FUNDING AGREEMENTS PRODUCT OUTLINE
(Last Updated May 3, 2013)

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FUNDING AGREEMENTS PRODUCT OUTLINE

This outline is current as of May 3, 2013. Subsequent changes to statutes, regulations, circular letters, etc., may not be reflected in the outline. In case of any doubt, please contact the Life Bureau.

I) Applicability

I.A) Scope

This product outline applies to all individual and group funding agreements delivered or issued for delivery in this state by an authorized insurer, regardless of whether the amounts paid to the insurer are allocated to the insurer's general account or one or more of its separate accounts.

A.1) Funding agreements generally provide for the accumulation of funds at guaranteed rates for a specified time period with repayment to the holder in lump sum or installments. Funding agreements may be simple interest contracts with interest paid out periodically

A.2) Funding agreements cannot provide for payments to or by the insurer based on mortality or morbidity contingencies.

I.B) Excluded Contracts:

All individual and group annuity contracts that provide for the payment or purchase of life contingent annuity benefits to covered person(s), regardless of whether the contract is funded through the company's general account or one or more separate accounts.

I.C) Definition of Funding Agreement

C.1) The term "funding agreement" is defined in §40.2(g) of Regulation No. 139 to be a contract described in §3222 of the Insurance Law. Section 3222(c) places two requirements on funding agreements. The requirements are as follows:

(a) No amounts shall be guaranteed or credited under any such funding agreement, except

(i) upon reasonable assumptions as to investment income and expenses, and

(ii) on a basis equitable to all holders of funding agreements of a given class.

(b) Such funding agreement shall not provide for payments to or by the insurer based on mortality or morbidity contingencies.

C.2) Section 3222 imposes no further design restrictions on funding agreements, except by limiting to whom they may be issued. It can be interpreted to allow most types of contracts to make periodic payments, as long as such contracts

eliminate all provisions that provide for payments to or by the insurer based on mortality or morbidity contingencies.

(a) The typical group funding agreement, when first authorized, resembled fixed rate/fixed maturity guaranteed interest contracts described in the *Guaranteed Interest Contracts Product Outline,* except that no provision is made for the purchase of annuities under the contract.

(b) However, group funding agreements today often provide for a fixed interest rate or indexed rate that is reset periodically and need not provide for a fixed maturity date.

I.D) Eligible Funding Agreement Holders

D.1) Another Insurer or Subsidiary Thereof.

§3222(b) provides that funding agreements may be issued to insurance companies (or their subsidiaries) without restriction as to purpose.

(a) An affiliate of an insurer (other than a subsidiary) must satisfy one of the purposes listed in §3222(b) to be eligible to purchase a funding agreement. See L.1984, c. 867, §2.

D.2) Other Entities And Individuals/Permitted Purpose

§3222(b) also provides that funding agreements may be issued to entities other than insurers and subsidiaries thereof and to individuals for the following purposes:

(a) Employee Benefit Plans. To fund benefits under any employee benefit plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq, maintained in the United States or in any foreign country.

(i) An "employee benefit plan" under ERISA means a welfare plan or a pension plan or a plan which is both a welfare plan and a pension plan. See §3(3) of ERISA.

(ii) A welfare plan means any plan, fund or program established or maintained by an employer or by an employee organization or by both for purpose of providing welfare benefits for its participants or their beneficiaries through the purchase of insurance or otherwise. Welfare benefits include medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, prepaid legal services, etc. See §3(1) of ERISA.

Funding agreements have been used to fund post-retirement health benefits.

(iii) A pension plan means any plan, fund or program established or maintained by an employer or by an employee organization or by both to the extent it (a) provides retirement income to employees, or (b) results in the deferral of income by employees for a period extending to the termination of the covered employment and beyond. See §3(2) of ERISA.

(iv) Note that the employee benefit plan does not necessarily have to be covered by or subject to ERISA.

(v) The holder of the funding agreement is typically the plan sponsor (employer or employee organization) or plan trustee. However, funding agreements that fund this purpose can be issued to individuals.

(b) Tax Exempt Organizations. To fund the activities of any organization exempt from taxation under IRC§501(c) or similar organization in any foreign country.

(c) Government Programs. To fund any program of the government of the United States, the government of any state, foreign country or political subdivision thereof, or any agency or instrumentality thereof.

(d) Structured Settlements. To fund any agreement providing for periodic payments in satisfaction of a claim. See L.1983, c.919, §2.

(e) Large Institution Program. To fund any program of an institution which has assets in excess of $25 million. See L.1984, c.867, §2. See Office of General Counsel Opinion No. 05-03-27 for a discussion of the term "assets" as used in this section of the law.

I.E) Key References

E.1) Insurance Law: §§ 2103, 2114, 2123, 3102, 3201, 3204, 3205, 3209, 3222, 4223, 4224, 4226, 4231, 4239, 4241

E.2) Regulations: Regulation 127 (11 NYCRR 44), Regulation 139 (11 NYCRR 40)

E.3) Circular Letters: CL 6 (1963), CL 1 (1964), CL 12 (1976), CL 13 (1989), CL 2 (1992), CL 14 (1997), CL 2 (1998), CL 8 (1999), CL 6 (2004).

II) Filing Process

II.A) Overview

A.1) Prior Approval Requirement:

Section 3201(b)(1) provides that 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 the Insurance Law* (standard and generally applicable provisions*)* and *not inconsistent with law* (federal and

state statutory, regulatory and decisional law). The term "policy form" is defined to include a funding agreement authorized by Section 3222.

A.2) Discretionary Authority For Disapproval

Section 3201(c)(1) and (2) permits the Superintendent to disapprove any policy form that contains provisions that are misleading, deceptive, unfair, unjust, or inequitable or if its issuance would be prejudicial to the interests of policyholders or members. See also §§2123, 3209, 4224, 4226, 4231, 4239.

A.3) No Filing Fee

II.B) Types of Filings

B.1) Prior Approval

Policy forms submitted under §3201(b)(1) of the Insurance Law are subject to the submission rules noted herein, especially Circular Letter Nos. 6 (1963) and 14 (1997). Submissions are generally handled on a first-in, first-out basis.

