



NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES
REPORT ON MARKET CONDUCT EXAMINATION
OF THE
THE UNITED STATES LIFE INSURANCE COMPANY
IN THE CITY OF NEW YORK

CONDITION:

DECEMBER 31, 2016

DATE OF REPORT:

JUNE 1, 2018

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EXAMINER:

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Linda A. Lacewell
Superintendent

January 28, 2020

Honorable Linda A. Lacewell
Superintendent of Financial Services
New York, New York 10004

Madam:

In accordance with instructions contained in Appointment No. 31626, dated April 28, 2017, and annexed hereto, a market conduct examination has been made into the condition and affairs of The United States Life Insurance Company in the City of New York, hereinafter referred to as “the Company,” at its administrative office located at 80 Pine Street, New York, NY 10005.

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 243.2(e) of 11 NYCRR 243 (Insurance Regulation 152) by failing to make available as requested by the examiner, data records that support the annual statement exhibits in the format and substance required within a reasonable time frame. This data related matter was raised in the Company's prior market conduct report on examination. (See item 4D of this report.)
- The Company violated Section 51.6(b)(3) of 11 NYCRR 51 (Insurance Regulation 60, Second Amendment) and Section 51.6(b)(4) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment) by failing to examine and ascertain that the Disclosure Statement was accurate and met the requirements of the Insurance Law. (See item 4A of this report.)
- The Company violated Section 3240(d)(2) of the New York Insurance Law by failing to perform cross-checks using the insured's social security number or where the insurer does not know the insured's social security number, the name and date of birth of the insured.
- The Company violated Section 3240(d)(4) of the New York Insurance Law and Section 226.4(e) of 11 NYCRR 226 (Insurance Regulation 200) by failing to implement reasonable procedures to account for common variation in data that would otherwise preclude an exact match with a death index. (See item 4C of this report.)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2012, through December 31, 2016. As necessary, the examiner reviewed matters occurring subsequent to December 31, 2016, 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 5 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 New York on February 25, 1850 and commenced business on March 4, 1850.

Under a special permit issued pursuant to Section 4231 of the New York Insurance Law, the Company writes both participating and non-participating business in all jurisdictions in which it is authorized to do business. The Company is licensed to transact business in all 50 states, the District of Columbia, and the territory of the U.S. Virgin Islands.

On June 17, 1997, American General Corporation (“AGC”) acquired control of the Company and its immediate parent, USLIFE Corporation (“USL”), through the merger of USLIFE Corporation with Texas Stars Corporation, a wholly-owned subsidiary of AGC. On August 29, 2001, AGC was acquired by American International Group, Inc. (“AIG”), a Delaware holding corporation, resulting in AIG becoming the Company’s ultimate parent.

On December 31, 2002, American General Life Insurance Company of New York, a New York domiciled insurer, merged with and into the Company. On December 31, 2003, North Central Life Insurance Company also merged with and into the Company.

During 2009, as part of AIG's restructuring, the Company consolidated its domestic life and retirement services subsidiaries under the SunAmerica Financial Group and the SunAmerica Retirement Services, Inc. umbrellas. AGC’s affiliates, including the Company, were realigned under SunAmerica Financial Group.

Effective December 31, 2010, subsequent to the receipt of regulatory approval from the Department, American International Life Assurance Company of New York merged with and into the Company, with the Company being the surviving entity; and effective December 31, 2011, subsequent to the receipt of regulatory approval from the Department, First SunAmerica Life Insurance Company also merged with and into the Company, with the Company again being the surviving entity.

In December 2012, AIG reorganized its life insurance and retirement services divisions to implement a less complex and more efficient holding company structure while continuing to market products and provide services under existing brands. The reorganization required several mergers involving the AGC Life Insurance Company (“AGCL”), a number of AIG’s life insurance

subsidiaries, and a number of other affiliates. The reorganization involved the following mergers and transactions, which were all completed on December 31, 2012:

SunAmerica Investments, Inc. (“SAII”) merged into SunAmerica Life Insurance Company (“SALIC”). The merger was approved by the Arizona Department of Insurance. SAII’s wholly owned subsidiaries, SunAmerica Affordable Housing Partners, Inc. (“SAAHP Inc.”) and AIG Advisor Group, Inc., became wholly owned subsidiaries of SALIC.

SALIC contributed 100% of its ownership interest in SAAHP Inc. to SA Affordable Housing, LLC, making it a wholly owned subsidiary of the latter. AIG Life Holdings, Inc. (formerly SunAmerica Financial Group, Inc.) contributed 100% of its ownership interests in SALIC and American General Assurance Company (“AGAC”) to AGCL, which were recognized by AGCL as capital contributions of \$3.1 billion and \$66.5 million, respectively, making SALIC and AGAC wholly owned subsidiaries of AGCL.

American General Life Insurance Company (“AGL”) distributed 100% of its ownership interest in Variable Annuity Life Insurance Company (“VALIC”) to the AGCL, making VALIC a wholly-owned subsidiary of AGCL. The distribution by AGL of its interest in VALIC and the receipt by AGCL of the interest in VALIC were approved by the Texas and Missouri Departments of Insurance.

Concurrent with the distribution of VALIC to AGCL, SunAmerica Annuity and Life Assurance Company merged into SALIC, with SALIC being the surviving entity. Immediately thereafter, SALIC, American General Life & Accident Insurance Company, American General Life Insurance Company of Delaware, AGAC and Western National Life Insurance Company merged into AGL, with AGL being the surviving entity.

