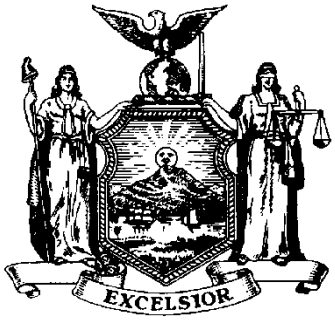

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

REPORT ON EXAMINATION

OF THE

AMERICAN PROGRESSIVE LIFE AND HEALTH INSURANCE COMPANY

OF NEW YORK

AS OF

DECEMBER 31, 2014

CONDITION: DECEMBER 31, 2014

DATE OF REPORT: MAY 24, 2016

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EXAMINER: RORY CUMMINGS

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Acting Superintendent

May 24, 2016

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

Madam:

In accordance with instructions contained in Appointment No. 31294, dated April 9, 2015 and annexed hereto, an examination has been made into the condition and affairs of American Progressive Life and Health Insurance Company of New York, hereinafter referred to as "the Company," at its home office located at 44 South Broadway, White Plains, NY 10601.

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 recommendation and violations contained in this report are summarized below.

- The examiner recommends that the Company continue to compute reserves using the assumptions and methodology as agreed upon with the Department. (See Section 6F of this Report)
- The Company violated Section 2112(d) of the New York Insurance Law by both failing to file the notice of termination of an agent with the Superintendent, and failing to file the notice of termination of an agent with the superintendent within thirty days of termination of the certificate of appointment. (See Section 7A of this Report)
- The Company violated Section 3224-a(b) of the New York Insurance Law by failing to notify the policyholder, covered person or health care provider in writing of regarding all or partial denial of major medical claims, within thirty calendar days of the receipt of the claim. (See Section 7C of this Report)
- The Company violated Section 3214(c) of the New York Insurance Law by failing to pay interest on death claims at the rate of interest paid on proceeds left under the interest settlement option as noted in the policy contract. (See Section 7C 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, 2015 Edition* (the "Handbook"). The examination covers the five-year period from January 1, 2010, through December 31, 2014. 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, 2014, 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.

The examination was coordinated in conjunction with the examination of the insurer's affiliates, Constitution Life Insurance Company ("Constitution Life"), a Texas domiciled life insurer, The Pyramid Life Insurance Company ("Pyramid"), a Kansas domiciled life insurer, SelectCare Health Plans of Texas, Inc. ("SelectCare Health Plans"), and SelectCare of Texas, Inc. ("SelectCare"). The coordinated examination was led by the State of Texas ("Texas") with participation from New York. Since the insurer and its affiliate share common controls and management, and Texas is accredited by the NAIC, it was deemed appropriate to rely on the work performed by Texas.

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 2010 through 2014, by the accounting firm of Ernst & Young. The Company received an unqualified opinion in all years. Certain audit work papers of the accounting firm were reviewed and relied upon in conjunction with this examination. The Company's parent, Universal American Corp. ("Universal American" or "UAM") 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 work papers 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 8 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 accident and health insurance company under the laws of the State of New York on September 22, 1945 under the name American Progressive Health Insurance Company of New York. It was licensed and commenced business on March 26, 1946. On January 25, 1979, its charter was amended to include the writing of life insurance and annuities. The Company's present name was adopted at that time.

Initial resources of $151,800, consisting of common capital stock of $101,200 and paid in and contributed surplus of $50,600, were provided through the sale of 1,012 shares of common stock (with a par value of $100 each) for $150 per share.

On April 29, 2011, the Company stopped writing Medicare Part D and sold its in-force block of Part D business to a non-affiliate, SilverScript Insurance Corporation, a subsidiary of CVS Caremark Corporation. On June 1, 2012, the Company stopped writing individual life and accident & health insurance. On July 31, 2013, the Company loaned $13 million to its parent Universal American to capitalize its affiliates that were formed pursuant to the Federal Patient Protection and Affordable Care Act.

On October 8, 2015, Universal American Corp. the parent of the Company entered into an agreement with Nassau Reinsurance Group ("Nassau") to sell the Company's traditional insurance business. Included in the sale are affiliates of the Company, Constitution Life and Pyramid. Under the terms of the agreement, Nassau will acquire all outstanding shares of Constitution Life and Pyramid, and the remaining portion of the traditional insurance business of the Company for approximately $43 million in cash. The transaction is expected to close in 2016.