B.2) Alternative Approval Procedure

Section 3201(b)(6) and Circular Letter No. 2 (1998) provide for an expedited approval procedure designed to prevent delays by deeming forms to be approved or denied if the Department or insurer fail to act in a timely manner.

Circular Letter No. 2 (1998) provides that the certification of compliance should make reference to any law or regulation that specifically applies or is unique to the type of contract form submitted. An alternative would be to submit a certification of compliance with the applicable laws and regulations cited in this product outline. A statement that the filing is in compliance with all applicable laws and regulations is not acceptable.

B.3) Prior Approval with Certification Procedure

Circular Letter No. 6 (2004) provides for an expedited approval procedure based on an appropriate certification of compliance signed by an officer of the company in the format provided by Circular Letter No. 6 (2004). Certifications that have altered or otherwise modified the language of the certification will <u>not</u> be accepted.

Funding agreement products with an initial deposit in excess of $50 million may not be filed under the Circular Letter No. 6 (2004) procedure without the Department's permission, pursuant to Filing Guidance dated 08/12/2009.

The original signed certification must be provided. The form number of each form and the memorandum of variable material for each form must be listed in the body of the certification. For long lists, it would be acceptable to begin the list in the body of the certification and include the rest of the list in an attachment to the certification. However, it would be unacceptable to list all of the forms in a separate attachment.

The submission letters for paper submissions and the Filing Description for submissions made via the System for Electronic Rate and Form Filing (SERFF) will need to comply with applicable circular letter and product outline guidance.

Substitution filings/follow-up correspondence with post-approval form changes requested prior to initial issuance of forms will not be permitted for Circular Letter No. 6 (2004) filings.

B.4) Out-of-State Filings

Pursuant to §3201(b)(2), domestic insurers must file with the Superintendent all unallocated group annuity contracts and funding agreements intended for delivery outside of the state.

II.C) Pre-filed Group Insurance Coverage - Circular Letter 1964-1

Circular Letter 64-1 permits insurers to provide or assume risk for group life and group annuity coverage prior to the filing or approval of such forms. This procedure can be used for funding agreements. The conditions include the following:

C.1) Immediate coverage requested to meet specific need of contractholder.

C.2) Insurer has reasonable expectation of approval or acceptance for filing. The reasonable expectation is usually based on the nature and extent of benefits provided and the similarity of the form (or provisions in the form) to other previously approved forms (or provisions) for the insurer or other insurers.

C.3) Confirmation letter sent to contractholder by insurer stating:

(a) The nature and extent of benefits or change in benefits.

(b) The forms may be executed and issued for delivery only after filing with or approval by the Department;

(c) An understanding that, if such forms are not filed or approved or are disapproved, the parties will be returned to status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval; and

(d) The effective date of coverage (Best Practice).

C.4) Department Notification

(a) A statement explaining the circumstances and reasons for the delay in submitting the forms must be submitted within twelve months.

(b) A follow-up statement must be submitted every six months until the form is submitted. If the reason for the delay is unacceptable, the Department may pursue a violation under Section 4241 for willful violation of the prior approval requirement.

C.5) Recommended Practice

(a) It is recommended that insurers notify the Department of coverage within 30 days (i.e., copy of the confirmation letter) of coverage and submit forms within six months, notwithstanding the twelve month period noted in Circular Letter 64-1.

(b) Insurers should review pre-filings periodically (monthly) to verify compliance with conditions for pre-filing.

(c) Insurers should vigorously pursue approval (or acceptance for out-of-state filings) of pre-filed cases after forms have been submitted to mitigate harm if forms are found not to comply with applicable requirements.

II.D) Preparation of Forms - Circular Letter 1963-6

D.1) Duplicates

Filings, except for SERFF, need to be made in duplicate. §I.E.7 of Circular Letter 63-6.

D.2) Form Numbers

Form numbers need to appear in lower left-hand corner of the cover page of the form. §I.D. of Circular Letter 63-6. The lower left-hand corner of the subsequent pages of the form should either contain the same form number as appears on the cover page or should be left blank. The subsequent pages should not contain form numbers that differ from the form number on the cover page.

D.3) Hypothetical Data

All blank spaces for policy forms need to be filled in with hypothetical data. § I.E.1 of Circular Letter 63-6.

D.4) Application

If an application will be attached to the contract, it must be submitted with the contract form for approval. If previously approved, the submission letter should so indicate. §I.E.4 of Circular Letter 63-6.

D.5) Final Format

Policy forms submitted for formal approval should be submitted in the form intended for actual issue. §I.F.1 of Circular Letter 63-6.

D.6) Submissions Made on Behalf of the Insurer

If the filing is made on behalf of the insurer by another party, a letter authorizing the third party to act on behalf of the insurer must be provided. The letter must be:

(a) on company letterhead or include the company name in the subject line of the letter;

(b) specifically addressed to the New York State Department of Financial Services;

(c) properly executed by an authorized officer of the insurer;

(d) dated and either:

(i) specific to the file submitted for approval by including form number(s); or

(ii) generally applicable to all policy forms filed on behalf of the insurer as long as a copy of such authorization is included in each submission.

It is the insurer's responsibility to ensure that their authorizations are accurate and reflect their current relationship with the third party filer.

D.7) Incorporation by Reference

All incorporations by reference should be attached to or accompany the submission. See also Section 3204.

II.E) Submission Letters/SERFF Requirements

E.1) Caption Requirement

For paper filings, the "re" of the submission letter must identify each form and the memorandum of variable material for each form that is being submitted for approval or filed for informational purposes and must be in compliance with Circular Letter No. 8 (1999). Section 3201(b)(6) ("Deemer") filings must be identified in the "re" or caption. Circular Letter No. 6 (2004) filings must be identified in bold print in the body of the submission letter or in the "re" or caption. Please see the Department's guidance for SERFF filings available on the Department's website at http://www.dfs.ny.gov/insurance/serflife.htm.