As a result of the reorganization, all of AIG’s subsidiaries that provided life insurance and retirement services products were merged and reduced into the following three U.S. life insurance companies for which AGCL is now the direct parent: AGL, VALIC and the Company.

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 all 50 states, the District of Columbia, and the territory of the U.S. Virgin Islands. In 2016, 59% of life premiums, 94.3% of annuity considerations, 35.7% of accident and health premiums, and 99% of deposit type funds were received from New York. 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 2016:

<u>Life Insurance Premiums</u>		<u>Accident and Health Insurance Premiums</u>	
New York	58.5%	New York	29.9%
Minnesota	6.6	California	12.1
New Jersey	4.9	Florida	6.0
Florida	3.6	New Jersey	5.4
California	<u>3.2</u>	Texas	<u>4.7</u>
Subtotal	76.8%	Subtotal	58.1%
All others	<u>23.2</u>	All others	<u>41.9</u>
Total	<u>100.0%</u>	Total	<u>100.0%</u>

The Company markets individual life insurance, individual annuities, group insurance, and certain credit life insurance. Individual life insurance products include term life, whole life, universal life, index universal life, and variable universal life insurance; individual annuities include fixed flexible premium differed annuities, single premium immediate annuities, and structured settlement contracts, and group insurance products include group life, immediate fixed annuities, fixed terminal funding annuities, accidental death and dismemberment, dental, vision, excess major medical, and disability insurance. The Company's group life and group accident and health insurance products are marketed to employers and professional and affinity associations. In October 2016, the Company made a strategic decision to refocus its group benefits business, which included the decision to cease quoting new business in its employer and voluntary group benefits lines and seek strategic alternatives for group products distributed through sponsored organizations

such as professional and affinity associations. The Company also offers company-owned life insurance, but it did not issue any policies during the examination period.

The Company's individual life insurance products are distributed through independent insurance agents, independent marketing organizations, financial advisors, and direct marketing; individual annuities are distributed through independent insurance agents, independent marketing organizations, broker-dealers, banks, and wirehouses; group annuities are distributed through independent insurance agents and broker-dealers, and group life and group accident and health insurance products are distributed through independent general agents, brokers and third-party administrators.

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 51.6(b) of 11 NYCRR 51 (Insurance Regulation 60, Second Amendment)
states, in part:

“Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall: . . .

(3) Examine any proposal used, including the sales material used in the sale of the proposed life insurance policy or annuity contract, and the "Disclosure Statement," and ascertain that they are accurate and meet the requirements of the Insurance Law and this Part . . .”

Section 51.7(a) of 11 NYCRR 51 (Insurance Regulation 60, Second Amendment)
states, in part:

“No insurer or insurance agent or broker shall:

(1) make or give any deceptive or misleading information in the ‘Disclosure Statement’ or in the sales material, including any proposal, used in the sale of the life insurance policy or annuity contract;” . . .

Section 51.6(b) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment)
states, in part:

“Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall: . . .

(4) examine the sales material, including any proposal, used in the sale of the life insurance policy or annuity contract, and the ‘Disclosure Statement’, and ascertain that they are accurate and meet the requirements of the Insurance Law and regulations . . .”

Section 51.7(a) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment) states, in part:

“No insurer or insurance agent or broker shall:

(1) make or give any deceptive or misleading information in the ‘Disclosure Statement’ or in the sales material, including any proposal, used in the sale of the life insurance policy or annuity contract;” . . .

The Office of General Counsel (“OGC”) opinion issued July 31, 2003, advises, in part:

“Under the circumstances surrounding the sale of sophisticated products, where the fees and charges may be a significant factor in a determination by a client to purchase a product, and possibly replace another product; the illustration of applicable fees and charges could be an essential element in the Regulation 60 disclosure. In addition, the Securities & Exchange Commission commented, when this Department was revising Regulation 60 in 1997, that it regarded the illustration of applicable fees and charges desirable so that the insured could ascertain that the applicable fees and charges were not excessive. The Department is aware that the Disclosure Statements established by the Superintendent of Insurance, N.Y. Comp. R. & Regs. tit. 11, Appendices 10A and 10B, do not specifically provide space for information concerning any applicable charges and fees. The Disclosure Statements do, however, contain a space for remarks, which may be utilized by the agent to describe applicable charges and fees.”

A. The examiner reviewed 56 external annuity replacements and 30 internal annuity replacements. The external annuity replacements were comprised of 26 fixed deferred annuities and 30 variable deferred annuities. The internal annuity replacements were comprised of 29 fixed annuities and 1 indexed annuity. The examiner also reviewed a sample of 40 external life and 30 internal life replacements.