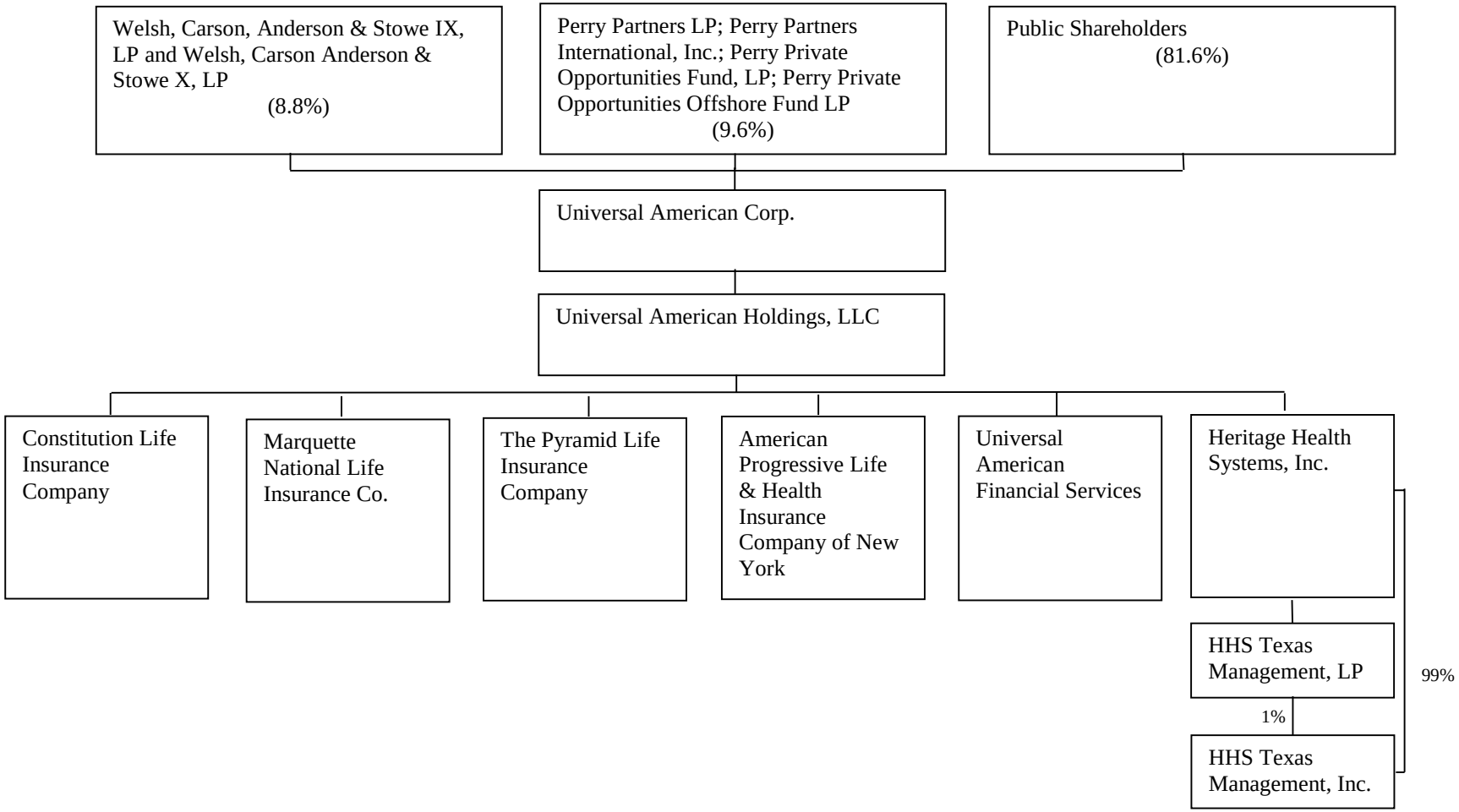
As of December 31, 2014, the Company had 16,667 shares of common stock outstanding and capital and paid in and contributed surplus of $2,500,050 and $94,466,497 respectively.

B. Holding Company

The Company is a wholly owned subsidiary of Universal American Holdings, LLC ("UAH") a Delaware domiciled limited liability Company. UAH is in turn a wholly owned subsidiary of UAM, a Delaware domiciled holding company. UAM is ultimately owned 81.6% by public shareholders and 18.4% by five limited partnerships and one corporation.

