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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

March 19, 2018

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

Madam:

In accordance with instructions contained in Appointment No. 30810, dated June 26, 2013, and annexed hereto, an examination has been made into the condition and affairs of First United American Life Insurance Company, hereinafter referred to as “the Company,” at its home office located at 1020 Seventh North Street, Liverpool, NY 13088.

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 this report are summarized below.

- The Company violated Section 1505(a) of the New York Insurance Law by failing to reimburse Torchmark Corporation ("TMK") for investment management services that it received on a regular and systematic basis during 2008, 2009, 2010, 2011 and 2012. (See item 3D of this report)
- The Company violated Section 91.4(f) of Department Regulation No. 33 by failing to allocate expenses between companies according to principles and methods that reasonably reflect the actual incidence of cost, and which consider the relative time spent, the extent of usage and the varying volume of work performed. (See item 3D of this report)
- The Company violated Section 219.5(a) of Department Regulation No. 34-A by failing to maintain a complete file containing a specimen copy of every printed, published or prepared life and annuity advertisement disseminated in New York, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. (See item 7A2 of this report)
- The Company violated Section 215.17(a) of Department Regulation no. 34 by failing to maintain a complete file containing every printed, published or prepared health advertisement disseminated in New York with a notation attached to each such advertisement indicating the manner and extent of distribution. (See item 7A2 of this report)
- The Company violated Sections 2122(a)(2) and 2122(b) of the New York Insurance Law by calling attention to an unauthorized insurer in advertisements disseminated in New York. (See item 7A3 of this report)
- The Company violated Section 219.4(q) of Department Regulation 34-A by making the name of the unauthorized insurer more prominent than the name of the authorized insurer in advertisements disseminated in New York. (See item 7A3 of this report)
- The Company violated Section 219.4(x) of Department Regulation 34-A by advertising a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the reduced initial premium. The initial premium offered differs from the amount of the renewal premium payable on the same mode for the New

York policy, and the advertisement did not contain the required full rate schedule for the New York policy. (See item 7A3 of this report)

- The Company violated Section 215.4 of Department Regulation No. 34 by disseminating advertisements in New York that were ambiguous with regard to the identity of the insurer and the fact that the insurance offered is not life insurance, credit insurance, or mortgage guarantee insurance, and is only payable if the insured's death is due to an accident. (See item 7A4 of this report)
- The Company violated Section 215.5(a) of Department Regulation No. 34 by using references that have the tendency to mislead or deceive the prospective applicant with respect to the identity of the Company and to the fact that the insurance policy is an accidental death and dismemberment policy, not credit life or disability insurance. (See item 7A4 of this report)
- The Company violated Section 215.5(c)(6) of Department Regulation No. 34 by failing to disclose the expected benefit ratio of the policy and by failing to include a statement that the policy provides accident insurance only and that the policy does not provide coverage for sickness. (See item 7A4 of this report)
- The Company violated Section 215.6(a)(3) of Department Regulation No. 34 and Section 52.61 of Department Regulation No. 62 by using direct response insert media labeled "Overview of Benefits" that did not accurately describe the benefits and exclusions afforded by the approved policy form on file with the Department. This can be misleading to the insureds if they do not read the policy, but rely on the advertisement for this information. (See item 7A4 of this report)
- The Company violated Section 215.6(c)(3) of Department Regulation No. 34 and Section 52.31(e) of Department Regulation No. 62 by using an application to be completed by the applicant and returned by mail for a direct response insurance product that was not identical to the form filed with and approved by the Department. (See item 7A4 of this report)
- The Company violated Section 215.14 of Department Regulation No. 34 by disseminating advertisements directed toward homeowners that imply the mortgagee was a member of a group or a quasi-group covered under a group policy eligible for special rates or underwriting privileges. (See item 7A4 of this report)

- The Company violated Section 215.15 of Department Regulation No. 34 by disseminating an advertisement in New York for an individual policy implying that the contract is a special offer, an offer that is available only to a specified group of individuals, and an offer that is not available at a later date (i.e., "this offer won't last long"). (See item 7A4 of this report)
- The Company violated Section 51.4 of Department Regulation No. 60 by failing to obtain approval of alternate procedures for the sale of its life insurance products electronically over the internet. (See item 7A5 of this report)
- The Company violated Section 51.6(e) of Department Regulation No. 60 by failing to file revised replacement procedures implemented during the examination period for the sale of insurance through unlicensed employees and licensed agents over the telephone. (See item 7A of this report)
- The Company violated Section 224.4(c) of Department Regulation No. 187 by issuing an annuity contract that was recommended to a consumer without having a reasonable basis to believe that the annuity was suitable based upon information obtained from the consumer as to his or her financial situation and needs. (See item 7A6 of this report)
- The Company violated Section 52.15(b)(15) of Department Regulation No. 62 by failing to obtain: 1) information necessary to determine if the applicant is overinsured by having existing specified disease coverage in force already or application(s) pending for another specified disease policy or certificate for the same specified disease with the same or a different insurer; and 2) the number of specified diseases for which either the applicant has coverage in force as of the date of the application or application(s) pending as of the date of the application for such coverage. (See item 7A7 of this report)
- The Company violated Section 52.54 of Department Regulation No. 62 by failing to provide accidental death and dismemberment policyholders the appropriate disclosure in Section 52.61 of this Part for policies sold during the examination period. (See item 7A8 of this report)
- The Company violated Section 3209(g) of the New York Insurance Law and Section 53-1.4(a) of Department Regulation No. 74 by failing to maintain, at its home office, a complete file containing one specimen copy of the preliminary information form

and the policy summary form authorized by the insurer for each policy form subject to this Part. (See item 7A9 of this report)

- The Company violated Section 3201(b)(1) of the New York Insurance Law by using application forms that were not filed with and approved by the Department prior to their use to issue life and accidental death and dismemberment insurance in New York. (See item 7B3 of this report)
- The Company violated Section 216.5(a) of Department Regulation No. 64 by failing to furnish the claimant with a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving notice of the claim. (See item 7C2 of this report)
- The Company violated Section 226.3(b) of Department Regulation No. 200 by failing to take all steps necessary to have each affiliate, parent, subsidiary, or other entity perform the search required by Section 226.3(a) of the Regulation. (See item 7C2 of this report)
- The Company violated Section 226.4(a)(1) of Department Regulation No. 200 by failing to request information, at no later than policy delivery or the establishment of an account and upon any change of insured, owner, account holder, or beneficiary, sufficient to ensure that all benefits or other monies are distributed to the appropriate persons upon the death of the insured or account holder. (See item 7C2 of this report)
- The Company violated Section 226.4(b)(1) of Department Regulation No. 200 by failing to use the latest available updated version of the death index to cross-check every policy and account at least quarterly. (See item 7C2 of this report)
- The Company violated Section 216.11 of Department Regulation No. 64 by failing to maintain within each claim file all communications, transactions, notes and workpapers, whether written or oral, emanating from or received by the insurer relating to the claim, and by failing to maintain claim files so that all events relating to a claim can be reconstructed by the Department's examiner. (See item 7C2 of this report)
- The Company violated Section 403(d) of the New York Insurance Law by using a claim form that does not contain a fraud warning statement that conforms to the New York Insurance Law. A similar violation appeared in the prior report on examination. (See item 7C3 of this report)

- The Company violated Sections 3111(a), (b), and (e) of the New York Insurance Law by failing to provide annual notice to senior citizen insureds of Medicare supplemental and long-term care insurance of their right to designate a third-party to receive notices of cancellation, nonrenewal and conditional renewal. (See item 7C4 of this report)
- The Company violated Section 4228(f)(1)(B) of the New York Insurance Law by paying agent compensation during the examination period to call center agents under a compensation arrangement that was never filed with the Department. A similar violation appeared in the prior report on examination. (See item 10 of this report)

## 2. SCOPE OF EXAMINATION

The examination of the Company was a full scope examination as defined in the *NAIC Financial Condition Examiners Handbook, 2013 Edition* (the "Handbook"). The examination covers the four-year period from January 31, 2009, through December 31, 2012. The examination was conducted observing the guidelines and procedures in the Handbook and, where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2012, but prior to the date of this report (i.e., the completion date of the examination) were also reviewed.

In the course of the examination, a review was also made of the manner in which the Company conducts its business and fulfills its contractual obligations to policyholders and claimants. The results of this review are contained in item 7 of this report.

The examination was conducted on a risk focused basis in accordance with the provisions of the Handbook published by the National Association of Insurance Commissioners ("NAIC"). The Handbook guidance provides for the establishment of an examination plan based on the examiner's assessment of risk in the insurer's operations and utilizing that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the current financial condition as well as identify prospective risks that may threaten the future solvency of the insurer. The examiner identified key processes, assessed the risks within those processes and evaluated the internal control systems and procedures used to mitigate those risks. The examination also included assessing the principles used and significant estimates made by management, evaluating the overall financial statement presentation, and determining management's compliance with New York statutes and Department guidelines, Statutory Accounting Principles as adopted by the Department, and annual statement instructions.

Information about the Company's organizational structure, business approach and control environment were utilized to develop the examination approach. The Company's risks and management activities were evaluated incorporating the NAIC's nine branded risk categories. These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market

- Liquidity
- Legal
- Reputational

The Company was audited annually, for the years 2009 through 2012, by the accounting firm of Deloitte & Touche LLP. The Company received an unqualified opinion in all years. Certain audit workpapers of the accounting firm were reviewed and relied upon in conjunction with this examination. The Company has an internal audit department which was given the task of assessing the internal control structure and compliance with the Sarbanes-Oxley Act of 2002 ("SOX"). Where applicable, SOX workpapers and reports were reviewed and portions were relied upon for this examination.