- i. In all 26 external fixed annuities (100%) and in 24 out of 30 internal annuity replacements (80%) reviewed, the Company did not disclose either in the Agents Statement or in the Remarks section of the Disclosure Statement that the guaranteed interest rate of the contract is guaranteed only for the guaranteed period stated in the contract, which is usually between 4 and 7 years, and not for the life of the contract. Also, in 13 out of 26 external fixed annuity replacements (50%) reviewed, the agent stated that the primary reasons for recommending the new product were better rates, higher interest rate, higher guaranteed rate, etc. However, the agent failed to disclose that the stated higher interest rate is guaranteed only for a specific period and not for

- the entire contract period. The Company failed to examine and ascertain that the Disclosure Statement was accurate.
- ii. In 9 out of 26 external fixed annuities (35%) and in 21 out of 30 internal annuity replacements (70%) reviewed, the guaranteed minimum interest rate of the replaced policy was higher (ranging from 1.5% to 3%) than the minimum guaranteed interest rate of the proposed policy, which is 1%. The agent did not disclose that the existing contract having a higher minimum guaranteed interest rate would be an advantage of continuing with the existing annuity contract. The Company failed to examine and ascertain that the Disclosure Statement was accurate.
 - iii. In 29 out of 30 external variable annuity replacements (97%) reviewed, where the optional guaranteed living benefit (Income Plus) and/or maximum anniversary value optional death benefit was elected, the agent failed to disclose the rider fees or charges in the remarks section of the disclosure statement in adherence to the OGC opinion issued July 31, 2013. Income Plus guarantees a lifetime of minimum income payments after a 7 to 10 year waiting period regardless of the contract investment performance. The income payments are based on the greater of the current contract value, the contract's highest anniversary value or the total of monies paid into the contract. The maximum anniversary value death benefit requires the contract holder to be age 80 or younger when the policy was issued and elect an optional living benefit. The death benefit amount is determined by the greater of the contract value on the date when all the required documentation is received by the Company, the total amount of monies paid into the contract before the contract holder's 86th birthday or greatest anniversary value prior to the contract holder's 83rd birthday and the date of death. The Company failed to examine and ascertain that the Disclosure Statement was complete by not requiring the disclosure of the rider fees or charges.
 - iv. In 2 out of 26 external fixed annuity replacements (8%) reviewed, the annuities being replaced were variable annuities with rider benefits. The agent failed to disclose the rider benefits in the agent's statement of the disclosure statement as an advantage of continuing with the existing annuity contract. The Company failed to examine and ascertain that the Disclosure Statement was accurate.

- v. In 5 out of 30 external variable annuity (16.7%) and in 3 out of 30 internal annuity replacements (10%) reviewed, the proposed annuity contract was replacing more than one existing contract, however the agent presented the surrender values and death benefits in separate disclosure statements instead of presenting a composite comparison for all existing annuity contracts to the proposed annuity contract. The agent also failed to list all the existing contracts affected in Section 1 of the Disclosure Statement. Per the instructions for completing Appendix 10B of Regulation 60, if more than one contract is being replaced and or being proposed, illustrated values are to be determined as the sum of the values for the individual contracts. The Company failed to examine and ascertain that the disclosure statement was complete.
- vi. In 1 out of 30 internal life replacements (3%) reviewed, the agent noted on the Remarks section of the Disclosure Statement that the existing universal life policy was limited due to the fixed interest rate. This contradicts the disclosure of the existing universal life policy's surrender value which shows different guaranteed and non-guaranteed values for "end of current year 5 year and 10 year hence". The Company failed to examine and ascertain that the disclosure statement was accurate.

The Company violated Section 51.6(b)(3) of 11 NYCRR 51 (Insurance Regulation 60, Second Amendment) and Section 51.6(b)(4) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment) in the above-mentioned instances, by failing to examine and ascertain that the Disclosure Statement was accurate and met the requirements of the Insurance Law.

The Company violated Section 51.7(a)(1) of 11 NYCRR 51 (Insurance Regulation 60) by providing misleading information in the Disclosure Statement in all 26 external fixed annuity replacements and in 24 out of 30 internal annuity replacements when it did not disclose that the guaranteed interest rate of the contract is guaranteed only for the period stated in the contract (usually 4 to 7 years) and not for the life of the contract.

Section 51.6(b) of 11 NYCRR 51 (Insurance Regulation 60, Second Amendment) states, in part:

"Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall:

(9) In the event the life insurance policy . . . issued differs from the life insurance policy . . . applied for, ensure that the requirements of this Part are met with respect to the information relating to the life insurance policy . . . as issued, including but not limited to the revised ‘Disclosure Statement’ . . .”

Section 51.6(b) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment) states, in part:

“Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall: . . .

(10) if an initial ‘Disclosure Statement’ was provided to the applicant prior to the delivery of the life insurance policy. . . and the life insurance policy . . . is issued other than as applied for, then the insurer shall provide the owner a revised ‘Disclosure Statement’ that conforms to the life insurance policy . . . as issued no later than the time of delivery of the policy . . .”

B. In 5 out of 40 external life (12.5%) and in 10 out of 30 internal life replacements (33%) where the policy issued to the applicant was different from the policy that was described as the proposed policy in the Disclosure Statement because the face amount or premium was revised, the Company failed to provide the applicant with a revised Disclosure Statement.

The Company violated Section 51.6(b)(9) of 11 NYCRR 51 (Insurance Regulation 60, Second Amendment) and Section 51.6(b)(10) of 11 NYCRR51 (Insurance Regulation 60, Third Amendment) by failing to provide the applicant with a revised disclosure statement when the policy was issued other than as applied for.

B. Underwriting and Policy Forms

The examiner reviewed a sample of new underwriting files, both issued and declined, and the applicable policy forms. The examiner reviewed a sample of 26 fixed deferred annuities. In 4 out of 26 (15%) instances where the replaced contract was the American Pathway Fixed Annuity 4, the Company inserted an endorsement titled, “IMPORTANT NOTICE” in the annuity contract. The form advises applicants to return the contract for a full refund of premium within 20 days of receiving the contract if the applicant is not satisfied with the contract. The statement contradicts the 60-day “Free Look” disclosure that is required by Insurance Regulation 60 when existing insurance is replaced.