C. Organizational Chart

An organization chart reflecting the relationship between the Company and significant entities in its holding company system as of December 31, 2014 follows:



D. Service Agreements

The Company had one active service agreement in effect with an affiliate during the examination period.

Type of Agreement and Department File Number	Effective Date	Provider(s) of Service(s)	Recipient(s) of Service(s)	Specific Service(s) Covered	Income/ (Expense)* For Each Year of the Examination
Services and Cost Sharing Agreement 29980	08/01/2002	Universal American Financial Services	The Company	General office and systems support	2010-$(35,265,244) 2011-$(36,228,878) 2012-$(18,780,171) 2013-$(17,707,078) 2014-$(14,593,543)

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

The decrease in expenses beginning in 2012 is primarily due to the Company's discontinuance of Medicare Part D business and expenses associated with administering that business.

E. Management

The Company's by-laws provide that the board of directors shall be comprised of not less than nine and not more than 21 directors. Directors are elected for a period of one year at the annual meeting of the stockholders held in March of each year. As of December 31, 2014, the board of directors consisted of nine members. Meetings of the board are held four times each year.

The nine board members and their principal business affiliation, as of December 31, 2014, were as follows:

Name and Residence	Principal Business Affiliation	Year First Elected
Richard Barasch New York, NY	Chairman of the Board of Directors Universal American Corp	1991
Richard Cannone Sanford, FL	Senior Vice President, Chief Financial Officer & Treasurer American Progressive Life & Health Insurance Company of New York	2011

Name and Residence	Principal Business Affiliation	Year First Elected
Walter Harris* New York, NY	President & CEO FOJP Service Corp	1991
Jeffrey Laikind* New York, NY	Retired Shikiar Asset Management	1995
Linda Lamel* New York, NY	Law Professor Brooklyn Law School	2005
David Monroe Southbury, CT	Senior Vice President, Finance American Progressive Life & Health Insurance Company of New York	2014
Robert Waegelein Pawling, NY	President American Progressive Life & Health Insurance Company of New York	1991
Christopher Wolfe* New York, NY	Principal, Capital Z Partners	2009
Anthony Wolk Short Hills, NJ	Senior Vice President, General Counsel & Secretary Universal American Corp.	2013

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

In June 2015, Adam Thackery was elected to the board of directors to replace the deceased Linda Lamel.

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, 2014:

Name	Title
Robert Waegelein	President
Theodore M. Carpenter, Jr	Executive Vice President
Richard Cannone	Senior Vice President, CFO & Treasurer
David R. Monroe	Senior Vice President, Finance
John Aprill	Senior Vice President & Chief Actuary
Travis M. Christie	Vice President & CFO, Medicare Division
Steve L. Carlton	Vice President, Secretary & General Counsel
Carl Cochrane	Vice President, Tax
Judy Borrell*	Vice President, Administration
Edward Ceglia	Assistant Vice President & Appointed Actuary

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

In May, 2015, Robert Waegelein retired as President and was replaced by Anthony Wolk in June, 2015.

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 29 states and the District of Columbia. In 2014, 71.1% of life premiums, 96.5% of annuity considerations and 72.7% of accident and health premiums were received from New York, while 12.7% of life premiums and 14.8% of accident and health premiums were received from Pennsylvania. Policies are written on a non-participating basis. The Company stopped writing traditional business in 2012.

A. Statutory and Special Deposits

As of December 31, 2014, the Company had $1,550,000 (par value) of United States Treasury Notes on deposit with the State of New York, its domiciliary state, for the benefit of all policyholders, claimants and creditors of the Company. As per confirmations received from the following states which were reported in Schedule E of the 2014 filed annual statement an additional, $2,135,231 was being held by the states of Arkansas, Florida, Georgia, Massachusetts, New Hampshire, New Mexico, North Carolina and Virginia.

B. Direct Operations

The Company's principal line of business during the examination period were Medicare Advantage ("MA"), and Medicare Supplement (reported as other accident and health business), and individual life. MA (94%), Medicare Supplement (3.5%) and individual life (1.00%) represented 98.5% of the net premiums received in 2014. Policies are written on a non-participating basis.

