MARKET CONDUCT REPORT ON EXAMINATION

OF THE

TALCOTT RESOLUTION LIFE INSURANCE COMPANY

AS OF DECEMBER 31, 2019

EXAMINER:	**PABLO RAMOS**
DATE OF REPORT:	**DECEMBER 15, 2021**

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September 29, 2023

Honorable Adrienne A. Harris
Superintendent of Financial Services
New York, New York 10004

Dear Adrienne A. Harris:

In accordance with instructions contained in Appointment No. 32090, dated May 14, 2020, and annexed hereto, an examination has been made into the condition and affairs of Talcott Resolution Life Insurance Company, hereinafter referred to as "the Company". The Company's home office is located at One American Row, Hartford, CT 06103. However, the examination was conducted remotely because of the COVID-19 pandemic.

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 findings and violations contained in this report are summarized below.

- The Company violated Section 4224(c) of the New York Insurance Law by offering inducements in the form of non-insurance services in connection with group insurance without the inducements being specified in such group policy and group certificates. (See item 4A-1 of this report.)
- The Company violated Section 59.7(a)(1) of 11 NYCRR 59 (Insurance Regulation 123) by failing to submit for the Superintendent's approval a plan for the monitoring of experience of life insurance certificates. (See item 5 of this report.)
- The Company violated Section 59.7(a)(2) of 11 NYCRR 59 (Insurance Regulation 123) by failing to annually submit to the Department any changes to a monitoring plan approved, a plan to be submitted for approval, notice of any monitoring unit for which the actual to expected ratio produced by the monitoring plan approved by the Department is less than the percentages in the table in Section 59.7(a)(2), and an adjustment plan, subject to the approval of the superintendent, which can be expected to bring the certificates into compliance with the minimum benefit ratio standards or an explanation, satisfactory to the superintendent, that the minimum benefit ratio is still expected to be met. (See item 5 of this report.)
- The Company violated Section 224.4(f) of 11 NYCRR 224 (Insurance Regulation 187) by failing to establish a supervision system to ensure that its agents and brokers obtain each consumers' suitability information for annuities subsequent deposits whose proceeds are derived from replaced annuity contracts. (See item 4A-2 of this report.)
- The Company violated Sections 224.4(a)(1) and 224.4(c) of 11 NYCRR 224 (Insurance Regulation 187) by failing to inform consumers of all the various features of the annuity contracts. (See item 4A-2 of this report.)
- The Company violated Section 51.6(c)(2) of 11 NYCRR 51 (Insurance Regulation 60) by failing to provide the replacing insurer with the existing policy information necessary to complete the Disclosure Statement within 20 days of receipt of the request. (See item 4A-3 of this report.)

- The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms that were not filed with and approved by the Superintendent. (See item 4B-1 of this report.)
- The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms that had been modified from the version filed with and approved by the Superintendent. (See item 4B-1 of this report.)
- The Company violated Sections 3201(c)(2) and (c)(3) of the New York Insurance Law by including a discretionary clause in the policy provisions that gives the Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy. A similar violation was cited in the prior report on examination. (See item 4B-2 of this report.)
- The Company violated Section 226.4(a) of 11 NYCRR 226 (Insurance Regulation 200) for failing to request beneficiary information such as the name, address, date of birth, social security number, and telephone number of every beneficiary of the policy certificates to ensure that all benefits payments are distributed to the appropriate persons upon the death of the insured. (See item 4B-4 of this report.)
- The Company violated Section 3227(c) of the New York Insurance Law by failing to pay the required interest on surrendered policies. (See item 4C-3 of this report.)
- The Company violated Section 3211(b)(2) of the New York Insurance Law by disseminating premium notices to life insurance policyholders that failed to contain the language "unless such payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or nonforfeiture benefit." (See item 4C-5 of this report.)
- The Company violated Section 3214(c) of the New York Insurance Law by failing to pay the interest required on five matured life insurance policies during the examination period. (See item 4C-11 of this report.)
- The Company violated Section 3211(g) of the New York Insurance Law by failing to provide an annual notification to policyholders that the policy contains a cash surrender value and that further information, including the amount thereof, is available from the insurer upon written request from the policyowner. (See item 4C-12 of this report.)