Section 51.6(d) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment) states, in part:

“Any insurer that issues a replacement life insurance policy or annuity contract shall provide to the policy or contract owner the right to return the policy or contract within 60 days from the date of delivery of such policy or contract and receive an unconditional full refund of all premiums or considerations paid on it, or in the case of a variable or market value adjustment policy or contract, a payment of the cash

surrender benefits provided under the policy or contract, plus the amount of all fees and other charges deducted from gross considerations or imposed under the policy or contract. . . .”

Section 3201(a) of the New York Insurance Law states, in part:

“ . . . ‘policy form’ means any policy, contract, certificate, or evidence of insurance and any application therefor, or rider or endorsement thereto, . . .

(b)(1) 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. . . .”

The examiner’s initial review of 26 fixed deferred annuity replacements found that the replaced contract American Pathway Fixed Annuity 4 included an endorsement titled, “IMPORTANT NOTICE” which incorrectly advised the applicant that the contract could be returned for a full refund within 20 days if the applicant was not satisfied with the contract. The examiner expanded the review to 60 fixed deferred annuity replacements for the limited purpose to determine how many American Pathway Fixed Annuity 4 contracts included an endorsement titled “IMPORTANT NOTICE”. The examiner’s review of 60 fixed annuity replacements revealed that in 6 out of 7 instances where the replaced contract was the “American Pathway Fixed Annuity 4”, an endorsement titled “IMPORTANT NOTICE” was not filed for approval by the Department. The form advises applicants to return the contract for a full refund of premium within 20 days of receiving the contract if the applicant is not satisfied with the contract. The statement contradicts the 60-day “Free Look” disclosure that is required by Insurance Regulation 60 when existing insurance is replaced.

The Company violated Section 51.6(d) of 11 NYCRR 51 (Insurance Regulation 60) and Section 3201(b)(1) of the New York Insurance Law by using a policy form that was not filed with the Department and by inserting an endorsement that contradicts this section when it advised the applicant to return the contract for a full refund of premium within 20 days of receiving the contract if the applicant is not satisfied with the contract.

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

Section 86.4(d) of 11 NYCRR 86 (Insurance Regulation 95) states:

“Location of warning statements and type size. The warning statements required by subdivisions (a), (b) and (e) of this section shall be placed immediately above the space provided for the signature of the person executing the application or claim form and shall be printed in type which will produce a warning statement of conspicuous size. On claim forms which require execution by a person other than the claimant, or in addition to the claimant, the warning statements required by subdivisions (a), (b) and (e) of this section shall be placed at the top of the first page of the claim form or in the page containing instructions, either in print, by stamp or by attachment and shall be in type size which will produce a warning statement of conspicuous size.” . . .

A. The examiner reviewed five long term care (“LTC”) paid claims from the Univita administrative system to determine if the claim forms were in compliance with the fraud warning requirements. In 5 out of 5 paid claims (100%) reviewed the claim form utilized did not contain the required fraud warning statement.

B. The examiner reviewed 20 LTC paid claims from the Aviva administrative system to determine if the claim forms were in compliance with the fraud warning requirements. In 20 out of the 20 claims (100%) reviewed, the claim forms utilized did not have the required fraud warning statement placed immediately above the space provided for the signature of the person executing the claim form.

C. The examiner reviewed 6 LTC denied claims to determine if the claim forms were in compliance with the fraud warning requirements. In 6 out of 6 denied claims (100%) reviewed, the claim form utilized did not contain the fraud warning statement.

D. The examiner reviewed 33 group accidental death and dismemberment (“AD&D”) paid claim files and 15 AD&D denied claims. The data file for group AD&D did not have an identifier for the issue state. Listed in the issue state column was the number “9”. The Company could not verify what the number “9” represented. The examiner verified from the claim files that there were 7 paid claim files and 4 denied claim files issued in New York. The examiner found that in 4 out of 7 paid claims (57%) reviewed, the claim form utilized did not contain the fraud warning statement. The examiner also found that in all 7 paid claim files (100%) reviewed and all 4 denied claim files (100%) reviewed, the claim forms utilized did not have the required fraud warning statement placed immediately above the space provided for the signature of the person executing the claim form.

E. The examiner reviewed 64 individual annuity death claims and 10 group annuity death claims processed by the Company during the examination period. In 2 out of 64 claims (3%) reviewed, the claims form utilized did not contain the fraud warning statement. Also, in 61 out of 64 individual annuity claims (95%) and in all 10 group annuity claims (100%) reviewed, the claim form utilized did not have the required fraud warning statement placed immediately above the space provided for the signature of the person executing the claim form.

F. The examiner reviewed 25 annuitization claims. In 14 out of 25 claims (56%) reviewed, the claim forms utilized did not have the required fraud warning statement placed immediately above the space provided for the signature of the person executing the claim form.