The Company's MA products are marketed under Preferred Provider Organization ("PPO") plans and Private "Fee For" Service ("PFFS") plans. The PPO plans are under contract with Centers for Medicare and Medicaid Services ("CMS") and provide basic Medicare covered benefits with reduced member cost sharing as well as additional supplemental benefits, including defined prescription drug benefits. The PPO plans are built around contracted networks of providers. The PFFS plans are also offered under contract with CMS and provide enhanced health

care benefits, compared to traditional Medicare, subject to cost sharing and other limitations. The PFFS plans have limited provider network restrictions which allow the members to have more flexibility in the delivery of their health care services than other MA plans. Following the passage of the 2008 Medicare Improvements for Patients and Providers Act, effective January 1, 2011, the Company will continue to offer PFFS products only in areas that have either met approved CMS network access requirements or are in certain designated rural areas.

The Company stopped marketing and selling its Medicare Supplement insurance products, ordinary life insurance product, fixed annuities, and other accident and health products, including long term care and major medical effective June 1, 2012.

The Company distributes MA through a career agency system, independent agents, direct sales and telemarketing. The life insurance products are distributed through career agents and independent agents. The Company compensates agents using a percentage of premium method for sales of traditional insurance products, and on a per application fee basis for sales of its MA plans.

C. Reinsurance

As of December 31, 2014, the Company had reinsurance treaties in effect with 17 companies, of which 14 were authorized or accredited. The Company's life, and accident and health business is reinsured on a coinsurance, stop loss and yearly renewable term basis. Reinsurance is provided on an automatic and facultative basis.

The maximum retention limit for individual life contracts is $50,000. The total face amount of life insurance ceded as of December 31, 2014 was $259,598,880 which represents 81.1% of the total face amount of life insurance in force. Reserve credit taken for reinsurance ceded to unauthorized companies, totaling $55,507,925 was supported by letters of credit and trust agreements.

The total premiums for accident and health business ceded as of December 31, 2014 were $5,370,847. The reserve credit taken for reinsurance to an unauthorized company totaling $5,799,509 was supported by a letter of credit.

As of December 31, 2014, the Company assumed life business from one insurer, Wilton Reassurance Life Company of New York. The total face amount of life insurance assumed as of December 31, 2014, was $8,447,135 with modified co-insurance reserve of $3,844,404.

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, 2009	December 31, 2014	Increase (Decrease)
Admitted assets	$244,822,775	$227,682,737	$(17,140,038)
Liabilities	$115,361,901	$111,289,840	$ (4,072,061)
Common capital stock	$ 2,500,050	$ 2,500,050	$ 0
Gross paid in and contributed surplus	94,466,497	94,466,497	0
SSAP 10R additional admitted DTA	3,386,547	0	(3,386,547)
ACA Fee Payable in 2015	0	7,200,000	7,200,000
Unassigned funds (surplus)	29,107,780	12,226,349	(16,881,431)
Total capital and surplus	$129,460,874	$116,392,896	$(13,067,978)
Total liabilities, capital and surplus	$244,822,775	$227,682,737	$(17,140,038)

The Company's invested assets as of December 31, 2014 were mainly comprised of bonds (95.8%), other invested assets (6.7%) and cash and short-term investments (-5.0%). The negative cash and short-term investment was a result of issued and outstanding checks cut against operating accounts. On the first business day of each month, the Company receives a substantial electronic payment from the government CMS, which covers these outstanding amounts.

The majority (98.51%) of the Company's bond portfolio, as of December 31, 2014, was comprised of investment grade obligations.

The following indicates, for each of the years listed below, the amount of life insurance issued and in force by type (in thousands of dollars):

	Individual Whole Life	
Year	Issued	In Force
2010	$26,322	$321,120
2011	$20,557	$316,255
2012	$ 7,229	$300,371
2013	$ 354	$313,742
2014	$ 0	$294,571

The decrease to zero by year end 2014 for individual whole life issued was the result of the Company not marketing traditional whole life business since June 2012. The majority of this block of business was ceded to First Allmerica Financial Life Insurance Company in 2009 and is in run-off.

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				
	2010	2011	2012	2013	2014
Outstanding, end of previous year	201,306	197,406	70,037	63,183	64,000
Issued during the year	2,005*	2,413*	1,326*	10,109	0*
Other net changes during the year	(5,905)	(129,782)	(8,180)	(9,292)	(7,078)
Outstanding, end of current year	197,406	70,037	63,183	64,000	56,922

*The Company indicated that for the calendar years 2010 through 2012 and 2014, MA issued polices were not included in the annual statement exhibits. The Company indicated that their MA operations and third party administrators were not able to provide the numbers for enrollment and disenrollment data timely to include the information in the annual statements. The correct amounts issued for Accident & Health policies in 2010, 2011, 2012 and 2014 were 40,912, 5,406, 5,930 and 3,417 respectively. The reduction of Accident & Health policies issued in 2010 from 40,912 to 5,406 policies in 2011 was the result of the Company selling its Medicare Part D business to SilverScript Insurance Company.