The examiner reviewed the corrective actions taken by the Company with respect to the violations and recommendations contained in the prior report on examination. The results of the examiner's review are contained in item 12 of this report.

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

## 3. DESCRIPTION OF COMPANY

### A. History

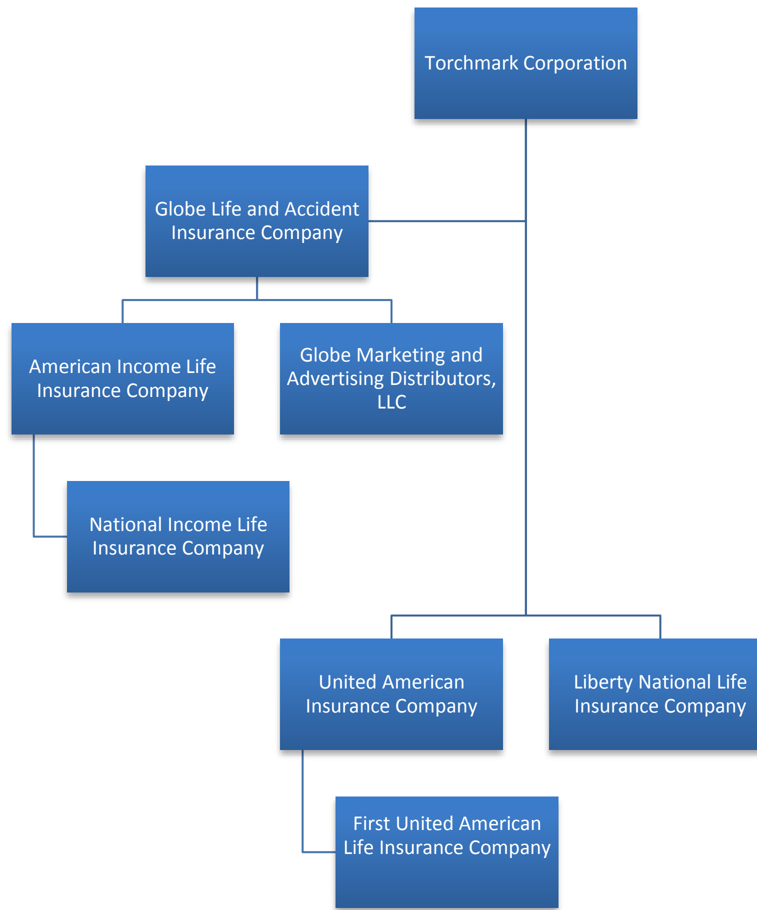
The Company was incorporated as a stock life insurance company under the laws of New York on June 16, 1981, under the name of Globe International Life Insurance Company. The Company was licensed and commenced business on December 10, 1984. The name of the Company was changed to First United American Life Insurance Company effective October 1, 1985. Initial resources of $6,428,480 consisting of common capital stock of $2,000,000 and paid in and contributed surplus of $4,428,480, were provided through the sale of 100 shares of common stock (with a par value of $20,000 each) for $64,284.80 per share. As of December 31, 2012, the Company's capital and paid in and contributed surplus were $2,000,000 and $4,428,480, respectively.

### B. Holding Company

The Company is a wholly owned subsidiary of United American Insurance Company ("UAIC"), a Delaware insurance company. UAIC is in turn a wholly owned subsidiary of TMK, the ultimate parent of the Company. TMK is a publicly traded Delaware investment advisory company. National Income Life Insurance Company ("NILIC") is an affiliate company which is also domiciled in the State of New York.

C. Organizational Chart

An organization chart reflecting the relationship between the Company and significant entities in its holding company system as of December 31, 2012, follows:



D. Service Agreements

The Company had five service agreements in effect with affiliates during the examination period.

| Type of Agreement and Department File Number | Effective Date | Provider of Service(s) | Recipient of Service(s) | Specific Service(s) Covered | Income/ (Expense)* For Each Year of the Examination |
|---|---|---|---|---|---|
| Service Agreement File No. 28815<br><br>Addendum #1 File No. 32816 | 08/01/2000<br><br>07/01/2004 | UAIC | The Company | Underwriting, claims and administrative support for certain health insurance and military business. Data processing, accounting, record retention, telephone, legal, and actuarial services.<br><br>Amended provisions including maintenance of books and accounts and ownership and custody of records. | 2009 $(1,027,365)<br>2010 $(1,015,930)<br>2011 $(1,074,824)<br>2012 $(1,133,502) |
| Service Agreement File No. 27016<br><br>Amended File No. 31378 | 04/01/2001<br><br>6/1/2003 | Globe Life and Accident Insurance Company ("Globe") | The Company | Billing, underwriting, claims, marketing and advertising for direct response business.<br><br>Amended provisions regarding billing services, maintenance of books records and custody of records. | 2009 $(4,237,521)<br>2010 $(3,870,810)<br>2011 $(3,408,835)<br>2012 $(5,443,416) |
| Service Agreement File No. 31541 | 11/01/2003 | The Company | NILIC | Supervisory, oversight, support and managerial services. | 2012 $4,550<br>2011 $4,550<br>2010 $4,550<br>2009 $4,550 |
| Sublease Agreement File No. 31541 | 03/05/2007 | The Company | NILIC | Sublease of office space | 2012 $2,009<br>2011 $2,009<br>2010 $2,009<br>2009 $2,009 |
| Investment Agreement File No. 21949 A & B | 01/01/1994 | TMK | The Company | Investment management services including rendering advice and services as necessary regarding the purchase, sale or other disposition of securities in accordance with Company's investment policies. | 2009 $0<br>2010 $0<br>2011 $0<br>2012 $0 |

* Amount of Income or (Expense) Incurred by the Company

The Company participates in a federal income tax allocation agreement with its parent and affiliates.

Section 1505(a) of the New York Insurance Law states:

> "Transactions within a holding company system to which a controlled insurer is a party shall be subject to the following:
> (1) the terms shall be fair and equitable;
> (2) charges or fees for services performed shall be reasonable; and
> (3) expenses incurred and payments received shall be allocated to the insurer on an equitable basis in conformity with customary insurance accounting practices consistently applied."

TMK provided investment management services to the Company during the examination period and during 2008. TMK did not bill the Company and the Company did not reimburse TMK for investment management services it received since 2007, contrary to the terms of the investment services agreement between the two companies effective November 1, 1994. The Company stated that the discontinuation of billing was an unintentional oversight at TMK and that TMK resumed billing the Company during 2013.

The Company stated that it should have paid TMK $12,000 per year in 2008, 2009, 2010, 2011 and 2012 for investment management services rendered. The Company did reimburse TMK $24,000 in 2013 for investment management services.

The Company violated Section 1505(a) of the New York Insurance Law by failing to reimburse TMK for investment management services that it received on a regular and systematic basis during 2008, 2009, 2010, 2011 and 2012.

Section 91.4 of Department Regulation No. 33 states, in part:

> "(a) General instructions. (1) It is the responsibility of each life insurer to use only such methods of allocation as will produce a suitable and equitable distribution of income and expenses by lines of business. Unless impractical or unfeasible, an insurer may use only such methods of allocation in its distribution of income and expenses within annual statement lines of business as are compatible with the methods it uses for distribution between annual statement lines of business . . .
>
> (5) Allocations of income and expenses between companies shall be treated in the same manner as if made for major annual statement lines of business . . .
>
> (f) General expenses, taxes, licenses and fees. (1) In distributing costs to lines of business, each company shall employ those principles and methods that will reasonably reflect the actual incidence of cost by line of business. The relative time

spent, the extent of usage and the varying volume of work performed for each line of business shall be considered in distributing cost to major annual statement lines of business and, to the extent practicable, to secondary annual statement lines of business. The costs of any unit of activity in performing work for one line of business and only incidentally for other lines may be allocated entirely to the single line of business . . ."

Article V of the Investment Agreement between the Company and TMK, effective November 1, 1994, states, in part:

"Section 1. FUALIC shall neither subsidize or be subsidized by Torchmark. Torchmark shall determine and provide an allocation to FUALIC (the "Company") of the estimated cost and expense of providing to the Company the services to be performed on an equitable basis in conformity with customary insurance accounting practices consistently applied. The allocation and classification of expenses under this Agreement will be made in accordance with New York State Insurance Department Regulation 33; the bases for determining such changes shall be those used by Torchmark for internal cost distribution. Those direct expenses such as salaries, rent, telephone, data processing equipment, postage, agency supplies, and any other general operating expenses paid on behalf of FUALIC, plus a reasonable charge for direct overhead, will be charged to FUALIC on a monthly basis. The bases for calculating the foregoing shall be modified and adjusted by mutual agreement where necessary or appropriate to reflect fairly and equitably the actual incidence of cost incurred by Torchmark on behalf of FUALIC.

Section 2. Any services that cannot be allocated in accordance with New York Insurance Department Regulation 33 shall be estimated on the basis of the market cost that would be incurred if the services were purchased from a non-affiliate. Cost analysis will be made from time to time by Torchmark to determine, as closely as possible, the actual cost of services rendered and facilities made available to FUALIC hereunder. . . ."

The examiner reviewed the method used to allocate investment management expenses to the Company by TMK in prior periods, namely 2006 and 2007, and in 2013. The examiner obtained detailed workpapers and related documentation from the Company to support the method used by TMK to allocate investment management expenses between companies in the TMK holding company system. Based upon the documentation provided, TMK billed the Company based upon the ratio of the Company's managed assets to the total assets managed by TMK prior to 2007 and in 2013, not on the basis of time spent in accordance with the terms of the service agreement. The service agreement between the Company and TMK provides for expenses to be allocated in accordance with Department Regulation No. 33 on the basis of time spent (i.e., time studies), not based upon a ratio of the total assets under TMK's management.

