failing to pay death claims according to the policy provisions.</p> <p>The Company acknowledged, during the examination, that it had inadvertently issued the incorrect payments and noted that it had relied on schedule information provided by the university. On August 26, 2009, the Company corrected the underpayments by issuing additional payments to the affected beneficiaries.</p>
B	<p>The Company is directed to provide the Department with a complete and accurate inventory of disability claims denied during the period January 1, 2006 through December 31, 2009. The inventory is to be provided within 90 days after the filing of this report on examination. The Department will perform a targeted examination of denied disability claims after it reviews the inventory provided by the Company.</p> <p>The Company responded to the Department's request for denied disability claim files and provided all files requested by early January 2011. The Company did not receive any further communication from the Department.</p>

7. SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in this report:

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
A	The Company violated Section 2112(b) of the New York Insurance Law for failing to notify the Superintendent or for failing to provide evidence to substantiate that it notified the Superintendent about the appointment of 25 producers.	6
B	The Company violated Section 216.4(e) of 11 NYCRR (Insurance Regulation 64) by failing to register and monitor all the complaints that are logged against the Company.	7
C	The examiner recommends that the Company establish an RAA only upon the affirmative election by the beneficiary as prescribed by Circular Letter No. 4 (2012).	8
D	The examiner recommends that an asterisk be affixed next to the check-off box where the claimant must sign for the CIGNAssurance Account to direct his or her attention to read the account's features and charges explained in the CIGNAssurance Program Disclosure Notice before making his or her selection.	8
E	The Company violated Section 3214(c) of the New York Insurance Law by failing to pay sufficient interest on death claims proceeds from the date of death to date of payment.	9
F	The Company violated Section 403(d) of the New York Insurance Law by failing to include the required fraud warning statement in its short-term disability claim forms.	10
G	The Company violated Section 226.3(a) of NYCRR 11 (Insurance Regulation 200) by failing to conduct a multiple policy search for the insured or account holder for every policy or account to determine whether the insurer has any other policies or accounts for the deceased insured or account holder.	10
H	The examiner recommends that the Company remove the language in the second paragraph in page 4 of the claim form that does not conform to the Department's observation on pages 14 and 15.	11

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
I	The examiner recommends that the Company use the proposed language on page 11 in all claim forms in which the Company had used the previous language in the fourth paragraph of page 4 of the claim form.	12
J	The examiner further recommends that the Company adhere to the above proposed revision on page 11 in all instances wherein the Company uses disclosure authorization language in its claim forms.	13
L	The Company violated Section 310(a) of the New York Insurance Law by failing to facilitate the examination by making records and documents readily available and accessible to the examiner.	16

Respectfully submitted,

_____/s/
Flora Egbuchulam
Senior Insurance Examiner

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

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

_____/s/
Flora Egbuchulam

Subscribed and sworn to before me
this _____ day of _____

APPOINTMENT NO. 31095

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, BENJAMIN M. LAWSKY, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

FLORA EGBUCHULAM

as a proper person to examine the affairs of the

CIGNA LIFE INSURANCE COMPANY OF NEW YORK

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

COMPANY

with such other information as she shall deem requisite.

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

this 29th day of September, 2014

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By:



MICHAEL MAFFEI
ASSISTANT DEPUTY SUPERINTENDENT
AND CHIEF OF THE LIFE BUREAU