The "Other net changes during the year" of (129,782) for 2011 was the result of the Company selling its Medicare Part D business to SilverScript Insurance Company.

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:

	2010	2011	2012	2013	2014
Ordinary:					
Life insurance	$ (434,092)	$ (286,239)	$ 170,879	$ 790,114	$ 322,050
Individual annuities	170,651	17,447	3,908	8,704	1,261
Total ordinary	$ (263,441)	$ (268,792)	$ 174,787	$ 798,818	$ 323,311
Accident and health:					
Group	$ 54,199	$ 186,498	$ 92,721	$ 192,037	$ 57,079
Other	37,173,509	4,666,340	14,461,063	12,498,974	2,736,612
Total accident and health	$37,227,708	$4,852,838	$14,553,784	$12,691,011	$2,793,691
Total	$36,964,266	$4,584,045	$14,728,572	$13,489,829	$3,117,001

The life insurance net loss from operations for 2010 and 2011 was the result of higher expenses due to issuance costs and 1st year commission due to the Company actively marketing those products during those years. The Company ceased marketing life business during June 2012. The net gain from operations for 2013 through 2014 was the result of investment income attributed to the life block.

The 90% reduction net gain from operations for annuities from year 2010 to 2011 was the result of an agreement where the Company allowed First Allmerica Financial Life Insurance Company to sell the reinsurance treaty they had with the Company to Athene Life Re. LTD.

The 87% reduction of net gain from operations for accident and health-other from 2010 to 2011 was the sale of Medicare Part D business and increase in the premium deficiency reserve in long term care business. The reduction of net gain from operations of $1.9 million (13.5%) in 2013 was the result of a decrease in MA reimbursement rates. The reduction of net gain from operations of $9.7 million (78.2%) in 2014 was the result of a decrease in MA premiums of $57 million, a decrease in MA reimbursement rates and new fees associated with the Affordable Care Act ("ACA") starting in 2014.

6. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital and surplus as of December 31, 2014, as contained in the Company's 2014 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, 2014 filed annual statement.

A. Independent Accountants

The firm of Ernst & Young was retained by the Company to audit the Company's combined statutory basis statements of financial position of the Company 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.

Ernst & Young 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	$185,747,006
Stocks:	
Preferred stocks	4,001,660
Cash, cash equivalents and short term investments	(9,716,737)
Contract loans	626,457
Other invested assets	13,000,000
Receivable for securities	252,469
Investment income due and accrued	1,489,353
Premiums and considerations:	
Uncollected premiums and agents' balances in the course of collection	11,388,979
Deferred premiums, agents' balances and installments booked but deferred and not yet due	1,334,068
Reinsurance:	
Amounts recoverable from reinsurers	211,570
Other amounts receivable under reinsurance contracts	710,971
Amounts receivable relating to uninsured plans	3,976,856
Net deferred tax asset	6,365,932
Guaranty funds receivable or on deposit	51,258
Receivables from parent, subsidiaries and affiliates	82,408
Health care and other amounts receivable	8,111,699
State Taxes Recoverable	48,790
Total admitted assets	$227,682,737

C. Liabilities, Capital and Surplus

Aggregate reserve for life policies and contracts	$ 8,887,146
Aggregate reserve for accident and health contracts	39,142,399
Contract claims:	
Life	647,693
Accident and health	33,602,230
Premiums and annuity considerations for life and accident and health contracts received in advance	958,034
Contract liabilities not included elsewhere:	
Provision for experience rating refunds	1,227,624
Other amounts payable on reinsurance	225,228
Interest maintenance reserve	1,024,236
Commissions to agents due or accrued	90,000
General expenses due or accrued	10,290,096
Current federal and foreign income taxes	1,045,826
Amounts withheld or retained by company as agent or trustee	1,657
Amounts held for agents' account	57,947
Remittances and items not allocated	1,551,733
Miscellaneous liabilities:	
Asset valuation reserve	1,636,520
Funds held under reinsurance treaties with unauthorized reinsurers	1,163,220
Payable to parent, subsidiaries and affiliates	9,366,383
Unclaimed Property Liability	371,867
Total liabilities	$111,289,840
Common capital stock	$ 2,500,050
Gross paid in and contributed surplus	94,466,497
ACA Fee Payable in 2015	7,200,000
Unassigned funds (surplus)	12,226,349
Surplus	113,892,846
Total capital and surplus	$116,392,896
Total liabilities, capital and surplus	$227,682,737