The documentation to support how expenses were allocated to the insurance subsidiaries by TMK showed that TMK used a basis for the Company that was different than the basis used for the other insurance subsidiaries within the holding company group. The Company failed to demonstrate that the [weighted average] methodology used more accurately reflects the actual incidence of cost or produces a more accurate and equitable allocation of expense than if time studies were used.

The service agreement with TMK provides that if services cannot be allocated in accordance with Department Regulation No. 33, that costs should be estimated on the basis of the market cost that would be incurred if services were purchased from a non-affiliate. The Company failed to demonstrate that an allocation of $12,000 per year during 2008, 2009, 2010, 2011, 2012 and $24,000 in 2013 is consistent with what the Company would have paid (i.e., market cost) if the Company received investment management services from a non-affiliate for the same periods.

The Company violated Section 91.4(f) of Department Regulation No. 33 by failing to allocate expenses between companies according to principles and methods that reasonably reflect the actual incidence of cost, and which consider the relative time spent, the extent of usage and the varying volume of work performed.

## E. Management

The Company's by-laws provide that the board of directors shall be comprised of not less than 9 and not more than 21 directors. The number of directors, however, shall be increased to not less than 13 within one year following the end of the calendar year in which the corporation exceeds $1.5 billion in admitted assets. Directors are elected for a period of one year at the annual meeting of the stockholders held at the time and on the date determined by the board of directors. As of December 31, 2012, the board of directors consisted of nine members. Meetings of the board are held quarterly.

The nine board members and their principal business affiliation, as of December 31, 2012, were as follows:

| Name and Residence | Principal Business Affiliation | Year First Elected |
|---|---|---|
| Jerry Greenspan*<br>Harrison, NY | Retired<br>RBC Dain Raucher | 2007 |
| Vern D. Herbel<br>McKinney, TX | President and Chief Executive Officer<br>First United American Life Insurance Company | 2004 |
| Ben W. Lutek<br>McKinney, TX | Senior Vice President and Chief Actuary<br>First United American Life Insurance Company | 2010 |
| Dirk Marschhausen*<br>Garden City, NY | Attorney at Law<br>Marschhausen and Fitzpatrick PC | 1997 |
| Robert B. Mitchell<br>Frisco, TX | Vice President, General Counsel, and Secretary<br>First United American Life Insurance Company | 2012 |
| Jules O. Pagano<br>Jamesville, NY | Retired<br>American Income Life Insurance Company | 2009 |
| James A. Savo<br>Liverpool, NY | Vice President, Operations and General Manager<br>First United American Life Insurance Company | 2000 |
| Stephen W. Still*<br>Mountain Brook, AL | Attorney at Law<br>Maynard, Cooper and Gale, PC | 2003 |
| Frank M. Svoboda<br>Grapevine, TX | Executive Vice President and Chief Financial Officer<br>Torchmark Corporation | 2012 |

* Not affiliated with the Company or any other company in the holding company system

In July 2013, Jules O. Pagano passed away, and in October 2013, he was replaced by Denis Hughes, an unaffiliated director.

The examiner's review of the minutes of the meetings of the board of directors and its committees indicated that meetings were well attended and that each director attended a majority of meetings.

The following is a listing of the principal officers of the Company as of December 31, 2012:

| Name | Title |
|---|---|
| Vern D. Herbel | President and Chief Executive Officer |
| Ben W. Lutek | Senior Vice President and Chief Actuary |
| Robert B. Mitchell | Senior Vice President, General Counsel and Secretary |
| Michael S. Henrie | Senior Vice President, Corporate Accounting, Chief Financial Officer and Treasurer |
| James S. Hawke | Vice President and Appointed Actuary |
| James A. Savo* | Vice President, Operations and General Manager |

* Designated consumer services officer per Section 216.4(c) of Department Regulation No. 64

## 4. TERRITORY AND PLAN OF OPERATIONS

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 New York. In 2012, all life, accident and health premiums, and annuity considerations were received from New York. Policies are written on a non-participating basis.

### A. Statutory and Special Deposits

As of December 31, 2012, the Company had $425,000 (par value) of United States Treasury Bonds on deposit with the State of New York, its domiciliary state, for the benefit of all policyholders, claimants and creditors of the Company.

### B. Direct Operations

Prior to 1994, the Company wrote, almost exclusively, individual Medicare supplement insurance. In 1994, the Company began writing individual life insurance, and in 1995, the Company began writing group Medicare supplement insurance and individual annuities.

The Company's individual Medicare supplement insurance and individual annuities are solicited through the Company's agency force, which operates on a general agency basis. Approximately 99% of the ordinary life business was sold through direct response marketing; the other 1% was marketed exclusively to military personnel by one general agency. All life insurance sold during the examination period was written on a simplified issue basis.

The Company's group Medicare supplement insurance is primarily solicited to employer and union groups through licensed brokers or agents; direct response marketing is also used but to a lesser extent. The group Medicare supplement business may be issued as mandatory or voluntary coverage depending upon the group. For mandatory business, the employer or union bears the cost of the insurance and all retirees are covered. For voluntary business, the group policyholder provides a list of retirees eligible for coverage and the Company sends direct response packages with enrollment forms to the retirees.

In 2006, the Company contracted with the Centers for Medicare and Medicaid Services ("CMS") to be an insurer under the government's new Medicare Part D stand-alone prescription

drug plan for Medicare beneficiaries. Unlike the Company's Medicare supplement plans, insurers participating in Medicare Part D are the primary insurers for plans regulated and funded in part by CMS. The Medicare Part D program generally calls for CMS to pay two-thirds of the premium with the insured Medicare beneficiary paying one-third of the premium. The Company's Medicare Part D product is primarily sold through direct response methods, but it is also sold by general agents.

The Company received approval for a lump sum cancer product, policy form No. NYCANLS-2, on April 19, 2012. New business sales began on September 6, 2012. The lump sum cancer product is sold by general agents.

Effective August 10, 2013, the Company stopped selling individual annuities.

C. Reinsurance

As of December 31, 2012, the Company had no reinsurance treaties in effect for new business. The Company reported total accident and health unearned premium and other than unearned premium reserve credits of $593,685. The accident and health reserve credit is related to a reinsurance treaty that was terminated on July 1, 1993, and covers the Company's long-term care business, which is currently in run-off.

The Company did not assume any business during the examination period.

## 5. SIGNIFICANT OPERATING RESULTS

Indicated below is significant information concerning the operations of the Company during the period under examination as extracted from its filed annual statements. Failure of items to add to the totals shown in any table in this report is due to rounding.

The following table indicates the Company's financial growth (decline) during the period under review:

| | December 31, 2008 | December 31, 2012 | Increase (Decrease) |
|---|---|---|---|
| Admitted assets | $125,418,007 | $165,372,626 | $39,954,619 |
| Liabilities | $ 87,612,094 | $131,045,926 | $43,433,832 |
| Common capital stock | $ 2,000,000 | $ 2,000,000 | $ 0 |
| Gross paid in and contributed surplus | 4,428,480 | 4,428,480 | 0 |
| Unassigned funds (surplus) | 31,377,433 | 27,898,220 | (3,479,213) |
| Total capital and surplus | $ 37,805,913 | $ 34,326,700 | $ (3,479,213) |
| Total liabilities, capital and surplus | $125,418,007 | $165,372,626 | $39,954,619 |

The Company's invested assets as of December 31, 2012 were mainly comprised of bonds (92.5%), cash and short-term investments (3.8%) and policy loans (3.7%).

The majority (93.1%) of the Company's bond portfolio, as of December 31, 2012, was comprised of investment grade obligations.

The ordinary lapse ratio for each of the examination years was 60.5% in 2009, 52.1% in 2010, 45.9% in 2011 and 41.4% in 2012. The Company has a high lapse ratio for its ordinary life business due to the nature of the product it sells. The Company's life business is sold through direct response which inherently carries a high lapse rate because it is a sale without contact and without an agent to explain the needs and benefits of the product. Persistency rates improved as a result of the decline in the number of life policies issued in 2011 and 2012.

The decrease in surplus over the current examination period is attributable to dividends paid upstream exceeding the net income during that period.

The following has been extracted from the Exhibits of Annuities in the filed annual statements for each of the years under review:

| | Ordinary Annuities | | | |
|---|---|---|---|---|
| | 2009 | 2010 | 2011 | 2012 |
| Outstanding, end of previous year | 372 | 333 | 321 | 437 |
| Issued during the year | 4 | 24 | 144 | 1,278 |
| Other net changes during the year | (43) | (36) | (28) | (19) |
| Outstanding, end of current year | 333 | 321 | 437 | 1,696 |

The increase in the number of ordinary annuities issued in 2012 was the result of the product's appeal to consumers because of its attractive minimum guaranteed interest rate of 3% in a low interest rate environment.

The following has been extracted from the Exhibits of Accident and Health Insurance in the filed annual statements for each of the years under review:

| | Ordinary | | | |
|---|---|---|---|---|
| | 2009 | 2010 | 2011 | 2012 |
| Outstanding, end of previous year | 21,750 | 21,503 | 20,224 | 20,894 |
| Issued during the year | 3,243 | 2,697 | 4,841 | 12,818 |
| Other net changes during the year | (3,490) | (3,976) | (4,171) | (6,441) |
| Outstanding, end of current year | 21,503 | 20,224 | 20,894 | 27,271 |

| | Group | | | |
|---|---|---|---|---|
| | 2009 | 2010 | 2011 | 2012 |
| Outstanding, end of previous year | 890 | 770 | 706 | 690 |
| Issued during the year | 55 | 28 | 96 | 469 |
| Other net changes during the year | (175) | (92) | (112) | (46) |
| Outstanding, end of current year | 770 | 706 | 690 | 1,113 |

The increase in the number of ordinary and group health policies issued during 2012 is related to the strong sales of Medicare Part D policies. In 2012, the Company offered a new low cost Medicare Part D plan. The plan enabled the Company to pick up a large number of low income auto-enrollees. Medicare Part D policies carry a smaller premium compared to other plans; the amount of premiums in force increased at a smaller percentage than the amount of policies in force.