E.2) Submission Letters/SERFF Filing Description

Circular Letter No. 6 (1963) §I.G.

(a) For paper submissions, the submission letter must be submitted in duplicate and signed by a representative of the company authorized to submit forms for the company.

(b) For SERFF submissions, the Life Bureau no longer requires that a separate signed cover letter be included with submissions. Instead, any information that would ordinarily be included in the signed Cover Letter must be placed in the SERFF Filing Description. Inclusion of "Please see cover letter" or phrases of similar intent in the filing description section will not be considered as meeting the filing requirements.

Note: References in this outline to submission letter content requirements are also requirements for the SERFF Filing Description unless otherwise noted.

(c) Advise as to whether or not form is replacing a previously submitted form. If there have not been a substantial number of changes, submit a highlighted copy showing the material differences or changes made to the form. If the changes are too extensive, then a highlighted copy is not required, but the changes must be identified in the submission letter. State whether the previously submitted form was approved, disapproved, withdrawn or otherwise disposed or is still pending approval (under review) with the Department and provide the form number and file number of the such form.

(d) If a form submitted for approval had previously been submitted for preliminary review, a reference to the previous submission and a statement setting out either (a) that the formal filing agrees precisely with the previous submission or (b) the changes made in the form since the time of preliminary review. Submit a highlighted copy showing the differences or changes made to the form. A redlined copy is helpful.

(e) If a form is intended to replace a very recently approved form because of an error found in the approved form and the approved form was not issued, the insurer may request to make a substitution of the approved form. The substitution request letter must confirm that the form has not been issued and identify the changes made to the corrected form. The insurer may, under these circumstances, use the same form number on the corrected form being submitted. If the original form was approved in paper format the insurer must also return the stamped original of the approved form to the Department. If, however, the form has been issued, the insurer must place a new form number on the corrected form and need not return the previously approved form. This option is not available for policy forms approved under Circular Letter 6 (2004) filings.

(f) If the form being submitted is other than a contract (i.e. rider, endorsement, or insert page), give the form number of the contract with which it will be used, or, if for more general use, describe the type or group of such forms as well as whether the pending form(s) will be used with new and/or previously issued/delivered contracts.

(g) When the policy form is designed as an insert page form, the insurer must submit a statement of the mandatory pages which must always be included in the policy form, and a list of all optional pages, if any, including application forms, together with an explanation of how the form will be used (previously approved forms should be identified by form number and approval date). We object to a company's use of the matrix approach that identifies benefit provisions within a document with separate form numbers. See Circular Letter No. 6 (1963) § I.G.8. and Circular Letter No. 4 (1963) § I.A.2.

(h) A statement as to how the form will be used as described in Circular Letter 1976-12.

(i) A description of the benefits/coverage provided. Circular Letter No. 6 (1963) § I.G.2 and 7.

(j) A description of the type of funding agreement holder, as set forth in Section 3222(b).

(k) A statement describing the type of pension plan or other program funded by the policy.

(l) A statement as to whether the contract is noncontributory, contributory or funded solely by employee or member contributions. If the policy is contributory for some insureds, or for some levels of insurance, or under some conditions, indicate what situations or conditions would permit or require contributions from the insureds.

(m) Submission letters should be as detailed as possible explaining any innovative or unique products or features and any special markets intended. (In general, an innovative or unique product or feature would include one that has not been previously approved by the Department for the insurer).

(n) If the contract does not comply with a specific product outline provision or if the Company has an alternate interpretation of a product outline provision, the submission letter must identify the provision and provide a complete explanation of the Company's position on the issue. Such submissions may not be submitted through the Circular Letter No. 6 (2004) certified process unless the Department has given permission.

E.3) Resubmissions

If the contract has been previously submitted to the Department and the file was closed or withdrawn, any resubmission of the contract to the Department must be complete by itself, reference the file number of the previously closed file and address all outstanding issues in the new submission letter.

E.4) Circular Letter No. 14 (1997)

Filings that are incomplete or do not comply with laws and regulations will be closed. See Circular Letter No. 14 (1997). Note a product that does not comply with a specific product outline requirement or which is considered a substantive noncomplying product will be a factor in determining whether a file will be closed, unless a noncompliance explanation is included in the submission letter.

E.5) Informational Filing

An informational filing should be identified in the "Re" of the submission letter. All informational filings will be acknowledged by the Department indicating that the information submitted has been placed on file with the Department for informational purposes only. The company should wait for the acknowledgement

from the Department that the information has been filed prior to its use. For the submission of an informational filing through SERFF, the company should use a SERFF TOI of "Life – Informational", a SERFF Sub-TOI of "Form or Rate Related", a SERFF Filing Type of "Form", and a SERFF requested Filing Mode of "Informational".

II.F) Attachments

F.1) Memorandum of Variable Material

The submission must include a separate detailed Memorandum of Variable Material to explain any variable material in the policy forms other than illustrative material (i.e. names, dates, etc). The Memorandum of Variable Material is subject to approval and must comply with all substantive and procedural filing guidance issued by the Department.

(a) Variable material must be clearly indicated in the forms (i.e., with bracketing or underlining).How material is designated as variable should be stated in the submission letter and in the Memorandum of Variable Material.

(b) The Memorandum of Variable Material should be drafted in sufficient detail to determine the scope of variation for each variable item. Where text is variable, the memorandum should include alternative text and/or an explanation of when the bracketed text will be omitted from the form. Similarly, variable numerical items should include the range (i.e. minimum and maximum) of variation. An explanation of variable material that the variations "will conform to law" or "as requested by the policyholder" is not acceptable.

(c) It should be clear which item in the explanation corresponds to which variable item in the form. One option would be to number the items in the explanation of variable material and place the number of the item from the explanation next to the corresponding variable item in the form.

(d) Open-face riders or endorsements may be filed for general use in amending illustrative or variable material within the scope of the approved memorandum of variable material for the form being amended. The memorandum should include an explanation to that effect.