- The Company violated Section 4223(k)(1) of the New York Insurance Law by failing to send annual statements to non-qualified fixed annuity contract holders. (See item 4C-14 of this report.)
- The Company violated Section 3230(b)(3) of the New York Insurance Law by failing to include the entire notice required by such section on its accelerated death claim forms. (See item 4C-10 of this report.)
- The Company violated Sections 3230(b)(4) and 3230(b)(5) of the New York Insurance Law by failing to include the notice required by such sections on its accelerated death claim forms. (See item 4C-10 of this report.)
- The Company violated Section 3230(d) of the New York Insurance Law by failing to provide certificate holders with the required disclosure information within five days of receipt of the applications to accelerate benefits. (See item 4C-10 of this report.)
- The Company violated Section 3224-a(b) of the New York Insurance Law by failing to deny all or part of the claims in writing to the policyholder, covered person or health care provider within 30 calendar days of the date of receipt of the claim. (See item 4C-17 of this report.)
- The Company violated Sections 3234(a) and (b) of New York Insurance Law by failing to provide EOBs to policyholders that included a description of the time limit, place, and manner in which an appeal of a denial of benefits must be brought under the policy and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection. (See item 4C-18 of this report.)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2015, to December 31, 2019. As necessary, the examiner reviewed matters occurring subsequent to December 31, 2019, but prior to the date of this report (i.e., the completion date of the examination).

The examination comprised a review of market conduct activities and utilized the National Association of Insurance Commissioners' *Market Regulations Handbook* or such other examination procedures, as deemed appropriate, in such review.

The examiner reviewed the corrective actions taken by the Company with respect to the market conduct violations and recommendations contained in the prior report on examination. The results of the examiner's review are contained in item 6 of this report.

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

3. DESCRIPTION OF COMPANY

A. History

The Company was originally incorporated as a stock life insurance company under the laws of the Commonwealth of Massachusetts in 1902, under the name Columbian National Life Insurance Company of Boston. In 1959, Hartford Fire Insurance Company purchased the Company and changed the Company's name to Hartford Life Insurance Company in 1960. In 1978, the Company was incorporated under the laws of the State of Connecticut.

Effective October 18, 2018, the Company's name was changed from Hartford Life Insurance Company to Talcott Resolution Life Insurance Company in conjunction with the May 2018 acquisition of Talcott Resolution Life, Inc., the direct parent of the Company.

B. Territory and Plan of Operation

The Company is authorized to write life insurance, annuities, and accident and health insurance as defined in paragraphs 1, 2 and 3 of Section 1113(a) of the New York Insurance Law. The Company is licensed to transact business in all 50 states and the District of Columbia. As of December 31, 2019, 48.94% of life insurance premiums, 20.13% of annuity considerations, 26.34% of accident and health insurance premiums, 5.61% of other considerations, and 3.07% of deposit-type contract funds were received from New York. Policies are written on a non-participating basis.

Effective January 1, 2013, Massachusetts Mutual Life Insurance Company ("MassMutual") acquired the Company's group annuity business, namely the Retirement Plans Group ("RPG") business. The Company and MassMutual also entered into a Reinsurance Agreement and an Administrative Services Agreement in connection with the RPG. Effective January 2, 2013, Prudential Insurance Company of America ("Prudential") acquired the Company's individual life insurance business by entering into a Reinsurance Agreement and an Administrative Services Agreement. Effective May 31, 2018, the Company entered into a Reinsurance Agreement and an Administrative Services agreement with Hartford Life and Accident Insurance Company ("HLA") regarding its accident and health policies.

Effective April 2012, the Company ceased new sales of individual annuity contract in the state of New York. The Company also discontinued marketing its individual life insurance

products and did not accept any new applications after December 31, 2013. Similarly, the Company discontinued marketing of its RPG products and did not accept any new or renewal applications after December 31, 2015. The Company's principal products sold during the examination period were group life and group disability, although sales of these products were subsequently discontinued in May 2020.

The following tables show the percentage of direct premiums received, by state, and by major lines of business for the year 2019:

Life Insurance Premiums	
New York	48.9%
South Carolina	7.3
Alaska	5.4
Florida	4.6
New Jersey	3.3
Subtotal	69.5%
All others	30.5
Total	100.0%

Annuity Considerations	
New York	20.1%
California	9.2
Florida	6.5
New Jersey	4.9
Illinois	3.9
Subtotal	44.6%
All others	55.4
Total	100.0%

Accident and Health Insurance Premiums	
New York	26.3%
Virginia	8.3
Florida	7.6
Hawaii	5.4
California	3.8
Subtotal	51.4%
All others	48.6
Total	100.0%

The Company's agency operations are conducted on a general agency basis. The Company's group life, group long term disability("LTD"), and group short term disability products are sold primarily through independent producers and consultants, who are appointed by the Company. The group life and group accident and health products are sold primarily through

independent producers and general agents. From 2015 and throughout the course of the examination period, the Company migrated its group business from its books to HLA.