The following is the net gain (loss) from operations by line of business after federal income taxes but before realized capital gains (losses) reported for each of the years under examination in the Company's filed annual statements:

| | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|
| Ordinary: | | | | |
| Life insurance | $2,529,264 | $2,840,743 | $2,003,512 | $2,749,057 |
| Individual annuities | 275,100 | (51,511) | (10,393) | (755,803) |
| Total ordinary | $2,804,364 | $2,789,232 | $1,993,119 | $1,993,254 |
| Accident and health: | | | | |
| Group | $ 96,330 | $ 189,079 | $ 73,363 | $ 252,221 |
| Other | 4,483,513 | 6,035,911 | 1,791,575 | 7,680,885 |
| Total accident and health | $4,579,843 | $6,224,990 | $1,864,938 | $7,933,106 |
| Total | $7,384,207 | $9,014,222 | $3,858,057 | $9,926,360 |

The claims reserves increased by $3.4 million in 2011 due to anticipation of Medicare exhaustion claims that could become payable in 2012. The Medicare exhaustion claims accrued for at year-end 2011 were less than anticipated. As a result, the accident and health claims expense showed a substantial increase in 2011 and a substantial decrease in 2012 due to the reversal of previously accrued claims reserves, which impacted the gain from operations on the individual accident and health line of business in 2011 and 2012.

The following ratios, applicable to the accident and health business of the Company, have been extracted from Schedule H for each of the indicated years:

| | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|
| Premiums earned | 100.0% | 100.0% | 100.0% | 100.0% |
| Incurred losses | 70.5% | 65.7% | 81.7% | 61.2% |
| Commissions | 11.5% | 11.0% | 10.9% | 10.1% |
| Expenses | 4.6% | 3.8% | 3.9% | 3.7% |
| Underwriting results | 13.4% | 19.5% | 3.4% | 25.0% |

The fluctuation in the incurred losses ratio between 2010 and 2011 and between 2011 and 2012 resulted from the accrual for anticipated Medicare exhaustion claims in 2011, and then the reversal of the accrual in 2012 attributable to the lower than anticipated Medicare exhaustion claims incurred by the Company at year-end 2011.

## 6. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital and surplus as of December 31, 2012, as contained in the Company's 2012 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for each of the years under review. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Company's financial condition as presented in its financial statements contained in the December 31, 2012, filed annual statement.

### A. Independent Accountants

The firm of Deloitte & Touche LLP was retained by the Company to audit the Company's combined statutory basis statements of financial position as of December 31st of each year in the examination period, and the related statutory-basis statements of operations, capital and surplus, and cash flows for the year then ended.

Deloitte & Touche LLP concluded that the statutory financial statements presented fairly, in all material respects, the financial position of the Company at the respective audit dates. Balances reported in these audited financial statements were reconciled to the corresponding years' annual statements with no discrepancies noted.

### B. Net Admitted Assets

| | |
|---|---|
| Bonds | $134,670,899 |
| Cash, cash equivalents and short term investments | 5,592,745 |
| Contract loans | 5,331,436 |
| Investment income due and accrued | 1,788,615 |
| Premiums and considerations: | |
| Uncollected premiums and agents' balances in the course of collection | 1,537,865 |
| Deferred premiums, agents' balances and installments booked but deferred and not yet due | 5,477,550 |
| Net deferred tax asset | 5,985,000 |
| Health care and other amounts receivable | 4,297,113 |
| New York Department adjustment | 691,403 |
| Total admitted assets | $165,372,626 |

C. Liabilities, Capital and Surplus

| | |
|---|---|
| Aggregate reserve for life policies and contracts | $109,195,903 |
| Aggregate reserve for accident and health contracts | 9,351,050 |
| Contract claims: | |
| Life | 2,592,000 |
| Accident and health | 4,396,000 |
| Premiums and annuity considerations for life and accident and health contracts received in advance | 1,497,225 |
| General expenses due or accrued | 498,000 |
| Taxes, licenses and fees due or accrued, excluding federal income taxes | 825,323 |
| Current federal and foreign income taxes | 574,500 |
| Amounts withheld or retained by company as agent or trustee | 306,750 |
| Amounts held for agents' account | 389,067 |
| Remittances and items not allocated | 117,583 |
| Asset valuation reserve | 860,422 |
| Payable to parent, subsidiaries and affiliates | 435,234 |
| Adjustment for nursing home business | 6,869 |
| Total liabilities | $131,045,926 |
| Common capital stock | 2,000,000 |
| Gross paid in and contributed surplus | 4,428,480 |
| Unassigned funds (surplus) | 27,898,220 |
| Surplus | $ 32,326,700 |
| Total capital and surplus | $ 34,326,700 |
| Total liabilities, capital and surplus | $165,372,626 |

The Company reported a health care receivable equal to $4,297,113 in 2012. $3,883,971 of this amount is attributable to the receivable for claims reimbursement due from the federal government's CMS for its share of Medicare Part D claims paid. The remainder is reported as non-admitted asset comprising agent debit balances.

The Company closes its ledger on December 24th each year instead of December 31st. The 1990 report on examination contained a recommendation that the Company establish an accrual for the period between December 24th and December 31st in order to comply with Section 307 of the New York Insurance law. The New York Department adjustments line in the annual statement represents an estimate of cash transactions for premiums, claims, commissions, investment income, etc., during the period between December 24th and December 31st of the current year.

insert media, that comprise a direct response solicitation. The Company does not have a mechanism, such as an electronic database, to maintain and manage their advertising material in such a manner that would enable them to readily provide necessary details, including the extent or number of times each insert media piece was mailed. The Company was unable to produce a listing of the insert media advertisement pieces that comprised each direct response mailing disseminated to New York residents during the examination period in a timely manner.

In addition, during the examination period, the Company engaged in a joint marketing program with its affiliate, Globe. The Company and Globe contracted with third-party media outlets to distribute their joint lead advertisements on a national basis. The proprietary mailing lists used to distribute the joint advertisements were owned by the third-party media outlets, not the Company. The Company and Globe were able to provide the total number of advertisements that were distributed on a national basis, but were unable to provide the information regarding the manner of distribution or the number of advertisements mailed specifically to New York residents.

The Company violated Section 215.2(b) of Department Regulation No. 34 by failing to establish and maintain a system of control over the content, form and method of dissemination of all advertisements of its accidental death policies.

The Company violated Section 219.2(b) of Department Regulation No. 34-A by failing to establish and maintain a system of control over the content, form and method of dissemination of all advertisements of its life policies.

The examiner recommends that the Company implement a database or other electronic tracking system to control the content, form and method of dissemination of Company advertisements in New York, specifically with respect to direct response media, that would allow the Company to readily produce upon request detailed information, including the unique advertisement identifier of each advertisement contained in a direct response package as well as the direct response package identification number.

The examiner recommends that the Company implement a control mechanism that would enable it to track, monitor and produce manner and extent of distribution information for joint advertisements distributed at the discretion of contracted media partners on behalf of the Company in New York.

2) Section 219.5(a) of Department Regulation No. 34-A states, in part:

> "Each insurer shall maintain at its home office a complete file containing a specimen copy of every printed, published or prepared advertisement hereafter disseminated in this state, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. In order to be complete, the file must contain all advertisements whether used by the company, its agents or solicitors or other persons. . . . "

Section 215.17(a) of Department Regulation No. 34 states, in part:

> ". . . Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by the department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time."

The advertising file maintained at the Company's home office did not include the joint advertisements with its affiliate, Globe, the advertisements for agent written products, the advertisements published on the internet, or the manner and extent of distribution information.

The Company violated Section 219.5(a) of Department Regulation No. 34-A by failing to maintain a complete file containing a specimen copy of every printed, published or prepared life and annuity advertisement disseminated in New York, with a notation indicating the manner and extent of distribution and the form number of any policy advertised.

The Company violated Section 215.17(a) of Department Regulation No. 34 by failing to maintain a complete file containing every printed, published or prepared health advertisement disseminated in New York, with a notation attached to each such advertisement indicating the manner and extent of distribution.

3) Section 2122(a)(2) of the New York Insurance Law state:

 “No insurance agent, insurance broker or other person, shall, by any advertisement or public announcement in this state, call attention to any unauthorized insurer or insurers.”

 Section 2122(b) of the New York Insurance Law state:

 “Every agent of any insurer and every insurance broker shall, in all advertisements, public announcements, signs, pamphlets, circulars and cards, which refer to an insurer, set forth therein the name in full of the insurer referred to and the name of the city, town or village in which it has its principal office in the United States.”

 Section 219.3(e) of Department Regulation No. 34-A states:

 “*Joint advertisement* means an advertisement that contains the names of, or refers to insurance policies sold by, a New York authorized insurer and its parent, subsidiary or affiliate.”

 Section 219.4 of Department Regulation No. 34-A states, in part:

 “ . . . (p) In all advertisements made by an insurer, or on its behalf, the name of the insurer shall be clearly identified, together with the name of the city, town or village in which it has its home office in the United States. . . .

 (q) . . . The name of the unauthorized insurer shall not be more prominent than the name of the authorized insurer. The disclaimer shall be of prominence and placement relative to references to unauthorized insurers or insurance policies not available in New York so as not to minimize, render obscure or otherwise diminish the importance of the information contained therein. . . .

 (x) An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from that of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised. . . .”

The Company engaged in a joint advertising program with its affiliate, Globe, offering life insurance marketed on a direct response basis. The joint direct response lead advertisements with Globe were distributed on a national basis. Globe is not licensed in New York.