F.2) No Readability Requirement

Flesch Score Certification - Section 3102(b)(H) excludes any funding agreement issued pursuant to §3222.

F.3) Group Annuity Summary Sheet

A completed summary sheet must be included with the submission regardless of the submission method. The summary sheet is available on the Department's website at:

http://www.dfs.ny.gov/insurance/life/product/ga_summary_08032012.pdf

III) Contract Provisions

III.A) Funding Agreements Issued to Fund Pension Plans

Generally, funding agreements that are used to fund pension plans have been modeled after guaranteed interest contracts. The majority of such funding agreements fund defined contribution plans. See *Guaranteed Interest Contract Outline* for additional information. In our view funding agreements funded solely by individual contributions are subject to the provisions of the Insurance Law applicable to individual annuities, as set forth in the *Group Fixed and/or Variable Annuity Contracts Subject to Individual Standards Outline*. However, we would not apply individual standards to funding agreements that are issued in connection with employee benefit plans. See §4223(b)(1)(B).

A.1) Cover Page of the Funding Agreement

(a) Company's Name and Address

(i) The New York licensed insurer's name must appear on the cover page (front or back).

(ii) Full street address of the company's Home Office (bracketed or underlined to reflect possible future changes) for disclosure purposes on the front or back cover page of the contract. For changes applicable to new business, an information filing is required. For changes applicable to existing business, an endorsement setting forth the new address must be submitted for approval and sent to all holders of in-force contracts. Please refer to the guidance available on the Department's website.

(iii) In addition to the home office address, the full street address of the administrative or service office (if different than the home office address) may be set forth on the front or back cover of each contract. The administrative or service office address, if any, should be bracketed or underlined to reflect possible future changes. (An informational filing is required for such changes.)

(iv) The forms must exclude any references to an insurer not licensed to do business in New York. Section 3201(c)(1).

(v) If the name of another entity is included on the cover page (insurance group designation, name of the licensed parent company or licensed affiliate, etc.) or if a logo, trademark or other device is included, such name or device shall not be displayed in a manner that would have a tendency to mislead or deceive as to the true identity of the insurer, or create the impression that someone other than the insurer would have any responsibility for the financial obligations under the contract. See §3201(c)(1). This would apply to applications as well.

(b) Form Identification Number

A form identification number (consisting of numerical digits, letters or both) must appear in the lower left-hand corner of the cover page pursuant to §I. D. of Circular Letter No. 6 (1963). (Each form number should be sufficiently unique so as to distinguish the form from all others used by the insurer.

(c) Brief Description of Contract – Participation Status

(i) A description of the contract, such as "Funding Agreement".

(ii) There must be a statement indicating whether the contract is participating or nonparticipating in the divisible surplus of the company. This requirement generally applies to contracts funded through the insurer's general account. See §II.F.1. of Circular Letter No. 4 (1963).

(d) Officer's Signatures

(i) The signature of at least one officer of the company is needed to execute the contract as a matter of contract law.

(ii) Signatures should be denoted as variable material.

(iii) When the signature is changed, the insurer should notify the Department for informational purposes. The contracts do not need to be re-filed.

A.2) Entire Contract Provision. A provision specifying the document or documents, which shall include the contract and, if a copy is attached thereto, the application of the contractholder, constituting the entire contract between the parties. See also §3204.

A.3) Grace Period Provision (for funding agreements with two or more scheduled deposits).

A.4) Plan Benefit Rule -- §40.4(a) of Regulation 139 – Any contract, including a funding agreement, issued in connection with a defined contribution plan which provides the contract holder with the right to withdraw from the contract the amounts required to pay lump sum benefits of the participant's individual account balance as they arise in accordance with the provisions of the plan upon bona fide termination of employment must provide for such withdrawals to be made on a basis pursuant to which neither the amount withdrawn from the contract nor the amount of the remaining principal balance of the accumulation fund following such withdrawal is adjusted to reflect changes in interest rates or asset values since the receipt of funds.

(a) Funding agreements do not need to be benefit responsive. However, if the funding agreement is benefit responsive, it must comply with this §40.4(a) of Regulation 139.

(b) The lump sum payment cannot be subject to a market value adjustment.

(c) No special interest rate adjustment may result from such withdrawals until the next reset.

A.5) Allocated Share of Benefit Payments -- §40.4(c) – In the event that there is more than one funding vehicle or cash is available under a defined contribution plan, a funding agreement need not provide for withdrawals (in accordance with the plan benefit rule) in an amount in excess of the contract's allocated share of benefit payments as determined pursuant to the agreement of the insurance company and funding agreement holder.

(a) This provision operates much like a coordination of benefits provision. If the contract is silent as to its allocable share, benefits will be paid as if it is the only funding vehicle.

(b) We have approved last-in, first-out provisions; first-in, first-out provisions; pro-rata provisions; buffer fund provisions and combination provisions.

A.6) Participant Directed Investment Option -- §40.4(d) –In the case of a contract which funds a participant directed investment option under which each contribution allocated to such option is credited with a specified rate of interest to a stated maturity date which rate and maturity date are disclosed to the participant prior to the allocation, such contract may provide that any withdrawals (other than withdrawals on account of bona fide termination of employment due to death or disability of the participant on whose behalf the withdrawal is made) be postponed until the stated maturity date for the contribution.

(a) In such cases, the contract may permit withdrawals prior to maturity for the contribution that are subject to a negative market value adjustment and/or surrender charge. We have not required positive market-value adjustments in the non-§4223 market.

(b) Such contracts must have at least one option for participants age 55 and over on the date contributions are received where the maturity date will not exceed five years. The "age 55" rule in §40.4(d) is similar to §44.3(t) in Regulation No. 127.

(c) The exception to the plan benefit rule is intended to recognize contracts that are similar to modified guaranteed annuities that include a market value adjustment to the surrender value as authorized by Chapter 864 of the Laws of 1985 and Regulation 127. Note that in contracts subject to §4223 and Regulation 127 the MVA must be positive as well as negative.