4. MARKET CONDUCT ACTIVITIES

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

A. Advertising and Sales Activities

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

1. Section 4224(c) of the New York Insurance Law states:

> "Except as permitted by section three thousand two hundred thirty-nine of this chapter or subsection (f) of this section, no such life insurance company and no such savings and insurance bank and no officer, agent, solicitor or representative thereof and no such insurer doing in this state the business of accident and health insurance and no officer, agent, solicitor or representative thereof, and no licensed insurance broker and no employee or other representative of any such insurer, agent or broker, shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to any person to insure, or shall give, sell or purchase, or offer to give, sell or purchase, as such inducement, or interdependent with any policy of life insurance or annuity contract or policy of accident and health insurance, any stocks, bonds, or other securities, or any dividends or profits accruing or to accrue thereon, or any valuable consideration or inducement whatever not specified in such policy or contract other than any valuable consideration, including but not limited to merchandise or periodical subscriptions, not exceeding twenty-five dollars in value; nor shall any person in this state knowingly receive as such inducement, any rebate of premium or policy fee or any special favor or advantage in the dividends or other benefits to accrue on any such policy or contract, or knowingly receive any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever which is not specified in such policy or contract."

Prior to and during the examination period, the Company offered the following non-insurance services that were sold in conjunction with the Company's group life insurance products:

- Funeral planning and concierge services.
- Estate planning services, including online will preparation.
- Beneficiary Assist Services, including emotional counseling services.

- Travel Assistance and Identity Theft Protection Services, including access to medical professionals across the globe for medical assistance when traveling 100 or more miles away from home for 90 days or less and identity theft protection 24 hours a day, 7 days a week.
- Ability Assist Counseling Services, including 24 hours, 7 days a week, 365 days a year access to counseling services.
- Healthcare Support Services, including unlimited access to Benefit Specialists and nurses for administrative and clinical support to address medical care and claims concerns.

The Company offered the aforesaid non-insurance services and benefits in connection with group life contracts; however, these services and benefits are not specified in its approved group life insurance policies and certificates.

The Company also offered a "Life Conversations" program that provided the above non-insurance services. These non-insurance services constitute inducements that are not specified in its approved policies or contracts.

The Company violated Section 4224(c) of the New York Insurance Law by offering inducements in the form of non-insurance services in connection with group insurance without the inducements being specified in such group policy and group certificates.

The Company indicated that on February 12, 2018, it completed the steps that resulted in the discontinuation of offering non-insurance services in its proposals to prospective policyholders who reside in the state of New York.

2. Section 224.3(e) of 11 NYCRR 224 (Insurance Regulation 187) states:

"Suitability information means information that is reasonably appropriate to determine the suitability of a recommendation, including the following:
(1) age;
(2) annual income;
(3) financial situation and needs, including the financial resources used for the funding of the annuity;
(4) financial experience;
(5) financial objectives;
(6) intended use of the annuity;
(7) financial time horizon;

(8) existing assets, including investment and life insurance holdings;
(9) liquidity needs;
(10) liquid net worth;
(11) risk tolerance; and
(12) tax status."

Section 224.4 of 11 NYCRR 224 (Insurance Regulation 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:
(1) the consumer has been reasonably informed of various features of the annuity contract, such as the potential surrender period and surrender charge, availability of cash value, potential tax implications if the consumer sells, surrenders or annuitizes the annuity contract, death benefit, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, guaranteed interest rates, insurance and investment components, and market risk; . . .
(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. . . . "

The examiner's review of a sample of 24 annuities subsequent deposits whose proceeds were from replaced annuity contracts and that were processed by the Company during the examination period revealed that in 17 cases (70.8%), the Company did not obtain all suitability information required under Section 224.3(e) of 11 NYCRR 224 (Insurance Regulation 187).

The Company violated Section 224.4(f) of 11 NYCRR 224 (Insurance Regulation 187) by failing to establish a supervision system to ensure that its agents and brokers obtain each consumers' suitability information for annuities subsequent deposits whose proceeds are derived from replaced annuity contracts.

In addition, the Company did not inform the contract holders of the various features of the annuity contracts.

The Company violated Sections 224.4(a)(1) and 224.4(c) of 11 NYCRR 224 (Insurance Regulation 187) by failing to inform consumers of all the various features of the annuity contracts.

3. Section 51.6 of 11 NYCRR 51 (Insurance Regulation 60) states, in part:

   "(c) Where a replacement has occurred or is likely to occur, the insurer whose life insurance policy or annuity contract is to be replaced shall: . . .