A review of 52 joint advertising materials mailed to prospective applicants in New York during the examination period revealed that in 30 of the 52 advertisements (57.7%), the name of

its unlicensed affiliate, Globe, was more prominent in the joint lead advertisements than the name of the Company, and the joint advertisements made reference to the following internet address: *www.startglobelife.com*. The joint advertisements also failed to contain the Company's home office address. The font size of the only disclaimer language contained in the joint advertisements "Offer varies by state. Available in NY from First United American" was much smaller than the font used in the remainder of the advertisement and was not sufficiently clear or conspicuous. The recipient of such an advertisement may not be able to easily identify that insurance available in New York is sold through the Company, and not Globe.

The joint advertisements offered the prospective applicant the opportunity to purchase an adult life insurance policy with a $50,000 benefit or a juvenile life insurance policy with a $20,000 benefit for a reduced initial of $1 for the first month. The joint advertisements did not contain a full rate schedule for the policy with respect to the $1 initial premium offer. The amount of the initial premium offered differs from amount of the renewal premium payable on the same mode for the policy available in New York.

The Company violated Sections 2122(a)(2) and 2122(b) of the New York Insurance Law by calling attention to an unauthorized insurer in advertisements disseminated in New York.

The Company violated Section 219.4(p) of Department Regulation 34-A by failing to clearly identify its name together with the name of the city, town or village in which it has its home office in the United States in advertisements disseminated in New York.

The Company violated Section 219.4(q) of Department Regulation 34-A by making the name of the unauthorized insurer more prominent than the name of the authorized insurer in advertisements disseminated in New York.

The Company violated Section 219.4(x) of Department Regulation 34-A by advertising a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the reduced initial premium. The initial premium offered differs from the amount of the renewal premium payable on the same mode for the New York policy, and the advertisement did not contain the required full rate schedule for the New York policy.

4) Section 215.4 of Department Regulation No. 34 states:

"All information required to be disclosed by this Part shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading."

Section 215.5 of Department Regulation No. 34 states, in part:

"(a) The format and content of an advertisement of an accident and health insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the superintendent from the overall impression that the advertisement may be reasonably expected to create upon a person of average education and intelligence, unique to the particular type of audience to which the advertisement is directed, and whether it may be reasonably comprehended by the segment of the public to which it is directed . . .
(c) An advertisement of a policy shall contain in a prominent place and style the appropriate statement for the coverage provided, as determined by the definitions in 11 NYCRR 52.5-52.11 (Regulation 62), as follows . . .
(6) This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is ____________________%. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy.
IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS."

Section 52.61 of Department Regulation No. 62 states:

"To comply with section 52.54 of this Part, policies of individual insurance meeting the definition of section 52.9 of this Part shall use the following statement only, except that appropriate policy identification may be included:

COMPANY NAME
ACCIDENT INSURANCE
REQUIRED DISCLOSURE STATEMENT

This policy provides insurance only for ACCIDENTS. It does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Department of Financial Services.

IMPORTANT NOTICE—THIS POLICY DOES NOT
PROVIDE COVERAGE FOR SICKNESS.

This policy:

( *Accurately list benefits, exclusions, reductions and limitations of the policy in a manner that does not encourage misrepresentation of the actual coverage provided.* )

This disclosure statement is a very brief summary of your policy.

The policy itself sets forth the rights and obligations of both you and the Insurance Company. It is therefore important that you READ YOUR POLICY carefully.

The expected benefit ratio for this policy is to __________%. This ratio is the portion of future premiums that the company expects to return as benefits when averaged over all people with this policy."

Section 215.6(a)(3) of Department Regulation 34 states:

"No advertisement shall contain any description of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a "benefit builder," or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered."

Section 215.6(c)(3) of Department Regulation No. 34 states:

"When an advertisement contains an application to be completed by the applicant and returned by mail for a direct response insurance product, such application shall be identical except for size to the application form approved for the policy being offered."

Section 52.31(e) of Department Regulation No. 62 states, in part:

"Forms submitted for approval shall be in the form intended for actual use. . . ."

Section 215.14 of Department Regulation 34 states:

"An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact."

Section 215.15 of Department Regulation No. 34 states, in part:

"(a)(1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at

> a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not describe an enrollment period as "special," or "limited," or use similar words or phrases when the insurer uses enrollment periods as the usual method of advertising accident and sickness insurance . . .
>
> (3) This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.
>
> (4) The phrase 'a particular insurance product' in paragraph (2) of this subdivision means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.
>
> (b) An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial premium . . ."

During the examination period, the Company marketed its accidental death and dismemberment insurance policies in New York on a direct response basis. The examiner reviewed a sample of 18 direct response solicitations for the Company's accidental death and dismemberment policy, policy form No. NYADDP. Each solicitation was comprised of multiple insert media pieces with unique identification numbers. The Company mailed the accidental death and dismemberment insurance solicitations to individuals that recently obtained mortgage loans. The Company purchased the identity of these individuals from a third-party vendor that collected this information from public county records.

In general, the format and content of the direct response solicitations for Policy Form NYADDP had the capacity to be misleading or confusing to the prospective applicant with respect to the identity of the insurer and that the insurance offer was for an accidental death and dismemberment policy where benefits are payable only if the insured's death is the result of an accident.

The direct response solicitations for policy form No. NYADDP did not include the required outline of coverage stating that the policy provides insurance for accidents only. The required disclosure was not delivered with the policy.

The same or substantially similar "insert media" advertisements (format and content) were used multiple times in different solicitations mailed to New York insurance consumers during the examination period. The following were noted:

1. The placement of the Company's name with respect to the phrase "HOME MORTGAGE PROTECTION GROUP" on the envelope and in the letter from the President, Vern D. Herbel, contained in these advertisements has the capacity to mislead or deceive or give the impression that "HOME MORTGAGE GROUP" is in some way a stand-alone entity, an affiliate or a subsidiary of the Company. An example includes: "Please consider this valuable and important protection available through the Home Mortgage Group of First United American Life Insurance Company."

2. The words "HOME MORTGAGE GROUP" appears in larger font size than the name of the Company on the version of the applications that were included in the solicitations.

3. The phrase "Update: Important Mortgage Information Enclosed Signature Required" appeared on the mailing envelope containing the solicitation.

4. The advertisements contained language that may confuse a prospective applicant into believing that they are purchasing mortgage protection insurance, not accidental death and dismemberment insurance. An example includes: " . . . our records indicate you have not responded to our Mortgage Protection Insurance offer . . . ATTENTION: YOU AND YOUR FAMILY HAVE QUALIFIED TO RECEIVE THIS OFFER FOR AFFORDABLE MORTGAGE PROTECTION INSURANCE . . . As a homeowner, it's important to do all you can to protect your home and your family if an unexpected accidental death prevents you from paying your mortgage. If you are not prepared, your home and everything you've worked for can be taken away . . . "

5. The solicitations included a letter from the Company's President, Vern D. Herbel, and an application that contained references to the mortgage lender. It is not clear that the mortgage lender gave the Company permission to use or has any knowledge of their name appearing in Company advertisements. The identity of the mortgage lender was obtained from public county records.

6. The solicitations contained phrases, or substantially similar phrases of the same import, that give the impression that the offer for accidental death and dismemberment insurance is a limited time only offer that is being made available to a specific or "special" group of individuals. Yet advertisements in substantially the same form and content were used during the four-year examination period, so it is difficult to make an argument that these offers for accident insurance were only available for a limited time, as in the following examples:

    i. "As a homeowner with a new mortgage, you are now eligible for our Mortgage Protection Insurance . . . "

ii. "This Offer Won't Last Long – Please Reply Today"

iii. "This offer is currently not available to everyone. It is only being made to homeowners like you . . . "

7. Twelve of the eighteen (66.67%) solicitations reviewed failed to contain the expected benefit ratio of the policy and language stating that the policy provides accident insurance only and does not provide coverage for sickness.

8. Twenty solicitations that were mailed multiple times during the examination period to New York consumers contained insert No. F6436 or insert No. N7867, which were both titled, "Overview of Benefits" and were substantially the same in format and content. The inserts exclude coverage for losses that are not described in the policy provisions. This may be misleading if the insured does not read the policy, but relies on the advertisement for this information. Additionally, the Company is prohibited by Law from excluding some of the losses shown in the advertisement.

The Company violated Section 215.4 of Department Regulation No. 34 by disseminating advertisements in New York that were ambiguous as to the identity of the insurer and the fact that the insurance offered is not life insurance, credit insurance, or mortgage guarantee insurance, and is only payable if the insured's death is due to an accident.

The Company violated Section 215.5(a) of Department Regulation No. 34 by using references that have the tendency to mislead or deceive the prospective applicant with respect to the identity of the Company and to the fact that the insurance policy is an accidental death and dismemberment policy, not credit life or disability insurance.

The Company violated Section 215.5(c)(6) of Department Regulation No. 34 by failing to disclose the expected benefit ratio of the policy and by failing to include a statement that the policy provides accident insurance only and that the policy does not provide coverage for sickness.

The Company violated Section 215.6(a)(3) of Department Regulation No. 34 and Section 52.61 of Department Regulation No. 62 by using direct response insert media labeled "Overview of Benefits" that did not accurately describe the benefits and exclusions afforded by the approved policy form on file with the Department. This can be misleading to the insureds if they do not read the policy, but rely on the advertisement for this information.

The Company violated Section 215.6(c)(3) of Department Regulation No. 34 and Section 52.31(e) of Department Regulation No. 62 by using an application to be completed by the applicant and returned by mail for a direct response insurance product that was not identical to the form filed with and approved by the Department.