D. Condensed Summary of Operations

	2010	2011	2012	2013	2014
Premiums and considerations	$744,322,340	$507,715,504	$419,311,874	$469,766,895	$412,905,477
Investment income	7,466,284	10,307,047	10,171,359	9,738,867	8,336,810
Commissions and reserve adjustments on reinsurance ceded	4,497,052	3,019,694	2,579,179	2,506,591	2,083,807
Miscellaneous income	362,190	18,749,058	158,451	43,209	15,313
Total income	$756,647,866	$539,791,303	$432,220,863	$482,055,562	$423,341,407
Benefit payments	$609,025,020	$435,218,261	$334,913,202	$395,064,350	$340,865,812
Increase in reserves	5,469,028	10,970,773	2,326,980	(7,528,118)	(8,695,029)
Commissions	23,504,039	17,490,386	15,000,334	14,852,575	12,485,219
General expenses and taxes	65,522,024	68,455,689	58,378,015	61,853,285	71,901,417
Increase in loading on deferred and uncollected premiums	119,290	(23,168)	(333,299)	175,350	(56,275)
Total deductions	$703,639,401	$532,111,941	$410,285,232	$464,417,442	$416,501,144
Net gain from operations	$ 53,008,465	$ 7,679,362	$ 21,935,631	$ 17,638,120	$ 6,840,263
Federal and foreign income taxes incurred	16,044,199	3,095,317	7,207,059	4,148,290	3,723,262
Net gain (loss) from operations before net realized capital gains	$ 36,964,266	$ 4,584,045	$ 14,728,572	$ 13,489,830	$ 3,117,001
Net realized capital gains (losses)	(1,735,477)	167,145	32,911	6,839	(441,188)
Net income	$ 35,228,789	$ 4,751,190	$ 14,761,482	$ 13,496,668	$ 2,675,813

The reduction of premiums and considerations of $236.6 million (30%) in 2011 and $88.4 million (17%) in 2012 was the result of the Company's sale of the Medicare Part D block of business to SilverScript Insurance Company. The sale was also the main reason for the reduction of benefit payments of $173.8 million (28.5%) in 2011 and $100.3 million (23%) in 2012.

The fluctuations in "increase in reserves" for 2011, 2013 and 2014 were mainly the result of changes in premium deficiency reserves ("PDR") on long term care ("LTC") business. In 2011 the PDR increased $9 million while in 2013 and 2014, the PDR decreased $5.8 million and $11.5 million respectively.

The reduction of net income of $30.4 million (86.5%) in 2011 was mainly the result of the Company's sale of its Medicare Part D business and an increase in PDR of $9 million on the LTC. The reduction of net income of $10.8 million (80.1%) in 2014 was the result of a decline in MA premiums of $57 million due to a higher benefit ratio and an ACA fee of $5.9 million.

E. Capital and Surplus Account

	2010	2011	2012	2013	2014
Capital and surplus, December 31, prior year	$129,460,874	$140,471,487	$131,966,368	$145,359,287	$122,326,995
Net income	$ 35,228,789	$ 4,751,190	$ 14,761,482	$ 13,496,668	$ 2,675,813
Change in net unrealized capital gains (losses)	1,478,205	(247,347)	798,534	(3,856)	0
Change in net deferred income tax	(2,639,401)	(803,500)	252,061	(1,894,063)	(704,141)
Change in non-admitted assets and related items	5,158,450	1,570,562	5,954,614	(1,759,790)	4,482,767
Change in asset valuation reserve	1,338	(143,611)	(963,648)	(368,488)	(160,774)
Dividends to stockholders	(12,000,000)	(13,300,000)	(4,500,000)	(32,250,000)	(11,975,000)
Change in deferred ceding allowance	(252,764)	(252,764)	(252,764)	(252,764)	(252,764)
SSAP 10R additional admitted DTA	(1,162,870)	(79,649)	(4,767,015)	0	0
Correction of prior period A&H reserves (Net of DTA)	(14,801,136)	0	2,109,656	0	0
Net change in capital and surplus for the year	11,010,611	(8,505,119)	13,392,920	(23,032,293)	(5,934,099)
Capital and surplus, December 31, current year	$140,471,487	$131,966,368	$145,359,287	$122,326,995	$116,392,896

F. Reserves

The Department conducted a review of reserves as of December 31, 2014. During the review, concerns were raised with the potential lack of conservatism in the assumptions and methodology used for the Company's asset adequacy analysis pursuant to Department Regulation No. 126 and the "sound value" analysis pursuant to Department Regulation No. 56. In response, the Company committed to refine its methodology in a manner acceptable to the Department and agreed to strengthen its Long Term Care reserves by $7.4 million as of December 31, 2015.

