

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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In the Matter of

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY,

Respondent.

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CONSENT ORDER

WHEREAS, the New York State Department of Financial Services (“DFS” or “Department”) commenced examinations pursuant to the New York State Insurance Law of Unity Mutual Life Insurance Company (“Unity”) and Columbian Mutual Life Insurance Company (“Columbian” or “Respondent”) (“Examinations”);

WHEREAS, subsequent to the Examinations, the Department commenced an investigation (“Investigation”) pursuant to Insurance Law Section 308 concerning Unity and Columbian’s contestable claim practices for the period of January 1, 2006, through December 31, 2015 (the “Relevant Period”);

WHEREAS, from 2006 through 2011, Unity marketed and sold small face value simplified issue life insurance policies to low- and middle-income consumers in New York and other states for funeral, burial, and other final expenses;

WHEREAS, from 2006 through 2015, Columbian marketed and sold small face value simplified issue life insurance policies to low- and middle-income consumers in New York and other states for funeral, burial, and other final expenses, as well as other types of small face amount life insurance policies with limited underwriting;

WHEREAS, the Department concluded that Unity and Columbian improperly denied coverage and unilaterally rescinded policies when policyholders died within the two-year contestable period without proving in an action a misrepresentation by the policyholder on the application for insurance as required by the Insurance Law;

WHEREAS, the Department further concluded that Unity and Columbian engaged in unfair claims settlement practices in violation of the New York Insurance Law by improperly misrepresenting facts and policy provisions relating to coverage and not attempting in good faith to effectuate prompt, fair, and equitable settlements of submitted claims in which liability had become reasonably clear;

WHEREAS, the Department further concluded that Unity and Columbian violated Insurance Department Regulations by failing to refer in writing to a specific policy provision, condition, or exclusion in a policy that was the basis for denying a claim, or by not providing a specific reason for disclaiming coverage;

NOW, THEREFORE, the Department and Respondent are willing to resolve the matters cited herein in lieu of proceeding by notice and a hearing.

FINDINGS

The findings of the Examinations and Investigation are as follows:

Relevant entities

1. Unity was organized as a fraternal benefit society in 1903 and commenced business in 1905. It was converted to a mutual life company in 1957 and adopted the name Unity Mutual Life Insurance Company in 1972. Its headquarters were in Syracuse, New York.

2. Columbian was incorporated as a charitable and benevolent association in New York under the name American Protective Association in 1882; in 1883, it obtained its license and

commenced business. In 1952, it converted to a mutual life insurance company and adopted the name Columbian Mutual Life Insurance Company. It is headquartered in Binghamton, New York.

3. On July 1, 2011, Columbian acquired Unity.

Terms

4. For purposes of this Consent Order, the following terms shall have the meanings as set forth herein:

- a. “Final expense product” is a life insurance product with a death benefit intended to cover burial and other expenses associated with bereavement. Final expense products often have little or even no underwriting.
- b. “Contestable period” means the period of two years dating from a policy’s date of issue or from the effective date of certain increases or changes to the policy, after which time a life insurance policy in force during the life of the policyholder becomes incontestable.
- c. “Contestable claim” is a life insurance claim made during the two-year contestable period.

Background

5. Unity marketed its final expense product in New York State from 2003 through 2007 and thereafter from April 2008 until the Columbian acquisition in 2011.

6. Though it offered other products, Unity’s primary product throughout the Relevant Period prior to its merger with Columbian was its final expense product.

7. Columbian is authorized to write life insurance, annuities, and accident and health insurance in New York State. New York State is Columbian's largest market in its life insurance business.

8. Columbian continues to sell final expense products which, in general, provide a death benefit of \$2,500 to \$10,000, as well as other types of small face amount life insurance policies with limited underwriting.

Unity Findings

9. The Department of Insurance¹ conducted a market conduct examination of Unity covering the period of January 1, 2006, through December 31, 2008 (the "Unity Examination").

10. As part of its review, during the Unity Examination the Department evaluated a sample of various types of claims. The Unity Examination also reviewed surrenders, charges, and lapsed policies, including a number of claims that were closed without payment.

11. A review of a sample of claims closed without payment showed that Unity did not advise the individual notifying the company of the policyholder's death or the beneficiary in writing that the claim was being closed without payment or was denied. Unity closed the claim on its claims administration system and no communication was made with the informant or beneficiary.

12. For claims in which the policyholder's death was reported by someone other than a beneficiary, the Unity Examination's review of records found no evidence that Unity personnel made a good faith attempt to locate the beneficiary or beneficiaries, either through a credit reporting agency or other means.