A.7) Plan Amendments or Changes In Plan Administration -- §40.4(e) – If the plan terms or the manner in which plan is administered materially change after issue, withdrawals from the contract to pay plan benefits are not subject to the plan benefit rule.

(a) Contracts should include this provision to protect against antiselection.

(b) If the insurer determines that the amendment or change will not adversely affect the insurer's rights and liabilities under the contract, benefit payments will continue to be subject to the plan benefit rule.

A.8) Bona Fide Termination of Employment -- §40.4(f) – The contract can include procedures or conditions in order to establish that a requested contractual withdrawal is being made in accordance with a bona fide termination of employment and in accordance with the plan provisions.

(a) Termination of employment means the cessation of an employment relationship with an employer, multiple employer or membership in an employee organization sponsoring the plan, including cessations due to retirement, death, and disability.

(b) Termination of employment does not include:

(i) Any temporary absence,

(ii) A change in position or other occurrence qualifying as a temporary break in service under the plan,

(iii) Transfer or other change of position resulting in employment by an entity controlling, controlled by, or under common control with the employer,

(iv) Cessation of an employment relationship resulting from a reorganization, merger, or sale or discontinuance of all or any part of the plan sponsor's business. The risk for these transactions is typically not considered by the insurer in making the guarantees provided in the contract. Such transaction may result in unexpected withdrawal activity that was not priced for when the contract was issued.

(v) Plan termination or partial plan termination.

A.9) Market-Value Adjustment Provision

(a) §40.2(o) of Regulation 139 defines market-value adjustment as an adjustment for increasing or decreasing the accumulation fund in the event of full or partial surrender or contract termination to reflect changes in interest rates or asset values since the receipt of funds by the insurer <u>according to a formula described in the contract</u>. *If the contract provides for a market value adjustment, the Insurance Law requires that the MVA formula be incorporated in the contract or attached to the contract. See §3201(c)(1 and 2); see also §3204.*

(i) The market-value adjustment formula is an essential term of the funding agreement and should be sufficiently clear so that the holder can calculate the adjustment at any time.

(ii) The factors used in the calculation should be sufficiently definite and not based items solely within the insurer's discretion. For example, the formula can refer to an outside index or to rates guaranteed or credited under the contract, but not to the earnings rate on supporting assets because the holder cannot verify such rate.

(b) Note that §40.5(i) of Regulation 139 which gives the insurer the right to change the method for determining the market-value adjustment upon at least 31 days prior written notice does not apply to guaranteed interest contracts. The insurer can amend the formula for new deposit windows under the same contract.

(c) Liability-Based Formula -- For guaranteed interest contracts and funding agreements, insurers should consider only using liability based adjustment formula. In Prohibited Transaction Exemption 81-82, the U.S. Department of Labor granted an exemption from the prohibited transaction rules for separate account GICs. The DOL did not believe that any requirements applicable to market-value adjustments were necessary "so long as the adjustment is not made with reference to the investment performance of a separate account".

(i) This exemption was repealed when the plan asset regulation was promulgated. 29 C.F.R. §2510.3-101(h) carves out an exception for separate accounts that are "maintained solely in connection with fixed contractual obligations of the insurance company under which the amounts payable, or credited, to the plan and to any participant or beneficiary of the plan (including an annuitant) are not affected in any manner by the investment performance of the separate account".

(ii) Asset-based market-value adjustment formulas in general account GICs and funding agreements may raise concerns with the DOL.

(iii) We may question an asset-based formula if the assets do not appear to closely match the contractual guarantees, especially with respect to duration.

(iv) Regulation 127 provides guidance with respect to liability-based market-value adjustments.

(d) Two-Way MVA Not Required – Although Regulation 127 requires a two-way market-value adjustment for contracts subject to §4223, we have not made this requirement applicable to GICs or funding agreements.

A.10) Liquidated Damages Provision -- §40.2(m) of Regulation 139 defines liquidated damages as the charges or adjustments which may become applicable in the

event contributions are not made in the amounts or on the dates specified in the contract and which reasonably reflect the actual losses anticipated by the insurer in making commitments in advance of the receipt of the specified contributions. A liquidated damages provision is an alternative to contract termination in the event that the funding agreement holder fails to make a scheduled contribution.

(a) We have objected to provisions that provide for a fixed charge or fixed interest rate reduction for any such failure to contribute

(b) The method for calculating the charge should be set forth in the contract. The funding agreement holder should be able to calculate the adjustment from the terms of the contract. Many insurers use an explicit formula similar to the market-value adjustment formula.

A.11) Non-Benefit Related Withdrawals and Transfers – For withdrawals that are not subject to §40.4(a), an insurer should protect against anti-selection. Such withdrawals are usually subject to a negative market-value adjustment. We have permitted insurers to make a certain percentage of such withdrawals from 10% to 20% on a book value basis annually. This percentage is often called the free corridor amount.

A.12) Clone Contract Provision– We have approved provisions that provide for the issuance of a substantially similar GIC with the same maturity date and interest rate in the event of a partial termination triggered by a reorganization, merger, or sale or discontinuance of all or part of the plan sponsor's business.

(a) The clone contract should satisfy the insurer's underwriting requirements.

(b) The cost of the conversion can be prorated among the two surviving contracts or covered by the plan sponsor. In any event, the actual charges, if any, should be specified in the contract.

A.13) Competing Funds Provision – We have approved provisions, which limit deposits and/or transfers to competing fixed income funds offered by the plan to plan participants. This provision is designed to ensure that all scheduled deposits are made to the contract and to prevent transfers to other fixed income or stable value funds when interest rates increase.

A.14) Liquidity Protection Provision – We encourage insurers to include a contractual liquidity protection provision in all benefit responsive GICs/funding agreements and all other such contracts that permit withdrawals prior to maturity. The Department and insurers need to monitor the liquidity exposure in their GIC portfolio and other liquid group annuity contracts. The market-value adjustment formula (even if liability-based) may reflect a close approximation of the market value of supporting assets; but it may not reflect the liquidation value.

(a) A six month deferral provision is most common.