The Company violated Section 215.14 of Department Regulation No. 34 by disseminating advertisements directed toward homeowners that imply the mortgagee was a member of a group or a quasi-group covered under a group policy eligible for special rates or underwriting privileges.

The Company violated Section 215.15 of Department Regulation No. 34 by disseminating an advertisement in New York for an individual policy implying that the contract is a special offer, an offer that is available only to a specified group of individuals, and an offer that is not available at a later date (i.e., "this offer won't last long").

5) Section 51.4 of Department Regulation No. 60 states, in part:

> "Procedures designed to meet the purposes of this Part, that are approved in advance and determined by the Superintendent of Financial Services not to be detrimental to policyholders and contractholders, may be substituted for this Part by an insurer where no sales agency force is used and the application is solicited and received by the insurer by mail or under other methods that are without agent or broker involvement. . . ."

Section 51.6(e) of Department Regulation No. 60 states, in part:

> "Both the insurer whose life insurance policy or annuity contract is being replaced and the insurer replacing the life insurance policy or annuity contract shall establish and implement procedures to ensure compliance with the requirements of this Part. . . . Such insurers shall also designate a principal officer specifically responsible for the monitoring and enforcement of these procedures. . . . Any changes in these procedures or the designated principal officer shall be furnished to the Superintendent of Financial Services within 30 days of such change."

During the examination period, the Company started selling its insurance policies electronically over the internet and by telephone. Between November 2009 and December 2011, unlicensed employees of Globe accepted applications for the Company's life insurance products over the phone. In May 2010, Globe instituted a call center where New York consumers are able to apply for insurance over the phone through a licensed agent.

The Company did not obtain approval of alternate replacement procedures for the sale of its life insurance policies over the internet where there is no agent or broker involvement.

In addition, the examiner reviewed the replacement procedures used by Globe employees when applications for life insurance were taken by telephone during the examination period. The replacement procedures in use did not coincide with the procedures filed with the Department and do not comply with Regulation No. 60 requirements. For example, although the procedures

required the agent to ask the applicant if the insured had existing life insurance at the point of sale, the procedures did not require the agent to recite the "Definition of Replacement" or the "New York Residents Only Important Replacement Notice" to the applicant.

The procedures filed with the Department for the sale of individual life insurance products where an agent or broker is involved state that the Company will decline an application where existing insurance may be replaced. However, the procedures in use during the examination period for telephone sales did not require the agent to decline any application where existing insurance may be replaced. The Company is also marketing policies and using applications on a direct response basis that are not listed in the alternate procedures filed with the Department.

The Company violated Section 51.4 of Department Regulation No. 60 by failing to obtain approval of alternate procedures for the sale of its life insurance products electronically over the internet.

The Company violated Section 51.6(e) of Department Regulation No. 60 by failing to file the replacement procedures used by agents or brokers during the examination period for the sale of its life insurance products over the telephone.

The examiner recommends that the Company file alternate replacement procedures for the sale of its life insurance products over the phone and electronically over the internet, and file such procedures with the Department.

The examiner further recommends that the Company notify the Department what policy forms and applications are marketed using alternate procedures (i.e., direct mail and internet sales).

6) Section 224.4 of Department Regulation No. 187 states, in part:

> "(a) In recommending to a consumer the purchase or replacement of an annuity contract, the insurance producer, or the insurer where no insurance producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance policies or contracts and as to the consumer's financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following . . .
>
> (b) Prior to the recommendation of a purchase or replacement of an annuity contract, an insurance producer, or an insurer where no insurance producer is involved, shall make reasonable efforts to obtain the consumer's suitability information.

(c) Except as provided under subdivision (d) of this section, an insurer shall not issue an annuity contract recommended to a consumer unless there is a reasonable basis to believe the annuity contract is suitable based on the consumer's suitability information . . .

(f) An insurer shall establish a supervision system that is reasonably designed to achieve the insurer's and insurance producers' compliance with this Part. An insurer may contract with a third party to establish and maintain a system of supervision with respect to insurance producers . . ."

During the examination period, the Company sold an individual fixed deferred annuity product with a guaranteed minimum interest crediting rate of 3%. The Company did not implement written and auditable suitability standards or procedures to ensure that: 1) the insurance needs and financial objectives of consumers were fully evaluated and addressed at the time of the transaction; and 2) that the recommendation to purchase a Company annuity contract was suitable and in the consumers' best interests.

The Company relied on the agent to make a reasonable effort to obtain suitability information and to consider the prospective insured's age, financial condition, need for insurance or an annuity as well as the values, benefits, surrender charges and the intended use of the annuity; however, no evidence of the needs based evaluation was documented or maintained in the policy record to show that the agent or the Company satisfied their responsibilities under Department Regulation No. 187 prior to recommending the purchase of the annuity.

The Company violated Section 224.4(c) of Department Regulation No. 187 by issuing an annuity contract that was recommended to a consumer without having a reasonable basis to believe that the annuity was suitable based upon information obtained from the consumer as to his or her financial situation and needs.

The Company violated Section 224.4(f) of Department Regulation No. 187 by failing to establish a supervision system designed to achieve compliance with this Part.

7) Section 52.15(b) of Department Regulation No. 62 states, in part:

"General rules. . . .
(8) An insurer shall file its overinsurance rules with the Department of Financial Services. Overinsurance shall be deemed to exist when an insured has more than one specified disease policy or certificate for the same specified disease whether it is with the same or a different insurer. In no event may an insurer issue a specified disease policy or certificate to any person that will result in that person being covered for eight or more specified diseases . . .

> (15) Application forms shall include questions designed to elicit:
> (i) whether, as of the date of the application, the applicant has in force or application(s) pending for another specified disease policy or certificate for the same specified disease with the same or a different insurer, and
> (ii) the number of specified diseases for which either the applicant has coverage in force as of the date of application or application(s) pending as of the date of application."

The Company started writing specified disease insurance in September 2012. Policy form No. NYCANLS is an indemnity and non-recurring policy that pays a lump sum benefit upon diagnosis.

The Company did not file its overinsurance rules with the Department in accordance with Section 52.15(b)(8) of Department Regulation No. 62.

The Company violated Section 52.15(b)(8) of Department Regulation No. 62 by failing to file its overinsurance rules with the Department.

Application form No. NYCANLS-AP does not contain questions to elicit information from the applicant as to whether or not they have an existing specified disease policy or certificate in force or another application pending with the Company or another insurer for specified disease coverage.

The Company violated Section 52.15(b)(15) of Department Regulation No. 62 by failing to obtain: 1) information necessary to determine if the applicant is overinsured by having existing specified disease coverage in force already or application(s) pending for another specified disease policy or certificate for the same specified disease with the same or a different insurer; and 2) the number of specified diseases for which either the applicant has coverage in force as of the date of the application or application(s) pending as of the date of the application for such coverage.

8) Section 52.54(a) of Department Regulation No. 62 states, in part:

> "No individual accident and health insurance policy shall be delivered or issued for delivery in this State, unless the appropriate disclosure form in sections 52.55 through 52.62 of this Part is completed as to such policy and accompanies or is incorporated in such policy when delivered, or unless such appropriate disclosure form is delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of such disclosure form is provided to the insurer. . . ."

The Company sold two accidental death products during the examination period, NYADDP and NYINDADP. The policies were marketed on a direct response basis. The

Company did not provide an outline of coverage containing the required disclosures to New York policyholders during the examination period. In addition, as explained earlier in this report, the direct response advertising packages did not include the expected benefit ratio or disclose that the policy provided accident only coverage.

The Company violated Section 52.54 of Department Regulation No. 62 by failing to provide accidental death and dismemberment policyholders the appropriate disclosure in Section 52.61 of this Part for policies sold during the examination period.

9) Section 3209(g) of the New York Insurance Law states:

   "Every insurer shall maintain, at its home office or principal office, a complete file containing one copy of each policy summary form authorized by the insurer for use pursuant to this section."

   Section 53-1.4(a) of Department Regulation No. 74 states, in part:

   "In addition to the requirements imposed by Section 53-3.5(e) of Subpart 53-3, each insurer shall maintain at its home or principal office, a complete file containing one specimen copy each of the preliminary information form, policy summary form, and sales illustrations authorized by the insurer for each policy form subject to this Part. Such files shall be subject to regular and periodic inspection by the Department. All such forms shall be maintained in said file for a period of either six years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time. . . . "

The Company does not maintain, at its home office, a complete file containing one specimen copy of the preliminary information form and the policy summary form authorized by the insurer for each policy form.

The Company violated Section 3209(g) of the New York Insurance Law and Section 53-1.4(a) of Department Regulation No. 74 by failing to maintain, at its home office, a complete file containing one specimen copy of the preliminary information form and the policy summary form authorized by the insurer for each policy form subject to this Part.

B. Underwriting and Policy Forms

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

1) Section I.F.1 of Department Circular Letter No. 6 (1963) advises:

> "'Policy forms' may be submitted for formal approval either after or without a preliminary review. 'Policy forms' submitted for formal approval should be submitted in the form intended for actual issue. In general, this will mean in printed form. If a 'policy form' will not be printed, it is important that the form when reproduced be clear and legible and in reasonably permanent form considering its probable lifetime. Typewritten forms may be used only for single cases or when their use will be too infrequent to justify other preparation."