G. The examiner reviewed 20 long-term disability (“LTD”) paid claims, 20 short-term disability (“STD”) paid claims and 5 STD denied claims files. The examiner’s review revealed that in 1 out of 20 LTD paid claims (5%), the claim form utilized did not contain the fraud warning statement. The examiner’s review also revealed that in 2 out of 20 LTD paid claims (10%), in 4 out of 20 STD paid claims (20%), and in 1 out of 5 STD denied claims (20%), the claim forms utilized did not have the required fraud warning statement placed immediately above the space provided for the signature of the person executing the claim form.

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

The Company violated Section 86.4(d) of 11 NYCRR 86 (Insurance Regulation 95) by using claim forms that did not have the required fraud warning statement placed immediately above the space provided for the signature of the person executing the claim form.

2. Section 3240(d) of the New York Insurance Law states:

“Standards for cross-checking policies. (1) An insurer shall use the death index to cross-check every policy and account subject to this section no less frequently than quarterly, except as specified in subsection (g) of this section. An insurer may perform the cross-check using the updates made to the death index since the date of the last cross-check performed by the insurer, provided that the insurer performs the cross-check using the entire death index at least once a year. The superintendent may promulgate rules and regulations that allow an insurer to perform the cross-checks less frequently than quarterly but not less frequently than semi-annually.

(2) The cross-checks shall be performed using: (A) the insured or account holder's social security number; or (B) where the insurer does not know the insured or account holder's social security number, the name and date of birth of the insured or account holder.

(3) If an insurer only has a partial name, social security number, date of birth, or a combination thereof, of the insured or account holder under a policy or account, then the insurer shall use the available information to perform the cross-check.

(4) An insurer shall implement reasonable procedures to account for common variations in data that would otherwise preclude an exact match with a death index.”

Section 226.4(e) of 11 NYCRR 226 (Insurance Regulation 200) states:

Every insurer shall implement reasonable procedures to account for common variations in data that would otherwise preclude an exact match with a death index, including:

“(1) nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names;

(2) compound last names, and blank spaces or apostrophes in last name;

(3) incomplete date of birth data, and transposition of the “month” and “date” portions of the date of birth;

(4) incomplete social security number; and

(5) common data entry errors in name, date of birth and social security data.”

The examiner selected a sample of 195 life policies from the 2015 in-force data file where the insured’s attained age was 80 years and over. The examiner also selected samples of 77 annuity contracts from the 2016 in-force data file where the contract holder’s attained age was 95 years or over, 31 matured policies, 25 lapsed policies and 6 expired policies.

The examiner used the insured’s social security number, the insured’s name and date of birth (“DOB”) to perform searches on two online death databases. The examiner’s search of the

samples revealed that a number of individuals whose policies are listed as in-force were either deceased as of December 31, 2016 or were deceased before the date the policy matured, lapsed or expired.

A. In 125 out of 195 life policies searched against the database (64%), the insured was deceased.

B. In 4 out of 77 annuity contracts searched against the database (5.1%), the insured was deceased.

C. In 9 out of 31 matured policies searched against the database (29%), the insured was deceased prior to the maturity date of the policy.

D. In 2 out of the 19 lapsed policies searched against the database (11%), the insured was deceased prior to the lapse date.

E. In 1 out of the 6 expired policies searched against the database (17%), the insured was deceased prior to the expiry date of the policy.

The Company indicated that the life policies identified by the examiner were the result of conversion from the administrative system of an acquired Company that did not maintain the insured's DOB. However, the administrative system maintained the insured's age at policy issue. Prior to the conversion, USL was an affiliate of American General Life Insurance Company "AGL" which was acquired by AIG in 2001. USL policies were converted to AGL administrative systems after acquisition. During the conversion, the DOB data field was filled with a "calculated" DOB. The calculated DOB was determined by using the first day of the policy issue month, while the year of birth was determined by subtracting the insured's age at policy issue from the policy issue date. Since the DOB was an approximation and the Social Security Number ("SSN") was not provided in the application, these policies would not be found in the potential death match searches since the Company's practice in cases where a match is identified on a policy by name but with a blank SSN, is to acknowledge a potential match only when there is an exact DOB match.

The Company violated Section 3240(d)(2) of the New York Insurance Law by failing to perform cross-checks using the insured's social security number or where the insurer does not know the insured's social security number, the name and date of birth of the insured.

The Company violated Section 3240(d)(4) of the New York Insurance Law and Section 226.4(e) of 11 NYCRR 226 (Insurance Regulation 200) by failing to implement reasonable

procedures to account for common variation in data that would otherwise preclude an exact match with a death index.

The Company has been directed to confirm the death of all insured or policyholders, perform a diligent search to locate the beneficiary of such proceeds and make prompt restitution to the beneficiary for benefits (including interest) from the date of death to payment, for which the Company is liable for in accordance with all applicable laws, rules and regulations. If the Company cannot locate the beneficiary within ninety (90) days of a potential match, the Company shall continue to perform such diligence searches for the beneficiary until the benefits escheat in accordance with applicable state law.

The Company reviewed a total of 7,717 records which included 4,139 active and 3,358 lapsed records. There were 258 true matches which resulted in the payment of 255 death claims. For the 3 remaining matches, the Company is awaiting documentation to complete these claims.