¹ On October 3, 2011, the Insurance Department merged with the Banking Department to create the New York State Department of Financial Services.

13. In 9 out of 29 sample claims reviewed that were closed without payment, the claim was filed within the policy's contestable period.

14. When policyholders died during the contestable period, Unity requested medical records. Unity closed these contestable claims without payment if it did not receive the policyholder's medical records upon demand to the beneficiary. There was no affirmative evidence in the 9 instances that the policyholder made material misrepresentations on the application for insurance, or that there was a breach of policy provisions.

15. In this sample of 9 contestable claims, beneficiaries provided the required proofs of death, including a certified death certificate.

16. The Unity Examination found that it was Unity's practice to close claims without payment if either a death certificate or medical records were not provided.

17. During the period covered by the Unity Examination, Unity did not provide beneficiaries any notice of its decision to close such claims and did not inform beneficiaries of any specific policy provision, condition, or exclusion in the policy that were the grounds of the denial, or cite any specific reason for disclaiming coverage.

18. When Unity closed such claims, although a claim for a death benefit had been made and there was some evidence that the policyholder died, Unity placed the policies back in active status and allowed them to lapse with no value. Naturally, these policies lapsed because the party responsible for premium payments—the policyholder—was deceased.

19. The Department found that Unity also unilaterally rescinded some policies if, after receiving medical records, it concluded that claims filed within the contestable period contained material misrepresentations. These determinations were made by the company only and not by a court in an action to rescind.

Columbian Findings

20. During the Relevant Period, Columbian routinely requested medical records from a deceased policyholder's beneficiary or beneficiaries if the death occurred within the contestable period.

21. If medical records were not produced, Columbian refused to pay the face amount of the policy. Instead, Columbian unilaterally rescinded the deceased's policy, notified the beneficiary or beneficiaries that the policy was rescinded because of the failure to provide medical records as requested, and returned the premiums to the beneficiary or beneficiaries.

22. During the Relevant Period, Columbian also unilaterally rescinded claims when it received medical records and concluded that the deceased made a material misrepresentation. Columbian did not obtain these rescissions through a court action. Upon rescission, Columbian returned the policyholder's premiums to his or her beneficiary or beneficiaries.

New York contestable claims

23. During the Relevant Period, Unity had 60 contestable claims with a face amount totaling \$361,962 in New York State in which the claims were closed without payment or remained pending because Unity did not receive a death certificate or medical records. In 2010 and 2011, Unity returned \$1,872 in premiums to beneficiaries for 6 of these contestable claims.

24. Starting in 2010, Unity also unilaterally rescinded 35 contestable claims with a face amount totaling \$300,620 based on alleged material misrepresentations. During the Relevant Period, Unity returned \$25,465 in premiums to beneficiaries for these claims.

25. During the Relevant Period, Columbian had 123 contestable claims in New York State with a face value totaling \$1,106,642 where Columbian closed claims or unilaterally rescinded policies because it did not receive a death certificate or medical records.

26. Colombian also unilaterally rescinded 39 contestable claims with a face amount of \$322,699 based on alleged material misrepresentation.

27. During the Relevant Period, Colombian paid \$70,447 in returned premiums to claimants in connection with 123 of the 162 contestable claims that it rescinded.

28. The face amount of Unity's and Colombian's 257 contestable claims is \$2,091,923.

Relevant statutes, regulations, and New York case law

29. Pursuant to Insurance Law Section 3203(a)(3), life insurance policies are incontestable after being in force during the life of the insured for a period of two years from its date of issue or, as to certain increases in the death benefit or changes in other policy provisions, from the effective date of those increases or changes. Pursuant to Insurance Law Sections 3203(a)(3), 3105(a), and 3105(b)(1), within the two-year contestable period, an insurer may only contest a covered claim on the basis of a misrepresentation if the insurer proves a material misrepresentation by the insured on the application for insurance.

30. Insurance Law Section 3105(a) provides that a misrepresentation is a false statement by an applicant concerning past or present fact made to the insurer at or before the making of the insurance contract as an inducement to make the contract, such as a false statement that the applicant has not had a particular disease, ailment, or medical impairment.

31. Under Insurance Law Section 3105(b), a misrepresentation will not avoid or defeat recovery under any insurance policy unless the misrepresentation was material. A misrepresentation is material if knowledge by the insurer of the facts misrepresented would have led to the insurer's refusal to make the contract.

32. Insurance Law Section 3105(d) provides: "If in any action to rescind any such [insurance] contract or to recover thereon, any such misrepresentation is proved by the insurer,

and the insured or any other person having or claiming a right under such contract shall prevent full disclosure and proof of the nature of such medical impairment, such misrepresentation shall be presumed to have been material.”