The examiner recommends that the Company continue to compute reserves using the assumptions and methodology as agreed upon with the Department.

7. MARKET CONDUCT ACTIVITIES

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

A. Advertising and Sales Activities

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

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

> "(a) Every insurer . . . doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, . . ."

> "(d) Every insurer . . . doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause. . . . "

The examiner's review of the Company's list of terminated agents revealed four agents for which the Company did not file a certificate of appointment with the superintendent. The review of the Company's list of terminated agents also revealed that the Company did not file termination notices with the Department for 12 agents, and did not file termination notices for 26 agents within 30 days.

The Company violated Section 2112(a) of the New York Insurance Law by failing to file a certificate of appointment with the Superintendent in order to appoint the insurance agent to represent the Company.

The Company violated Section 2112(d) of the New York Insurance Law by both failing to file a notice of termination with the Superintendent and failing to file a notice of termination with the superintendent within thirty days of termination of the certificate of appointment.

The examiner requested copies of the filed statement of facts relative to the purported termination for cause of the agents noted in the Company' data file. The Company did not produce a statement of facts for three of four agents terminated for cause.

The Company violated Section 2112(d) of the New York Insurance Law by failing to file a statement of facts relative to the termination for cause of the agents with the Superintendent.

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

> "(m) In the event an advertisement uses nonmedical, no medical examination required, or similar terms where issue is not guaranteed, such terms shall be accompanied, in each instance, by a disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy or payment of benefits may depend upon the answers given in the application and the truthfulness thereof."
>
> "(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 . . ."

Section 219.5(a) of the 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 manner and extent of distribution and the form number of any policy advertised…"

The examiner reviewed 10 advertisement files and found one (10%) advertisement related to the sale of the Company's "Senior Tribute Life Insurance" where "no medical exam" was used but excluded a disclosure that issuance of the policy or payment of benefits may depend upon the answers given in the application.

The Company violated Section 219.4(m) of the Department Regulation No. 34-A by using the term "No medical exam" but excluded a disclosure to the effect that issuance of the policy or payment of benefits may depend upon the answers given in the application and the truthfulness thereof in the advertisement.

The examiner found three of the 10 (30%) advertisements excluded the name of the city, town or village in which the Company has its home office.

The Company violated Section 219.4(p) of the Department Regulation No. 34-A by excluding the name of the city, town, or village in which the Company has its home office in the United States in the advertisements.

The examiner requested a notation indicating the extent of distribution of the 10 advertisement reviewed. The Company did not produce a notation indicating the extent of distribution of 7 of 10 (70%) advertisements reviewed.

The Company violated Section 219.5(a) of the Department Regulation No. 34-A by not maintaining at its home office a notation indicating extent of distribution for the advertisements of its life policies.

As stated in Section 4 of this report, the Company stopped writing traditional business in 2012.

B. Underwriting and Policy Forms

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

Based upon the sample reviewed, no significant findings were noted.

C. Treatment of Policyholders

The examiner reviewed a sample of various types of claims, surrenders, changes and lapses. The examiner also reviewed the various controls involved, checked the accuracy of the computations and traced the accounting data to the books of account.

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

"In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefit covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

(1) that it is not obligated to pay the claim or make the medical payment, stating specific reasons why it is not liable. . . . "

The examiner reviewed 15 denied major medical claims and found that in four of 15 (27%) instances, the denial of the claim was issued more than 30 calendar days after receipt of claim.

The Company violated Section 3224-a(b) of the New York Insurance Law by failing to deny all or part claims to the policyholder, covered person or health care provider in writing within 30 calendar days of the receipt of the claim.