(b) A contractual provision that gives the insurer the option on the maturity date of paying funds in lump sum or installments over five years or less (at book value with the interest rate specified in the contract) is approvable.

(c) An insurer should consider a diversification requirement applicable to contractholders. No single contractholder, such as GIC broker should have a disproportionate share of the insurer's liquid contracts.

(d) A contractual formula embedding a "spread" over the benchmark rate used to calculate a one-way market value adjustment is approvable.

III.B) Funding Agreements Issued To Fund Other Purposes Or Issued To Other Insurers (And Their Subsidiaries).

B.1) Cover Page of the Funding Agreement

Please see the Cover Page Requirements set forth in Section III.A.1 above.

B.2) Common Provisions

(a) Entire Contract Provision. A provision specifying the document or documents, which shall include the contract and, if a copy is attached thereto, the application of the contractholder, constituting the entire contract between the parties. See also §3204.

(b) Grace Period Provision (for funding agreements with two or more scheduled deposits)

(c) Liquidated Damages Provision.

(d) Interest Rate Guarantee

(i) Specify the fixed interest rate or index if index rate.

(ii) Specify duration of the guarantee and, if applicable, the reset periods.

(e) Expense Charges and Fees.

(f) Maturity Date, if fixed at issue.

(g) Termination Provisions

(i) Insurer's right to terminate the funding agreement.

(ii) The funding agreement holder's rights to terminate the funding agreement.

(iii) Specify any surrender charges.

(iv) Specify the market-value adjustment formula.

(h) Pre-Maturity Withdrawal Provisions

(i) Specify whether any such withdrawals are permitted and the purpose of such withdrawals.

(ii) Specify any charges applicable premature withdrawals.

B.3) Enumerated Purpose and Entity:

(a) The reviewing attorney or actuary, if applicable, will make sure that the purpose requirement is satisfied and will rely on broad discretionary approval authority in reviewing such products.

(b) For example, a funding agreement that provides for the accumulation of funds, either in the insurer's general account or one or more separate accounts, to fund the post-retirement health benefits would be subject to the requirements applicable to similar funding agreements funding pension plans, to the extent practicable.

B.4) Structured Settlement Agreements:

Structured settlement agreements, such as those subject to Articles 50-A and 50-B of the Civil Practice Laws and Rules ("CPLR"), may need to comply with other state and federal laws. For example, structured settlement agreements subject to Article 50-B may include a commutation provision. See VI. B. and C. below.

IV) Department Interpretations

IV.A) Maximum Window Period

We have permitted deposit windows for recurring deposits of up to two years, without requiring any actuarial justification.

A.1) When the deposit window exceeds two years, an actuarial demonstration that the contract can be hedged will be requested.

A.2) For deposit windows that exceed two years, if the required deposits are not fixed in the contract, the contract should specify the minimum and maximum deposits as well as the ratio of initial deposits to the deposit maximum. If the range between the minimum and maximum deposit is too wide, the contract will be impossible to hedge.

IV.B) Maximum Guarantee Period

In connection with the form filing process, we have limited the guarantee duration attributable to any deposit cell in funding agreements to ten years, but we are willing to reconsider this requirement on an exception basis. No surrender charge should apply at the expiration of the interest rate guarantee. Otherwise, the interest rate guarantee can be viewed as misleading (i.e., the interest rate guarantee should be calculated so as to amortize any charges prior to maturity). Funding agreements with a guarantee duration longer than ten years may not be filed under the Circular Letter No. 6 (2004) procedure without the Department's permission.

IV.C) Credit Rating Downgrade Provisions

C.1) Circular Letter No. 2 (1992) states that the Department will not approve a provision which would permit the holder to terminate the contract prior to

maturity at book value due only to the insurer's credit rating downgrade. The provision is considered unfair, unjust and inequitable pursuant to §3201(c)(2).

(a) Waiver of a surrender charge or market value adjustment upon credit rating downgrade would be unfair, unjust and inequitable to persisting holders who would be required to subsidize the withdrawal activity of other contract holders. Surrender charges and market-value adjustments are designed to protect against disintermediation.

(b) A credit rating bailout provision would enhance the probability of a panic run that could impair or threaten the solvency of the insurer and result in regulatory intervention under Article 74.

C.2) Circular Letter No. 2 (1992) also states that we will disapprove any such provision submitted by a domestic insurer for use outside of New York on the grounds that the issuance would be prejudicial to the interests of policyholders pursuant to §3201(c)(6).

C.3) We have disapproved any credit rating downgrade provision included in a funding agreement funding a pension plan that gives the holder the right to terminate a contract prior to maturity even if the withdrawals are subject to a negative market-value adjustment because the provision will increase the risk of disintermediation.

C.4) For the municipal GIC market (funded by funding agreements), we have approved on a limited and experimental basis an over collateralization option that is triggered on a credit rating downgrade in which the insurer pledges the lesser of market value of supporting assets in the general account or book value to the holder. A reinsurer or other mechanism is used to satisfy the overcollaterization amount if market value is less than book value.

(a) The approval was granted, in part, because of the differences in the municipal bond and the pension markets.

(i) Without a downgrade remedy provision, the insurers cannot participate in the muni-GIC market. However, a credit rating downgrade provision is not required in the pension market. Although the USDOL proposed a regulation that included the insurer's credit rating as a selection criteria for plan fiduciaries, the proposal was never adopted.

(ii) Pension plan sponsors are much more concerned with the interest rates credited than holders of muni-GICs. In addition, muni-GIC holders are not as likely to trigger a termination because the premature termination might jeopardize the entire municipal program

(b) The provision that we approved does not allow the holder to terminate the contract and demand that either book value or market value of the contract funds be paid out immediately. As such, the contract is not terminated and

the muni-GIC continues in effect until it matures. The likelihood of a run caused by a credit rating downgrade is minimized.

(c) The insurer may offer to pay book value when market value exceeds book value, but the holder does not have to accept such payment. The holder may prefer to continue the funding agreement (i.e., the overcollaterization option) because it will not unravel the entire municipal bond program.