33. Under relevant New York jurisprudence, if there is a change in the status quo, such as the death of the insured, then an insurer must obtain rescission through a judicial determination or by all beneficiaries agreeing to rescission after being made aware of their rights to contest the rescission claim in an action.

34. Pursuant to Insurance Law Section 2601(a)(1), (2), and (4), it is an unfair claim settlement practice for an insurer to commit the following acts without just cause and with such frequency to indicate a general business practice:

- a. Knowingly misrepresenting to claimants pertinent facts and policy provisions relating to coverages at issue;
- b. Failing to acknowledge with reasonable promptness pertinent communications regarding claims arising under its policies; and
- c. Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

35. Pursuant to Department Regulation No. 64, 11 N.Y.C.R.R. Section 216.3(b), no insurer shall deny any element of a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is made in writing to the insured, beneficiary, or claimant.

36. Also pursuant to Department Regulation No. 64, 11 N.Y.C.R.R. Section 216.6(d), an insurer shall inform the claimant in writing as soon as it is determined that there was no policy in

force or that the insurer is disclaiming liability because of a breach of policy provisions by the policyholder. The insurer must also explain its specific reasons for disclaiming coverage.

Violations

37. The Department finds that Respondent violated Insurance Law Section 2601(a)(1), (2), and (4) by misrepresenting facts and policy provisions relating to coverage, failing to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies, and failing to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability had become reasonably clear.

38. The Department finds that Respondent violated Sections 216.3(b) and 216.6(d) of Department Regulation No. 64 by failing to refer in writing to a specific policy provision, condition, or exclusion in the policy that was the ground for denial of a claim, or by failing to provide a specific reason for disclaiming coverage.

AGREEMENT

IT IS HEREBY UNDERSTOOD AND AGREED by Respondent, and all subsidiaries, affiliates, successors, assigns, agents, representatives, employees, and subcontractors, that:

Cease and desist

39. Respondent shall cease and desist the practices found by the Department to have violated the Insurance Law and Regulations.

Other injunctive terms

40. In order to comply with the requirements of Insurance Law Sections 2601, 3105, and 3203, Respondent shall adopt the following practices with respect to payment and investigation of contestable claims:

- a. If Respondent has evidence or notice of an insured's death, it shall not lapse the insured's policy for non-payment of premiums.
- b. Respondent, not beneficiaries or a policyholder's estate, bears the burden of investigating claims submitted within the contestable period;
- c. In investigating claims submitted within the contestable period, Respondent may request a death certificate but will also accept alternative satisfactory proof of loss if a death certificate cannot be obtained.
- d. Respondent may only contest a contestable claim on evidence of a material misrepresentation by the insured on the application for insurance, as provided in Insurance Law Sections 3105(a) and 3105(b)(1);
- e. The materiality of a misrepresentation shall be whether, had the Respondent known the facts misrepresented, it would have refused to make such contract, as provided in Insurance Law Section 3105(b)(1);
- f. A presumption of materiality of a misrepresentation shall arise in an action to rescind or defeat recovery, as provided in Insurance Law Section 3105(d);
- g. If a contestable claim is incurred and there has been a change in the status quo, Respondent shall only obtain a rescission of the policy by prevailing in a court action or by all beneficiaries agreeing to rescission after being made aware of their rights to contest the rescission claim in an action.

Restitution

41. For all identified contestable claims that Unity or Columbian closed without payment or unilaterally rescinded, Respondent shall pay the face amount of each such policy plus interest

dating from the date of death to the date of such payment, unless the Third Party Administrator described in paragraph 43 determines, based upon a review of the claim, that the insured made a material misrepresentation in his or her application for such policy, as provided in Insurance Law Section 3105.

42. Any payments described in paragraph 41 shall be reduced by any amounts already paid by Respondent to beneficiaries as premium refunds for rescinded policies.

Third party administrator

43. As soon as practicable, but no later than sixty days from the execution of this Consent Order, DFS shall select an independent third party administrator (“TPA”) to review and administer the contestable claims review and restitution process, as provided in paragraphs 41 and 42 of this Consent Order. Respondent will retain the TPA after the Department’s review and approval of the retainer agreement. Respondent shall be fully and solely responsible for all proper fees, expenses, and disbursements of the TPA in connection with the review and restitution process provided for in this Consent Order and the TPA’s retainer agreement.

44. The TPA shall, as part of its operations, establish and maintain throughout the duration of its obligations pursuant to this Consent Order, multiple cost-free means for affected beneficiaries to contact it, including an electronic mail address, a website, and a toll-free telephone number.