Department Circular Letter No. 12 (1976) advises, in part:

> ". . . In order to more effectively regulate the products being offered in New York State, it is requested that all future submissions of life and annuity forms . . . include as part of the filing information an exact description of how the form will be used and how it will be marketed. An approval of the form will be limited to the use and method of marketing set forth in the filing information.
>
> The company's filing information should include the following, and any additional information which may be necessary to completely understand the use of the form:
>
> 1. Exactly how the form will be marketed: issued individually, mass merchandised through mass media, association membership, union membership, etc.
>
> 2. The market for which the form is intended: particularly note any specialized market such as older persons, keymen, debtors, professionals, etc.
>
> 3. The underwriting rules to be used, indicating any deviation from the company's normal underwriting rules: medical, non-medical, guaranteed issue, simplified application, etc.
>
> 4. Any limitation of the use of the form by certain agents or brokers.
>
> 5. An explanation of any change in benefits which occurs while the contract is in force with a reference to the contract provisions which relate to the benefit change.
>
> 6. Indicate for individual forms whether the commissions and gross premium rates are consistent with those of the company' individual policies. If the assumptions underlying the premium rates differ from the Company's regular individual policies, explain the difference and justify that the use of the form does not result in unfair discrimination or violate the Department's wholesale rules . . ."

Department Circular Letter No. 6 (2004) advises, in part:

> “As part of the Department's continuing efforts to improve the "speed to market" objective for life insurance and annuity products, the Life Bureau will be implementing a new streamlined certification procedure. . . .
>
> The new procedure will require the completion of a certification of compliance in the form prescribed by the Department . . . Submission letters will need to comply with applicable circular letter and product outline guidance available on the Department website. The Department's approval of policy forms will be based on the acceptability of the certification of compliance. The certification of compliance will certify that the policy form submission is complete and was reviewed for compliance with applicable requirements prior to its submission to the Department . . .
> the Department provides the substantive and procedural requirements for policy form submissions in product outlines maintained on its website at [http://www.dfs.ny.gov]. The Department will view compliance with the product outlines as a good faith effort by insurers to meet statutory and regulatory requirements. . . .”

During the examination period, the Company commenced selling life insurance and accidental death insurance plans electronically via the telephone and the internet using previously approved life and health applications that were approved for use in the direct response market only.

Department Circular Letter No. 12 (1976) advises insurers selling life products to include an exact description of how the form will be used and how it will be marketed when a policy form is filed for approval. Approval of the policy form is limited to the use and method of distribution that is set forth in the filing.

The Company did not obtain an extension of approval to use previously approved applications for the sale of its life and accidental death and dismemberment policies through electronic means by telephone and internet. The Department views the use of the approved applications in telephone sales or via the internet as the use of an approved policy form in an unapproved manner.

The examiner recommends that the Company file a request to extend approval of applications that are being used to solicit life and health insurance over the telephone and electronically over the internet.

The examiner reviewed a sample of billing notices that were disseminated to policyholders on policies that lapsed for non-payment of premium in 2012 or later. In five of the eight policies

reviewed, the billing notice of premium due under the life insurance policy contained an application for additional insurance coverage.

The examiner compared the applications contained in the billing notices to the approved version of the application on file with the Department. The applications were filed using the streamlined certification procedure in accordance with Department Circular Letter No. 6 (2004). Department approval of the applications was based upon the certification by a Company officer that the applications conformed to statutory requirements for policy forms published by this Department.

Section 1.F.1 of Department Circular Letter No. 6 (1963) requires policy form submissions to include the policy form in the form, format, and context intended for actual issue or use with the insurance buying public. When the Company filed the applications for approval with the Department, the Company failed to indicate their intention to use these applications on a premium due notice. Had the Company complied with statutory filing requirements by including the exact application in the format and context that it intended for use with consumers and by including an exact description of how the application would be used, the Department would not have approved the application for use in this context, i.e., contained in a billing notice for the premium due under an existing life insurance policy.

The examiner recommends that the Company submit the exact application that it intends to use with prospective applicants or existing policyholders when submitting the policy form for approval and include any additional information that may be necessary for the Department to completely understand the manner and context the application would be used.

In addition, the format, placement and inclusion of an offer for additional coverage on the top portion of the premium due notice may have the tendency to confuse the policyholder. The policyholder may view the mail as an advertisement instead of the notice of premium due that is required by Section 3211 of the New York Insurance Law. The title of each section, "Additional Coverage" and "Current Coverage," does not draw attention to the fact that this is a premium due notice.

The examiner recommends that the Company provide its policyholders with a separate, clear and conspicuous notice of premium due going forward, eliminate the offer for additional insurance from the notice, and replace the words "current coverage" with "premium due notice."

The examiner recommends that the Company exercise due diligence and proper care when certifying its compliance with the statutory filing requirements published in the applicable circular letter and product outline guidance available on the Department website for future policy form submissions.

2) Section 3209(b)(1) of the New York Insurance Laws states, in part:

> "No policy of life insurance shall be delivered or issued for delivery in this state . . . unless the prospective purchaser has been provided with the following:
> (A) a copy of the most recent buyer's guide and the preliminary information required by subsection (d) of this section, at or prior to the time an application is taken. When sales solicitations are made by mail, without the involvement of an agent or broker, each initial solicitation must include a copy of the buyer's guide unless the policy for which application is made provides for a period of at least thirty days within which the applicant may return the policy for an unconditional refund of the premiums paid, in which event the buyer's guide must be delivered with the policy . . ."

During the examination period, the Company commenced selling life insurance policies through the internet and telephone. The Company did not provide applicants with a copy of the most recent buyer's guide and the preliminary information at or prior to the time the application was taken. As of February 2016, the Company ceased selling policies over the phone or internet.

The Company violated Section 3209(b)(1)(A) of the New York Insurance by failing to provide prospective purchasers with a copy of the most recent buyer's guide and the preliminary information at or prior to the time the application was taken.

The examiner recommends that the Company establish procedures to comply with Section 3209(b)(1)(A) of the New York Insurance Law to provide prospective purchasers with a copy of the most recent buyer's guide and the preliminary information at or prior to the time an application is taken for all future life products sold through the internet and telephone.

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

> "(a) In this article, "policy form" means any policy, contract, certificate, or evidence of insurance and any application therefor, or rider or endorsement thereto, affording benefits of the kinds of insurance specified in paragraph one, two, three or twenty-four of subsection (a) of section one thousand one hundred thirteen of this chapter . . .

> (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 review of a sample of new life insurance policies applied for over the telephone or electronically over the internet revealed that the application used in the sale did not correspond to the policy form on file with the Department.

In addition, the examiner’s review of a sample of direct response solicitation packages for the Company’s accidental death and dismemberment policy form No. NYADDP revealed that the version of the application form that the Company used in its direct response advertising is not identical to the version of the application form that was stamped approved by the Department (File Nos. 01120013 and 01120203) on December 11, 2001.

The Company violated Section 3201(b)(1) of the New York Insurance Law by using application forms that were not filed with and approved by the Department prior to their use to issue life and accidental death and dismemberment insurance in New York.

The Company violated Section 215.6(c)(3) of Department Regulation No. 34 and Section 52.31(e) of Department Regulation No. 62 by using a version of application form No. NYAG that is not identical to the application form filed with and approved by the Department.

The examiner recommends that the Company file and obtain approval of application form No. NYAG and like application forms in the form intended for actual use with the insurance buying public in compliance with Section 52.31(e) of Department Regulation No. 62.

4) Section II.D of Department Circular Letter No. 4 (1963) advises:

> “Juvenile Plans
>
> 1. Limitation of Benefits Provision
>
> Plans to which Section 147 of the Insurance Law is applicable must contain a provision, by rider or otherwise, which will substantially reflect the requirements of that section.
>
> 2. Payor Benefit Age Adjustment
>
> Any provision for age adjustment must include both the ages of the insured and the payor and must be based upon the aggregate premium paid for all benefits.”

Section III.B of Department Circular Letter No. 4 (1963) states, in part:

"Juvenile Insurance Limitations

> 1. The policy must contain a limitation of benefits provision, by rider or otherwise, reflecting the requirements and prohibitions of Section 147 of the Insurance Law. Any statement in relation to refund of excess premiums may specify a dollar amount or an amount as provided in a schedule filed with the Superintendent, and such schedule shall accompany the submission letter."

The examiner selected a sample of life insurance policies effectuated on the lives of minors between zero and fourteen and a half years of age. In a number of instances, the Company issued life insurance effectuated on the juvenile in excess of $25,000. Although the Company did not issue life insurance policies that exceeded the monetary limits imposed by Section 3207 of the New York Insurance Law, it issued rider form No. NYJUVR2 with such policies, which limits the amount payable under the contract to $25,000. Furthermore, the statutory limits described in form No. NYJUVR2 are no longer consistent with current monetary limits set forth in Section 3207 of the New York Insurance Law.

The Company failed to comply with Department Circular Letter No. 4 (1963) by issuing rider form No. NYJUV2 that describes monetary limitations inconsistent with the limits set forth in Section 3207 of the New York Insurance Law.

The examiner recommends that the Company issue an endorsement containing the correct monetary limitations set forth in Section 3207 of the New York Insurance Law to any affected policyholder with an in force policy that was issued after October 2009 on the life of a minor for an amount of insurance in excess of $25,000. A similar recommendation was contained in the prior report on examination.

The examiner recommends that the Company revise policy form No. NYJUVR2 so that the monetary limitations described therein are consistent with the limits set forth in Section 3207 of the New York Insurance Law and file the revised policy form with the Department.

C. <u>Treatment of Policyholders</u>

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 2601(a) of the New York Insurance Law states, in part:

> "No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices: . . .
>
> (3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies . . ."