3. Section 3203(a) of the New York Insurance Law states, in part:

“All life insurance policies . . . delivered or issued for delivery in this state, shall contain in substance the following provisions, or provisions which the superintendent deems to be more favorable to policyholders:

(1) that, for policies in which the amount and frequency of premiums may vary, after payment of the first premium, the policyholder is entitled to a sixty-one day grace period, beginning on the day when the insurer determines that the policy's net cash surrender value is insufficient to pay the total charges necessary to keep the policy in force for one month from that day, within which to pay sufficient premium to keep the policy in force for three months from the date the insufficiency was determined. For all other policies, after payment of the first premium, the policyholder is entitled to a thirty-one-day grace period or of one month following any subsequent premium due date within which to make payment of the premium then due. During such grace period, the policy shall continue in full force;”

Section 3211(a)(1) of the New York Insurance Law states, in part:

“ . . . a notice shall have been duly mailed at least fifteen and not more than forty-five days prior to the day when such payment becomes due, or for life insurance policies in which the amount and frequency of premiums may vary, no earlier than and within thirty days after the day when the insurer determines that the net cash surrender value under the policy is insufficient to pay the total charges that are necessary to keep the policy in force.” . . .

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

“The notice required by paragraph one of subsection (a) hereof shall: . . .

(2) state the amount of such payment, the date when due, the place where and the person to whom it is payable; and shall also state that unless such payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or non-forfeiture benefit.”

A. The examiner reviewed a sample of 32 lapsed policy files. The sample consisted of 18 universal life policies and 14 term life policies. In 8 out of the 18 lapsed universal life policies reviewed (44%), the Company lapsed the policies during the grace period.

The Company violated Section 3203(a)(1) of the New York Insurance Law when it lapsed policies during the grace period.

B. The examiner’s review revealed that in 5 out of 14 lapsed term policies (36%), the Company mailed the premium due notice on the premium due date, after the premium due date or the notice was not mailed at all.

The Company violated Section 3211(a)(1) of the New York Insurance Law by failing to have a notice duly mailed at least fifteen and not more than forty-five days prior to the day when such payment becomes due.

C. The examiner’s review also revealed that in 28 out of 32 lapsed policies (88%), the premium due notices sent to the policyholders did not contain the statement, “except as to the right to any cash surrender value or non-forfeiture benefits”.

The Company violated Section 3211(b)(2) of the New York Insurance Law by not having Term and Universal life premium due notices that contain the language “except as to the right to any cash surrender value or non-forfeiture benefit”.

The Company conducted a study to identify insureds who have died within one year of the lapse of their policies. The Company’s research included a cross-check through the Social Security Death Master File. The Company identified 94 policies where death occurred within one year of the policy lapse processing.

The Company has determined that a claim should not be paid for 93 of the 94 policies based on the following reasons:

- 71 policies – the applicable language was included on the Notice of premium due as required.
- 18 policies – the Company acknowledges that the required language was not included on Notice of premium due... The Company respectfully asserts that the Department’s finding is technical in nature and no harm to the consumers could be identified. Therefore, the Company respectfully disagrees with the Department’s position that payment of death benefits to beneficiaries should be required in these cases.
- 4 policies – the Company has determined that the language is included on the Notice of premium due/lapse notices when mailed. However, the Company did not maintain a record of such notices. The Company will ensure that they are retained going forward.

The examiner reviewed exhibits of premium due notices provided by the Company after the completion of their study. The language “except as to the right to any cash surrender value or non-forfeiture benefit” were found on the second page of the premium due notices exhibits which was not provided during the examination.

The examiner recommends that the Company investigate and pay the appropriate beneficiary or beneficiaries the total death benefit due under the policies where death occurred within one year of policy lapse processing.

4. 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.”

The examiner reviewed a sample of 62 matured policies, 31 of which was reviewed as part of the Regulation 200 review. The examiner’s review revealed that in 9 out of the 31 maturities, the insured’s death preceded the maturity date of the policy. The Company was not able to locate the beneficiaries in all nine claims and escheated the proceeds as unclaimed funds. The Company failed to pay interest from date of death of the insured to the date of payment in five instances and

applied an incorrect settlement rate at the maturity date instead of a blended rate from date of death to the date of payment in the other four instances.

The remaining 31 policies were reviewed as maturities. The matured policies were comprised of 9 ordinary life and 22 matured endowment contracts. In 8 out of 22 matured policies reviewed (36%), the Company failed to pay interest on these eight endowment contracts.

The Company violated Section 3214(c) of the New York Insurance Law by not paying interest on maturities escheated as death claims or not paying the correct rate of interest left under the settlement option.

The Company violated Section 3214(c) of the New York Insurance Law by failing to pay interest on the proceeds of endowment contracts at a rate of interest currently left under the interest settlement option.

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

"In a case where the obligation of an insurer . . . to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, . . . for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer . . . shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

- (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
- (2) to request all additional information needed to determine liability to pay the claim or make the health care payment. . . ."

The examiner reviewed a sample of 30 group health denied claims. In 7 out of 30 of the claims processed (23%), the Company failed to provide a notification of denial to the claimant within 30 calendar days of receipt of the claim.

The Company violated Section 3224-a(b) of the New York Insurance Law by failing to provide a notification of denial of the payment of a claim within thirty calendar days of receipt of the claim.

6. Section 3234(a) and (b) of the New York Insurance Law states, in part:

"Every insurer . . . is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or

certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expenses or home care expense benefits.

(b) The explanation of benefits form must include at least the following: . . .

(1) the name of the provider of service . . .

(7) . . . a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy . . . and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made.”

The examiner reviewed a sample of 45 LTC paid claims, 40 group health paid claims (major medical) and 45 group health denied claims (30 major medical and 15 specified disease) processed during the examination period.