45. Within thirty days after retention of the TPA, Respondent shall provide the TPA for its review all information in their possession, custody, or control, including but not limited to policy records and complete claims files, for all identified claims made within the contestable period for New York policies.

46. The TPA may request from Respondent any information and data it reasonably believes it will need to fulfill its obligations under this Consent Order, and Respondent shall provide the requested information and data within seven days of receiving such a request from the TPA.

47. The TPA shall determine, according to the provisions and standards set forth in its retainer agreement, the following:

- a. Which identified contestable claims were lawfully closed without payment as noted above; and
- b. Which identified contestable claims were unlawfully closed without payment as noted above.

48. For claims that Respondent unlawfully closed without payment as described in paragraph 47, the TPA shall determine the death benefit to be paid according to the policy. If records for contestable claims unlawfully closed without payment are incomplete and it is not known whether payment was made, the claims shall be paid according to the policy. Benefits shall be reduced by any amounts already paid by Respondent to beneficiaries, and shall include interest as required by Insurance Law Section 3214(c).

49. The TPA shall also identify and locate the beneficiaries of all identified contestable claims Respondent unlawfully closed without payment.

50. Within thirty days of the TPA's final determination of all amounts owed to affected beneficiaries, Respondent shall wire-transfer to the TPA the total amount owed by Respondent to the beneficiaries.

51. Within thirty days of receiving the wire-transfer described in paragraph 50, the TPA shall deposit in the facilities of the U.S. Post Office, for delivery by prepaid first-class mail to

each beneficiary to whom Respondent owes payment, a check in the required amount payable to the individual beneficiary. All checks must be valid for six months. Such payment shall be accompanied by a letter from the Department, in the form annexed hereto as Exhibit A.

52. For any payment to a beneficiary that is returned to the TPA as undeliverable or not deposited within six months, the TPA shall conduct a reasonable search, as provided in its retainer agreement, for a current address. The TPA may cancel checks not deposited within six months. Should the search show a more current address, the TPA shall re-issue a check valid for six months in the amount of the returned or un-deposited check and send the reissued check to the more current address within fifteen days in the manner provided in paragraph 51. After doing so, no further action shall be required by the TPA to complete the mailing process.

53. In the event that a beneficiary does not cash his or her check before the expiration date of the check or the check was returned after the TPA re-posts the check as described in paragraph 52, the TPA shall follow all applicable provisions of the New York Abandoned Property Law, including all reporting, mailing, and remittance requirements.

54. The TPA shall provide reports to the Department as provided in the retainer agreement to confirm compliance with this Consent Order.

55. The TPA's obligations under this Consent Order are satisfied when the process described in paragraphs 47 through 54 is completed.

Monetary penalty

56. Respondent shall pay a civil penalty of two hundred fifty-seven thousand dollars (\$257,000) to DFS within ten days of the Effective Date. The payment shall be in the form of a wire transfer in accordance with instructions provided by DFS.

57. Respondent agrees that it will not claim, assert, or apply for a tax deduction or tax credit with regard to any U.S. federal, state, or local tax, directly or indirectly, for any portion of the civil monetary penalty paid pursuant to this Consent Order.

Other relief

58. Respondent submits to the authority of the Department to effectuate this Consent Order.

59. Respondent will cease and desist from engaging in any acts in violation of the New York Insurance Law and will comply with this and every other New York law.

60. Respondent may not bring any claim, action, or proceeding against the TPA.

61. Respondent represents and warrants, through the signatures below, that the terms and conditions of this Consent Order are duly approved, and execution of this Consent Order is duly authorized.

Breach of the consent order

62. In the event that the Department believes Respondent to be materially in breach of the Consent Order (“Breach”), DFS will provide written notice to Respondent of the Breach and Respondent must, within ten business days from the date of receipt of said notice, or on a later date if so determined in the sole discretion of the Department, appear before DFS and shall have an opportunity to rebut the evidence, if any, of DFS that a Breach has occurred and, to the extent pertinent, to demonstrate that any such Breach is not material or has been cured.

63. The Respondent understands and agrees that Respondent’s failure to appear before the Department to make the required demonstration within the specified period as set forth in paragraph 62 is presumptive evidence of Respondent’s Breach. Upon a finding of Breach, DFS has all the remedies available to it under the New York Insurance Law, Financial Services Law,

or other applicable laws and may use any and all evidence available to DFS for all ensuing hearings, notices, orders, and other remedies that may be available under the New York Insurance Law, Financial Services Law, or other applicable laws.