(d) The approval limited the amount of muni-GIC business that the insurer can write and required periodic reporting to monitor the provision.

IV.D) Market Value Make-Up/Advance Interest Credit Provisions

(a) The Department has permitted provisions that enable insurers to credit an initial book value amount in excess of the actual contribution to the contract. The amount of the excess credit is equal to the market-value adjustment charged on the transfer of funds from the plan sponsor's terminating contract. The excess credit, also called a book-in, allows the plan sponsor to maintain book value accounting at the plan participant level. In order to recoup the excess credit, the insurer will credit a reduced interest rate designed to amortize the excess credit over the life of the contract.

(b) The Department has permitted the use of these provisions under the following conditions and circumstances:

(i) The advance interest credit or book-in amount cannot exceed 5% of the market value of the amount deposited. The Department will consider book-ins that exceed this amount on a case-by-case basis taking into account the safeguards in place to address the risk assumed by the company.

(ii) The book-in provision can only be used with unallocated contracts funding defined contribution plans and the funds cannot derive from equity separate account agreements. This provision should not be used to recover losses on equity investments.

(iii) The insurer must not be proactive in using book-ins as a marketing strategy. Book-ins should only be used as a business conservation measure or in limited cases at the request of a plan sponsor. Book-ins used in connection with new business should represent a small percentage of new business and only a small number (i.e., less than ten) per year. As an alternative, we would consider an aggregate book-in limit, the amount of which will depend on the circumstances of each insurer.

(iv) The contract must provide that in the event that the contract is terminated or discontinued prior to the date on which the advance credit is fully amortized, the unrecouped amount will be deducted as

a separate charge prior to any final payment to the contractholder.

(v) The insurer must notify the Department each year of the circumstances of each book-in, including the credit provided (dollar value and as a percentage of the initial deposit), the amortization period and the source of funds (business conservation or new business). Such notification is not required if the insurer has (1) fewer than 20 book-ins per year or a total book-in amount of less than $5 million per year and (2) an aggregate book-in amount of less than $25 million.

IV.E) Rebating Commissions for Placement of Structured Settlements

Circular Letter No. 13 (1989).

E.1) Articles 50-A and 50-B of the Civil Practice Laws and Rules ("CPLR") require that damage awards in excess of $500,000 or $250,000, respectively, be paid in periodic installments, unless otherwise ordered by the court. Periodic payments may be spread up to, but not more than, ten years. Security must be posted by the defendant(s) or their insurance carrier(s) in the form of an annuity contract issued by a qualified insurer approved by the Superintendent and the court entering the judgment. See L.1985, c.294 and L.1986, c.682.

E.2) With respect to annuity contracts written to fulfill the security requirements under the CPLR, property/casualty insurers cannot require a rebate of a portion of the commission as a condition of giving the business to an agent when purchasing such annuity contracts. Such practice violates §§2114, 2103(i) and 4224 which prohibit discrimination and rebating in the sale of annuity contracts.

(a) The rebate cannot be paid to the insurer's subsidiary, unless the subsidiary is licensed as an agent and performs services in placing the coverage on which the commission is earned and paid. However, the limitations set forth in §2103(i) as they relate to the receipt of commissions earned on insurance of properties or risks of the parent insurer must be considered.

(b) Agents cannot offer to reduce their commissions by rebating directly to the property/casualty insurer purchasing the annuity contract.

(c) A property/casualty insurer purchasing an annuity contract is not one of the parties specified in §2114 who can lawfully be paid all of, or share in, the commission earned for the placement of an annuity contract.

IV.F) Beneficiary Designation for Structured Settlements. Insurable Interest.

F.1) A property/casualty insurer can be the owner of a structured settlement annuity contract/funding agreement.

(a) The ownership of the contract does not necessarily create a wagering contract or endanger the life of the annuitant. The contract is the agreed upon funding vehicle for the structured settlement agreement.

(b) The owner/casualty insurer may not have a lawful insurable interest in the continuance of the payee's life (i.e., there does not appear to be any reason why the owner/casualty insurer may profit on the death of the payee if the claimant has received all payments required by the structured settlement as indicated by the contract's stated guarantee period for guaranteed payments).

(c) If no beneficiary is designated, any remaining payments or a lump sum payment must be paid to the estate of the payee. Sections 5035(b) and 5045(b) of the CPLR require that in the event of the death of a judgment creditor any remaining payments due under the annuity (or funding agreement) shall be paid to persons whom the judgment creditor owed a duty of support immediately prior to his/her death, and if no such person exists, then payment must be made to his/her estate.

F.2) The annuitant/judgment creditor must choose the beneficiary not the insurer. It has been argued that a casualty insurer having control of the beneficiary designation and exercising such designation to favor itself would result in a lack of insurable interest under §3205 of the Insurance Law.

(a) Actual control of the beneficiary designation is prescribed by the settlement agreement between the insurer and the claimant.

(b) The casualty claimant (named annuitant) should have control of the beneficiary designation and assignment of the contract.

IV.G) Salary Reduction Plans And Other Individual Market Or Employee Pay-all Programs

Pension plans that are funded solely by individual contributions are subject to the provisions of the Insurance Law applicable to individual market annuities to the extent practicable. See the *Group Fixed and/or Variable Annuity Contracts Subject to Individual Standards Outline*. However, funding agreements funded solely by individual contributions are not subject to such individual standards if they are issued in connection with employee benefit plans. See §4223(b)(1)(B).

V) Advertising and Disclosure

With respect to funding agreements subject to Regulation 139, Section 40.3 sets forth disclosure requirements. Written statement and/or specimen contract with a statement citing location in contract of disclosures required by paragraphs (1),(3),(4),(5),(6),(9) and (10) of §40.3(b) of Regulation 139. See §40.3(a)

A.1) Statement indicating any restrictions as to amount and timing of contributions, and penalties for non-payment. §40.3(b)(1)

A.2) Description of the right to discontinue contributions to contract, and penalties resulting from such action. §40.3(b)(2)

A.3) Statement of all current fees and charges that are or may be assessed against the holder or deducted from the funding agreement, including a description of

the extent and frequency to which such fees and charges may be modified and the extent to which they take precedence over other payments. §40.3(b)(3).