Department Circular Letter No. 9 (1999) advises, in part:

> "The recent enactments of numerous Federal and New York State statutes have greatly affected the business of providing health insurance benefits and prepaid health services. Taken together these enactments impose significant responsibilities upon insurers who write health insurance and . . . the management and board of directors who are responsible for the overall management and control of the company's operations. The directors of an insurer licensed to write health insurance and of a health maintenance organization (collectively referred to as "company") and, in the case of a controlled company, the parent company must, under long standing principles of corporate governance, confirm that the company is fulfilling all of its responsibilities. However, the requirements of this Letter, including the acknowledgement and confirmation to this Department, apply only to the insurers who are writing health insurance in this State.
>
> In order to fulfill its responsibility to oversee the claims adjudication process it is critical that the board adopt procedures to ensure that all claims are being processed accurately, uniformly, and in accordance with applicable statutes, rules, and regulations. One way for the board to ensure itself that such procedures are in place is to direct the officers responsible for claims adjudication to (i) issue, and up-date as necessary, a claims manual which sets forth the company's claims adjudication procedures; (ii) distribute the claims manual and necessary up-dates to all persons responsible for the supervision, processing and settlement of claims and obtain an acknowledgement of receipt; and (iii) provide the training necessary to ensure the claim manual's implementation including a formal educational program and periodic re-training. It is recommended that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in

> the current claims manual, are in accordance with applicable statutes, rules and regulations.
>
> The board is reminded that its responsibilities to oversee management's handling of the claims adjudication process extends to outside parties who, pursuant to a management, administrative service, provider or other contract with the company, perform one or more of the claim adjudication procedures normally done by the company itself.
>
> Of equal importance is the adoption of written procedures to enable the board to assure itself that the company's operations in other key areas are being conducted in accordance with applicable statutes, rules and regulations. . . ."

The Company does not have written claims adjudication procedures for processing life, long-term care, or Medicare supplement claims. The Company informed the examiner that it does not maintain a written claims procedural manual; however, it has claim specialists who specialize in adjudicating various types of claims.

The Company failed to comply with Department Circular Letter No. 9 (1999) by not adopting a written claims manual setting forth the Company's claims adjudication procedures for the Company's health insurance products.

The examiner recommends that the Company adopt written procedures for adjudicating life, long term care and Medicare supplement claims to ensure prompt, consistent, fair and equitable settlement of claims among its policyholders in accordance with Section 2601(a)(3) of the New York Insurance Law and consistent with the advice in Department Circular Letter No. 9 (1999). A similar recommendation was contained in the prior report on examination.

2) Section 216.5(a) of Department Regulation No. 64 states, in part:

> "Every insurer shall establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant's authorized representative, within 15 business days of receipt of notice of claim. An insurer shall furnish to every claimant, or claimant's representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days or receiving notice of the claim. . . . "

Section 216.11 of Department Regulation No. 64 states:

> "To verify compliance with this Part and related statutes, [Department of Financial Services] examiners will investigate the market performance of insurers. To enable department personnel to reconstruct an insurer's activities, all insurers subject to the

provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the [Department of Financial Services] examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants."

Section 243.2 of Department Regulation No. 152 states, in part:

"(a) In addition to any other requirement contained in Insurance Law Section 325, any other Section of the Insurance Law or other law, or any other provision of this Title, every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent, in accordance with the provisions of this Part.

(b) Except as otherwise required by law or regulation, an insurer shall maintain:
. . .
(4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received. . . . "

As part of verifying that the Company took corrective action to the prior report on examination, the examiner reviewed the Company's current procedures for processing life insurance claims, including communications with informants and beneficiaries.

The examiner acknowledges that there are cases when the beneficiary of a life insurance policy may assign benefits, in part or whole, to a funeral home. However, it is doubtful that a funeral home has legal standing to obtain or provide certain proof requirements, such as the authorization for release of medical records, a list of hospitals and physicians, executorship papers, and other records of this nature. During the examination period, when a claim was reported by a funeral home, the Company notified the funeral home, not the beneficiary, in writing of all the items, statements and forms required to process the claim. A copy of the notification was not mailed to the beneficiary or the beneficiary's authorized representative (i.e., attorney).

The examiner recommends that the Company copy the beneficiary on all correspondence concerning a claim for benefits that is sent to a funeral home.

The examiner reviewed the Company's handling of life insurance claims reported by phone, including the information maintained in the Company's claims administration system

(NDTH screen). For incontestable claims, the Company's procedure is to verbally advise the informant what documentation is required in order for the Company to process and pay the claim. The Company does not have a procedure in place for its Customer Service Representatives ("CSRs") to record or make a notation in the electronic claim record what specific proofs are verbally communicated to and requested of the informant in order to process and pay the life claim. The CSR record minimal information in the claims administration system, such as the name of the informant (the caller) and the date that the informant called to report the insured's death. A written communication specifying all of the items, statements and forms required by the Company is not sent to the informant or beneficiary upon notice of the insured's death.

The claims administration automatically assigns a follow-up date 30 days from the date the claim is entered. On a weekly basis, a "Cumulative Pending Report" that lists all pending life claims and their assigned follow-up dates is generated from the claims administration system. The report is used by the Company's Claims Department to manually research and identify outstanding requirements for each pending life claim. When this process is complete, the Claims Department generates a letter to the informant outlining the outstanding proof requirements.

For an incontestable claim, a written notice itemizing the statements and forms required to process and pay the claim is generated 30 calendar days after the notice of the insured's death, whereas if the claim is contestable, the Company sends a written notice to the informant outlining what proofs are required to process the claim immediately (within 48 to 72 hours of being notified of the insured's death) and another written notice 30 days later. If the Company does not receive any correspondence or proofs for either a contestable or an incontestable claim 60 days after the notice of death of the insured, it closes the claim.

The Company violated Section 216.5(a) of Department Regulation No. 64 by failing to furnish the claimant with a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving notice of the claim.

The Company violated Section 216.11 of Department Regulation No. 64 by failing to maintain within each claim file all communications, transactions, notes and workpapers, whether written or oral, emanating from or received by the insurer relating to the claim and by failing to maintain claim files so that all events relating to a claim can be reconstructed by the Department's examiner.

The Company violated Section 243.2(b)(4) of Department Regulation No. 152 by failing to maintain its claim records in a manner that shows clearly the inception, handling and disposition of the claim.

Section 226.3 of Department Regulation 200 states:

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

(b) An insurer that receives a notification of death of an insured or account holder, or identifies a death index match, shall notify each United States affiliate, parent, or subsidiary, and any entity with which the insurer contracts that may maintain or control records relating to policies or accounts covered by this Part of the notification or verified death index match. An insurer shall take all steps necessary to have each affiliate, parent, subsidiary, or other entity perform the search required by subdivision (a) of this section."

Section 226.4 of Department Regulation No. 200 states, in part:

"(a)(1) Except as set forth in paragraph (2) of this subdivision, at no later than policy delivery or the establishment of an account and upon any change of insured, owner, account holder, or beneficiary, an insurer shall request information sufficient to ensure that all benefits or other monies are distributed to the appropriate persons upon the death of the insured or account holder, including, at a minimum, the name, address, date of birth, social security number, and telephone number of every owner, account holder, insured and beneficiary of such policy or account, as applicable . . .

(b)(1) An insurer shall use the latest available updated version of the death index to cross-check every policy and account subject to this Part, except as specified in subdivision (h) of this section. The cross-checks shall be performed no less frequently than quarterly. . . .

(e) 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. . . ."

During the examination period and through the last day of fieldwork, the Company was still in the process of implementing procedures and processes to comply with Department Regulation No. 200.

The Company had not implemented procedures to notify its affiliates or parent when it receives notification of death of an insured or account holder or identifies a death index match.

The Company violated Section 226.3(b) of Department Regulation No. 200 by failing to take all steps necessary to have each affiliate, parent, subsidiary, or other entity perform the search required by Section 226.3(a) of the Regulation.

The Company had also not implemented procedures to collect and obtain, at a minimum, the name, address, date of birth, social security number, and telephone number of every beneficiary of new or existing business.

The Company violated Section 226.4(a)(1) of Department Regulation No. 200 by failing to request information, at no later than policy delivery or the establishment of an account and upon any change of insured, owner, account holder, or beneficiary, sufficient to ensure that all benefits or other monies are distributed to the appropriate persons upon the death of the insured or account holder.

The Company violated Section 226.4(b)(1) of Department Regulation No. 200 by failing to use the latest available updated version of the death index to cross-check every policy and account at least quarterly.

The Company's last crosscheck submission pursuant to the Section 308 Letter, dated July 5, 2011, was in May 2012, when it was no longer required to complete monthly reporting to the Department. No quarterly cross-checks were performed after May 2012.

The Company had not established written and auditable procedures to locate beneficiaries so that prompt payments or distributions could be made in the event of a positive match.

3) Section 403(d) of the New York Insurance Law states:

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

## 12. 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:

| Item | Description |
|---|---|
| A | The Company violated Section 325(a) of the New York Insurance Law by failing to maintain the minutes for all of its board of directors and board committee meetings at its principal office in this state. A similar violation appeared in the prior report on examination.<br><br>The examiner's review indicated that the minutes of the board of directors, and committees thereof, are maintained at the Company's home office. |
| B | The Company violated Section 3209(b)(1)(A) of the New York Insurance Law by failing to disclose in its direct mail solicitation that the prospective purchaser has the right to receive, upon request, a buyer's guide and a policy summary prior to delivery of the policy; and provide a policy summary upon delivery of the policy.<br><br>The examiner's review of a sample of direct response advertisements disseminated during the examination period indicated that the advertisements contain a disclosure that the prospective purchaser has the right to receive, upon request, a buyer's guide and a policy summary prior to delivery of the policy; and provide a policy summary upon delivery of the policy. |
| C | The Company violated Section 2112(d) of the New York Insurance Law by failing to notify the Superintendent of the agent's termination of appointment with the Company within thirty days of the effective date of such termination.<br><br>The examiner's review of a sample of agents whose appointment was terminated during the examination period revealed that the Company notified the Superintendent in accordance with Section 2112(d) of the New York Insurance Law. |
| D | The Company violated Section 243.2(b)(5) of Department Regulation No. 152 by failing to maintain all licensing records, clearly showing the dates of appointment and termination of each licensee. |