Other provisions

64. If Respondent defaults on any of its obligations under this Consent Order, DFS may terminate this Consent Order, at its sole discretion, upon ten days' written notice to Respondent. In the event of such termination, Respondent expressly agrees and acknowledges that this Consent Order shall in no way bar or otherwise preclude the Department from commencing, conducting, or prosecuting any investigation, action, or proceeding, however denominated, related to the Consent Order, against them, or from using in any way statements, documents, or other materials produced or provided by Respondents prior to or after the date of this Consent Order, including, without limitation, such statements, documents, or other materials, if any, provided for purposes of settlement negotiations.

65. The Department has agreed to the terms of this Consent Order based on, among other things, the representations made to the Department by Respondent and its counsel and DFS's own Examinations and Investigation. To the extent that representations made by Respondent or its counsel are later found to be materially incomplete or inaccurate, this Consent Order or certain provisions thereof are voidable by the Department in its sole discretion.

66. All notices, reports, requests, certifications, and other communications to any party pursuant to this Consent Order shall be in writing and shall be directed as follows:

If to DFS:

New York Department of Financial Services
One State Street
New York, New York 10004-1511
Attention: Anna MacCormack, Assistant Counsel

If to Respondent:

Columbian Mutual Life Insurance Company
4704 Vestal Parkway East
P.O. Box 1381
Binghamton, New York 13902-2472
Attention: Frank L. Lettera, Esq.

with a copy to:

Debevoise & Plimpton LLP
919 Third Avenue
New York, New York 10022
Attention: Eric R. Dinallo, Esq.

67. This Consent Order and any dispute thereunder shall be governed by the laws of the State of New York without regard to any conflicts of laws principles.

68. Respondent waives its right to further notice and hearing in this matter as to any allegations of past violations up to and including the Effective Date and agree that no provision of the Consent Order is subject to review in any court or tribunal outside the Department.

69. This Consent Order may not be amended except by an instrument in writing signed on behalf of all the parties to this Consent Order.

70. This Consent Order constitutes the entire agreement between the Department and Respondent and supersedes any prior communication, understanding, or agreement, whether written or oral, concerning the subject matter of this Consent Order. No inducement, promise, understanding, condition, or warranty not set forth in this Consent Order has been relied upon by any party to this Consent Order.

71. In the event that one or more provisions contained in this Consent Order shall for any reason be held invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Consent Order.

72. Upon execution by the parties to this Consent Order, the Department will discontinue the Investigation as and against Respondent solely with respect to the identified contestable claims. No further action will be taken by the Department against Respondent for the conduct with respect to the contestable claims identified found to have violated the Insurance Law and Regulations as set forth in the Consent Order provided that Respondent complies fully with the terms of the Consent Order.

73. This Consent Order may be executed in one or more counterparts, and shall become effective when such counterparts have been signed by each of the parties hereto and the Consent Order is So Ordered by the Superintendent of Financial Services or her designee ("Effective Date").

WHEREFORE, the signatures evidencing assent to this Consent Order have been affixed
hereto on the dates set forth below.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

By: Joy Feigenbaum
Joy Feigenbaum
Executive Deputy Superintendent
Financial Frauds & Consumer Protection Division

December 21, 2016

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY

By: Frank A. Rutter

December 14, 2016

THE FOREGOING IS HEREBY APPROVED.
IT IS SO ORDERED.

Dated: New York, New York
December 21, 2016

Maria T. Vullo
MARIA T. VULLO
Superintendent of Financial Services

[Date]

[Beneficiary's Address]

Dear [Beneficiary],

You are receiving this notice pursuant to a settlement reached between Columbian Mutual Life Insurance Company ("Columbian") and the New York State Department of Financial Services. The settlement concerns the contestable claims practices of Columbian and another company, Unity Mutual Life Insurance Company, which Columbian acquired in 2011.

Records indicate that you are the beneficiary of a policy, [Columbian/Unity Policy #####], that is affected by this settlement. We write to notify you that, pursuant to the settlement with the New York State Department of Financial Services, Columbian is paying the face amount of this policy, plus interest dating from the policyholder's date of death. This amount may be reduced by amounts already paid as premium refunds for improperly rescinded policies.

This settlement was obtained by the New York State Department of Financial Services. Nothing in the settlement prevents or limits you from pursuing any right or remedy at law you may have or requires you to release any rights.

If you have any further problems regarding Policy [####], or if you have questions concerning this settlement or any refund provided, you can contact the New York State Department of Financial Services at 1-800-342-3736 and at [email address to be provided], or you may contact the Third Party Administrator, [name of TPA], that is administering this settlement at [toll-free number], [email address], or [website].

Sincerely,