In all 45 LTC claims processed, the explanation of benefits (“EOB”) did not include a description of the time limit, place and manner in which an appeal of denial of benefits must be brought under the policy or a notification that failure to comply with the indicated requirements for appealing denied benefits may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made.

In 31 out of 40 group health paid claims processed (78%), the EOB did not include a description of the time limit or a notification that failure to comply with the indicated requirements for appealing denied benefits may lead to forfeiture of a consumer’s right to challenge a denial or rejection, even when a request for clarification has been made.

In all 15 group health denied claims (specified disease) processed (100%), the EOB did not include a notification that failure to comply with the indicated requirements for appealing denied benefits may lead to forfeiture of a consumer’s right to challenge a denial or rejection, even when a request for clarification has been made.

In all 30 group major medical denied claims (100%), the EOB did not include the description of the time limit, the place and manner in which an appeal of a denial of benefits must be brought under the policy or a notification that failure to comply with the indicated requirements for appealing denied benefits may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made.

The Company violated Section 3234(b)(7) of the New York Insurance Law by failing to include on the EOB, the description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to

comply with the indicated requirements for appealing denied benefits may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made for claims that were processed.

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

“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. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this part. A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to Section 243.3(a) of this Part. 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. Binders shall be retained if a contract or policy was not issued; . . .

(8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review.”

The examiner reviewed a sample of 50 accident and health reinstated policy files. In 36 out of the 50 reinstated policies reviewed (72%), the Company was unable to provide a copy of the application/enrollment form. In 20 out of 50 reinstated policies (72%) reviewed, the Company failed to provide a copy of the policy contract. In 44 out of the 50 reinstated policy files reviewed (88%), the Company failed to maintain a copy of the lapse notice. In addition, in 48 out of 50 reinstated policy files (96%), the Company failed to maintain a copy of the reinstatement notice.

The Company violated Section 243.2(b)(1)(ii) and 243.2(b)(1)(iii) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain a copy of the application and or policy contract 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.

The Company violated Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain a copy of the lapse notice and the reinstatement notice 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.

D. Data Files

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. The records shall be in a readable form. . . . 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 market conduct examination was conducted concurrent with a financial examination of the Company. In advance of both examinations, the Department requested that the Company prepare certain data files, covering the period of January 1, 2012, through December 31, 2016. The data requested was to be used for both the financial condition and the market conduct examination. To verify the validity of the underlying data supporting the annual statement exhibits, the Department also requested that some of the data files, such as those for claims and surrender benefits, be reconciled to the annual statement exhibits in advance of the examiner’s selection of samples to review for the market conduct examination. Despite its best efforts and while financial information in the Company’s annual statements tied to information presented on an aggregate basis in the applicable annual statement exhibits, the Company failed to provide the requested data in the format and substance required by the Department within a reasonable time frame. Several extensions were granted to the Company to provide the requested data, for which the Company was unable to meet.

The Company violated Section 243.2(e) of 11 NYCRR 243 (Insurance Regulation 152) by failing to make available as requested by the examiner, data records that support the annual statement exhibits in the format and substance required within a reasonable time frame. This data related matter was raised in the Company’s prior market conduct report on examination.

E. Incorrect Life Settlement Rates

Section 3201(c)(1) of the New York Insurance Law states:

“The Superintendent may disapprove any policy form for delivery or issuance for delivery in this state if he finds that the same contains any provision or has any title,

heading, backing or other indication of the contents of any or all of its provisions, which is likely to mislead the policyholder, contract holder or certificate holder.”

Section 3203(a) of the New York Insurance Law states, in part:

“All life insurance policies . . . delivered or issued for delivery in this state, shall contain in substance the following provisions, or provisions which the superintendent deems to be more favorable to policyholders: . . .

(9) a table showing the amounts of the applicable installment . . . if the policy proceeds are payable in installments . . .”

A review by the Department’s Policy Forms Unit revealed that 68 previously approved policy forms contained incorrect settlement rates in the Option 3 Table (Payments for Life with Period Certain). The rates shown in the Option 3 Table were less favorable than the rates calculated with the settlement rates stated in the forms. The review was expanded to include all potential in-force policies with incorrect payout rates shown in the Option 3 Table and it was determined that the Company had issued 20,984 policies utilizing previously approved policy forms with incorrect payout rates shown in the Option 3 table.

The Company violated Section 3201(c)(1) of the New York Insurance Law by providing a misleading table with incorrect rates in the policy. The Company violated Section 3203(a)(9) of the New York Insurance Law by failing to include a table in the policy showing the correct amounts of the applicable installment payment.