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

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

The examiner initially reviewed 20 life insurance death claims for the examination period. The examiner found that in six out of 20 (30%) claims reviewed, the Company paid the interest settlement option rate at 3.25% instead of 3.50% as noted in the policy contract. These six errors were restricted to the calendar years 2010 through 2011. The examiner reviewed an additional 6 claims per calendar year 2010 and 2011 to verify the interest rate applied under the interest settlement option. The examiner found that six of 12 (50%) claims reviewed did not pay the interest settlement option rate of 3.50% as noted in the policy contract. The total results for calendar year 2010 and 2011 were 12 out of 20 (60%) claims reviewed did not pay the interest settlement option rate of 3.50% as noted in the policy contract

The Company violated Section 3214(c) of the New York Insurance Law by failing to pay claims at the rate of interest on proceeds left under the interest settlement option as noted in the policy contract.

The Company subsequently paid the beneficiaries the additional interest owed.

8. 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 4226(a) (1) of the New York Insurance Law by using an advertisement that made it appear that an applicant would obtain coverage if the information card is returned within 5 days when in fact an underwriting approval process was required. The Company pulled the advertisement from the listing available for use. In addition, the Company ceased writing traditional business in 2012.
B	The Company violated Section 219.4(k) of Department Regulation No. 34-A by listing a graded death benefit policy on advertisements that failed to include a statement that benefit payments, during the first three years of the policy, will be less than the policy's face amount. The Company ceased using the advertisements that referenced the graded death benefit. The Company pulled five of the advertisement from the listing available for use and revised the three remaining by removing the reference to the graded death benefit. In addition, the Company stopped writing traditional business in 2012.
C	The Company violated Section 86.4(a) of Department Regulation No.95 by using a fraud warning statement which differed from the language prescribed in such Section and by failing to obtain prior approval for such language. The Company revised the fraud warning statement on the claim forms to conform to Section 86.4(a) of Department Regulation No. 95.
D	The examiner recommends that the Company continue to compute reserves using the assumptions and methodology as agreed upon with the Department. The Company followed the recommendation as agreed with the Department in regards to the assumptions used in the computation of premium deficiency reserves for long-tail products.
E	The examiner recommends that the Company monitor the implemented changes to their self-support analysis procedures to ensure future compliance with Section 4228(h) of the New York Insurance Law. The Company stopped writing traditional business in 2012 and as a result the Company was not required to continue the monitoring of their self-support analysis procedures.

9. SUMMARY AND CONCLUSIONS

Following are the violations, recommendations and comments contained in this report:

Item	Description	Page No(s).
A	The examiner recommends that the Company continue to compute reserves using the assumptions and methodology as agreed upon with the Department.	22
B	The Company violated Section 2112(a) of the New York Insurance Law for failing to file certificate of appointment with the Superintendent in order to appoint insurance agents to represent the Company.	23
C	The Company violated Section 2112(d) of the New York Insurance Law for failing to file notice of termination with the Superintendent and failing to file notice of termination with the superintendent within thirty days of termination of the certificate of appointment.	23
D	The Company violated Section 2112(d) of the New York Insurance Law for failing to file a statement of facts relative to the termination for cause of the agents with the Superintendent.	24
E	The Company violated Section 219.4(m) of the Department Regulation No. 34-A by using the term "No medical exam" but excluded a disclosure to the effect that issuance of the policy or payment of benefits may depend upon the answers given in the application and the truthfulness thereof in the advertisement.	24
F	The Company violated Section 219.4(p) of the Department Regulation No. 34-A by excluding the name of the city, town, or village in which the Company has its home office in the United States in the advertisements.	24
G	The Company violated Section 219.5(a) of the Department Regulation No. 34-A by not maintaining at its home office a notation indicating extent of distribution for the advertisements of its life policies.	25
H	The Company violated Section 3224-a(b) of the New York Insurance Law by failing to notify all or partial denial to the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim.	26
I	The Company violated Section 3214(c) of the New York Insurance Law by failing to pay the claims at the rate of interest on proceeds left under the interest settlement option.	26-27

Respectfully submitted,

/s/
Rory Cummings
Associate Insurance Examiner

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

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

/s/
Rory Cummings

Subscribed and sworn to before me

this_____ day of _____

APPOINTMENT NO. 31294

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

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

RORY CUMMINGS

as a proper person to examine the affairs of the

AMERICAN PROGRESSIVE LIFE AND HEALTH INSURANCE COMPANY OF NEW YORK

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

COMPANY

with such other information as he shall deem requisite.

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

this 9th day of April, 2015

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

MICHAEL MAFFEI
ASSISTANT DEPUTY SUPERINTENDENT
AND CHIEF OF THE LIFE BUREAU