A.4) Statement of the interest rates and/or method of determination of rates and a description as to how any withdrawals, transfers or payments will affect the amount of interest credited. §40.3(b)(4).

A.5) Description of expense, interest and benefit guarantees under the contract and any rights to modify or eliminate such guarantees, including the right to apply surrender charges or market-value adjustments to plan benefit payments if there are plan amendments or changes in the manner of plan administration. §40.3(b)(5).

A.6) Description of the holder's and participant's right to withdraw funds (or apply to purchase annuities), along with a description of any charges, fees or market-value adjustments applicable to such withdrawals or a statement that no such withdrawals or payment are permissible prior to maturity or the happening of a certain event. §40.3(b)(6).

A.7) Statement indicating any pro rata, percentage or other limitations that may apply to benefit payments to be purchased or provided under the contract when the plan is not funded entirely under the contract. §40.3(b)(7).

A.8) Statement that the holder or participant withdrawals under the contract are to be made in a FIFO or LIFO basis or other applicable basis. §40.3(b)(8).

A.9) Statement that the contract may be amended, including any right of the insurer to unilaterally amend the contract. §40.3(b)(9).

A.10) Statement, if applicable, that any dividends and experience rate credits are subject to the insurer's discretion. § 40.3(b)(10).

A.11) Statement, if applicable, that any dividends and experience rate credits are subject to the insurer's discretion. § 40.3(b)(10).

A.12) Statement that the holder or plan sponsor is solely responsible for determining whether the contract is a suitable funding vehicle. §40.3(b)(12).

A.13) Statement, if applicable, that the insurer does not have responsibility to reconcile participants' individual account balances with the accumulation fund balance where the insurer does not maintain individual account balances. §40.3(b)(13).

VI) Additional Matters

VI.A) IRC Section 457 Public Deferred Compensation Plans.

See New York State Deferred Compensation Board Rules 9 NYCRR 9000 et seq.

A.1) Maximum contract term for NY State Deferred Compensation Board is five years unless the contract falls under certain exceptions set forth in the Board Rules. See §9003.5.

A.2) New contracts subject to a bidding process.

A.3) Every contract must contain a provision that the contract is subject to the plan and regulation, and that such plan and regulation are made a part of the contract. See §9006.2.

VI.B) Article 50-A of the Civil Practice Laws and Rules.

B.1) Periodic Payment of Judgments in Medical Malpractice and Dental Malpractice Actions. "Annuity" under the CPLR includes funding agreements, even though this is not true under the NY Insurance Code.

B.2) §5031 of the CPLR. Damage awards in excess of $500,000 must be paid in periodic installments, unless otherwise ordered by the court. Periodic payments may be spread up to, but not more than, ten years.

B.3) §5032 of the CPLR. Security must be posted by the defendant(s) or their insurance carrier(s) in the form of an annuity contract issued by a qualified insurer approved by the Superintendent and the court entering the judgment.

B.4) §5036 of the CPLR. The court can order that remaining payments (or portion thereof) be paid in lump sum calculated on the basis of the present value of the annuity contract, which shall be based on its cost at such time, for remaining payments or portion thereof, that are converted into a lump sum. As a result, insurers must use current interest rates rather than the original pricing assumptions. In no event shall such lump sum payment be greater than the present value of the annuity contract for the remaining periodic payments.

(a) Insurers typically are unwilling to write life contingent annuities with the right to invade principal. Section 3222 prohibits the writing of funding agreements that provide for payments based on mortality contingencies.

(b) In view of Articles 50-A and 50-B, the Department has requested that insurers add language to the effect: "Payment may not be accelerated, increased, decreased, commuted or encumbered, except by court order."

(c) We strongly suggest that contracts issued pursuant to Article 50-B also include language to the effect: "Notwithstanding any other provision to the contrary, we will make a lump sum payment of amounts due hereunder or any portion of such amounts, if so ordered by a court of competent jurisdiction in accordance with Section 5046 of the CPLR. Any future payments that remain due hereunder after such lump sum payment shall be reduced by us accordingly. We shall calculate any such lump sum payment on the basis of the present value of any remaining amounts due hereunder or any portion thereof that is converted into such lump sum payment. The present value of any such lump sum payment shall be calculated based on the interest rate and mortality assumptions, if applicable, at the time such lump sum payment is made as determined by us."

(d) The ability to accelerate the structured award under Section 5036 and 5046 raise the question as whether the need for a court order is a substantial restriction on the insured's right to accelerate the award for purposes of constructive receipt under the Internal Revenue Code. See Private Letter Ruling 9017011.

B.5) §5038 of the CPLR needs to be consulted with respect to permissible assignments of periodic installments.

B.6) §5039 of the CPLR requires the Superintendent to establish rules and procedures for determining qualified insurers.

VI.C) Article 50-B of the Civil Practice Laws and Rules.

Periodic Payments of Judgments in Personal Injury, Injury to Property and Wrongful Death Actions. [Virtually identical to Article 50-A with the exception that the dollar amount threshold for damage awards that must be paid in periodic installments is $250,000]. However, Section 5046(b) expressly provides that the method for determining present value be in accordance with regulations promulgated by the Superintendent. [No such regulations have been promulgated at this time. However, we review each form and insurer's procedures for fairness and to ensure that current interest rates are used as opposed to the original pricing assumptions.]

VI.D) 12 CFR 9 Fiduciary Powers of National Banks

The Office of the Controller of the Currency requires that a federally-chartered bank permit commingled fund investors to withdraw from the fund with twelve months notice. Insurers may issue funding agreements to commingled GIC-BIC (Bank Investment Contract) pools that are managed by GIC brokers. These pools provide a stable value fund to defined contribution plans. The Department permits a funding agreement to contain a provision allowing the contractholder, upon 12 months advance written notice to the insurer, to withdraw at book value the portion attributable to the withdrawing plan.