5. 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:

<u>Item</u>	<u>Description</u>
A	<p>The Company violated Section 3211(g) of the New York Insurance Law by failing to provide policyholders with an annual notification demonstrating that their policies contained cash surrender value.</p> <p>The examiner requested a sample of annual notification of policies that contained cash surrender values and determined that the Company was issuing these annual notifications.</p>
B	<p>The Company violated Section 3209(b)(2)A through H of the New York Insurance Law by failing to provide disclosure statements to its prospective annuitants for equity index annuities.</p> <p>The examiner's review of index annuities revealed that the Company is providing disclosure statements to its prospective annuitants for equity index annuities.</p>
C	<p>The Company violated Section 3224-a(a) of the New York Insurance Law by failing to pay medical claims received via paper within forty-five days of receipt of proof of the claim.</p> <p>The current examination did not reveal any instances where the Company failed to pay medical claims within forty-five days.</p>
D	<p>The examiner recommended that the Company develop and implement effective procedures to ensure that policy level data be reconciled to the various policy exhibits and schedules as reported in the Company's filed annual statements.</p> <p>The Company failed to take corrective action in response to this prior report recommendation. (See item 4D of this report.)</p>
E	<p>The examiner further recommended that, in the future, such data and supporting schedules are provided to the examiners in a timely manner.</p> <p>The Company did not provide the requested data within a reasonable time frame. (See item 4D of this report.)</p>

6. SUMMARY AND CONCLUSIONS

Following are the violations contained in this report:

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
A	The Company violated Section 51.6(b)(3) of 11 NYCRR 51 (Insurance Regulation 60, Second Amendment) and Section 51.6(b)(4) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment) by failing to examine and ascertain that the Disclosure Statement was accurate and met the requirements of the Insurance Law	11
B	The Company violated Section 51.7(a)(1) of 11 NYCRR 51 (Insurance Regulation 60) by providing misleading information in the Disclosure Statement in all 26 external fixed annuity replacements and in 24 out of 30 internal annuity replacements when it did not disclose that the guaranteed interest rate of the contract is guaranteed only for the period stated in the contract (usually 4 to 7 years) and not for the life of the contract.	11
C	The Company violated Section 51.6(b)(9) of 11 NYCRR 51 (Insurance Regulation 60, Second Amendment) and Section 51.6(b)(10) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment) by failing to provide the applicant with a revised disclosure statement when the policy was issued other than applied for.	12
D	The Company violated Section 51.6(d) of 11 NYCRR 51 (Insurance Regulation 60) and Section 3201(b)(1) of the New York Insurance Law by using a policy form that was not filed with the Department and by inserting an endorsement that contradicts this section when it advised the applicant to return the contract for a full refund of premium within 20 days of receiving the contract if the applicant is not satisfied with the contract.	13
E	The Company violated Section 403(d) of the New York Insurance Law by failing to include the required fraud warning statement on its claim forms.	15

F	The Company violated Section 86.4(d) of 11 NYCRR 86 (Insurance Regulation 95) by using claim forms that did not have the required fraud warning statement placed immediately above the space provided for the signature of the person executing the claim form.	16
G	The Company violated Section 3240(d)(2) of the New York Insurance Law by failing to perform cross-checks using the insured's social security number or where the insurer does not know the insured's social security number, the name and date of birth of the insured.	17
H	The Company violated Section 3240(d)(4) of the New York Insurance Law and Section 226.4(e) of 11 NYCRR 226 (Insurance Regulation 200) by failing to implement reasonable procedures to account for common variation in data that would otherwise preclude an exact match with a death index	17
I	The Company violated Section 3203(a)(1) of the New York Insurance Law when it lapsed policies during the grace period.	19
J	The Company violated Section 3211(a)(1) of the New York Insurance Law by failing to have a notice duly mailed at least fifteen and not more than forty-five days prior to the day when such payment becomes due.	19
K	The Company violated Section 3211(b)(2) of the New York Insurance Law by not having Term and Universal life premium due notices that contain the language "except as to the right to any cash surrender value or non-forfeiture benefit".	19
L	The Company violated Section 3214(c) of the New York Insurance Law by not paying interest on maturities escheated as death claims or not paying the correct rate of interest left under the settlement option. The Company also violated Section 3214(c) of the New York Insurance law by failing to pay interest on the proceeds of the endowment contracts at a rate of interest currently left under the interest settlement option.	21
M	The Company violated Section 3224-a(b) of the New York Insurance Law by failing to provide a notification of denial of the payment of a claim within thirty calendar days of receipt of the claim.	21

- N The Company violated Section 3234(b)(7) of the New York Insurance Law by failing to include on the EOB, the description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with the indicated requirements for appealing denied benefits may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made for claims that were processed. 22
- O The Company violated Section 243.2(b)(1)(ii) and 243.2(b)(1)(iii) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain a copy of the application and or policy contract 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. The Company violated Insurance Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain a copy of the lapse notice and the reinstatement notice 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. 23
- P The Company violated Section 243.2(e) of 11 NYCRR 243 (Insurance Regulation 152) by failing to make available as requested by the examiner, data records that support the annual statement exhibits in the format and substance required within a reasonable time frame. This data related matter was raised in the Company's prior market conduct report on examination. 24
- Q The Company violated Section 3201(c)(1) of the New York Insurance Law by providing a misleading table with incorrect rates in the policy. The Company violated Section 3203(a)(9) of the New York Insurance Law by failing to include a table in the policy showing the correct amounts of the applicable installment payment. 25

Respectfully submitted,

_____/s/
Rory Cummings
Associate Insurance Examiner

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

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

_____/s/
Rory Cummings

Subscribed and sworn to before me
this _____ day of _____

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, MARIA T. VULLO, 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:

RORY CUMMINGS

as a proper person to examine the affairs of the

UNITED STATES LIFE INSURANCE COMPANY IN THE CITY OF NEW YORK

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

COMPANY

with such other information as he 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 28th day of April, 2017

MARIA T. VULLO
Superintendent of Financial Services

By:



MARK MCLEOD
DEPUTY CHIEF - LIFE BUREAU