   (2) Within twenty days of receipt of a request from a licensee of the Department, for information necessary for completion of the "Disclosure Statement" with respect to the life insurance policy or annuity contract proposed to be replaced, together with proper authorization from the applicant, furnish the required information simultaneously to the agent or broker of record of the existing life insurance policy or annuity contract being replaced and the agent or broker and insurer replacing the life insurance policy or annuity contract. This information shall include the insurer's customer service telephone number, the current status of the existing life insurance policy or annuity contract and the currently illustrated dividends/interest and other non-guaranteed costs and benefits."

The examiner's review of six replaced government annuity contracts revealed that in all cases (100%), the replacing insurer notified the Company of the proposed replacement and requested the information necessary to complete the Disclosure Statement. However, the Company did not provide the replacing insurer with the existing policy information necessary to complete the Disclosure Statement within 20 days of receipt of the request.

The Company violated Section 51.6(c)(2) of 11 NYCRR 51 (Insurance Regulation 60) by failing to provide the replacing insurer with the existing policy information necessary to complete the Disclosure Statement within 20 days of receipt of the request.

4. Review of replaced life insurance policies

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

   "(c) Where a replacement has occurred or is likely to occur, the insurer that issued the life insurance policy or annuity contract that is to be replaced shall: . . .
   (2) within 20 days of receipt of a request from a licensee of the department, for information necessary for completion of the 'Disclosure Statement' with respect to

> the life insurance policy or annuity contract proposed to be replaced, together with proper authorization from the applicant, furnish the required information simultaneously to the insurance agent or broker of record of the existing life insurance policy or annuity contract being replaced and the agent or broker and insurer replacing the life insurance policy or annuity contract. This information shall include the insurer's customer service telephone number, the current status of the existing life insurance policy or annuity contract, and the currently illustrated dividends/interest and other non-guaranteed costs and benefits. . . . "

The examiner's review of a sample of 75 surrendered life insurance policies administered by Prudential on behalf of the Company revealed that in 21 of the cases reviewed, the surrendered policies were replaced by other insurers. In 4 out of the 21 cases (19.05%), the Company did not provide the information requested by the replacing insurers concerning the existing life insurance policies (i.e., the Company's replaced policies) within 20 days of receipt of the request.

The Company violated Section 51.6(c)(2) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment) by failing to provide the external replacing insurers with the information necessary for the completion of the Disclosure Statement within 20 days of receipt of the request from the replacing insurer.

B. Underwriting and Policy Forms

The examiner reviewed a sample of new underwriting files and the applicable policy forms.

1. Section 3201(b)(1) of the New York Insurance Law states, in part:

   "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 reviewed a sample of 347 group policies and certificates (30 group policies and 317 group certificates) issued during the examination period. In 112 instances, the Company used policy forms that were not filed with and approved by the Superintendent. Overall, the Company used nine different unapproved policy forms.

The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms that were not filed with and approved by the Superintendent.

The examiner's review also revealed 15 instances in which the policy files contained an administrative form that contained the name of a third party administrator ("TPA") to provide services under the policies.

The examiner recommends that the Company properly identify the use of TPAs prominently on its application forms and policy forms. This means, as a best practice, the Company should include the name of the TPA on the first page of any application or policy.

The examiner also reviewed a sample of 25 group policies issued during the examination period. The sample consisted of 10 Core Life policies (which includes group term life insurance and group accident and health policies); 10 employee travel business ("ETB") policies; and 5 accidental death and dismemberment policies.

In 17 of the 25 (68%) group policies reviewed, each policy file contained at least one policy form that was modified from the version approved by the Superintendent. In total, the Company utilized 110 forms that were modified from the version approved by the Superintendent.

The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms that had been modified from the version filed with and approved by the Superintendent.

2. Section 3201 of the New York Insurance Law state, in part:

> "(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. . . .
> (c)(2) The superintendent may disapprove any life insurance policy form, or any form of annuity contract or group annuity certificate, or any form of funding agreement for delivery or issuance for delivery in this state, if its issuance would be prejudicial to the interests of policyholders or members or it contains provisions which are unjust, unfair or inequitable."
> (3) The superintendent may disapprove any accident and health insurance policy form for delivery or issuance for delivery in this state if the benefits provided therein are unreasonable in relation to the premium charged or any such form contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive, or contrary to law or to the public policy of this state."

The examiner reviewed a sample of 30 group policies issued. The examiner's review revealed that one long term disability certificate issued with form GBD-1200 and five accidental death and dismemberment certificates issued with form GBD-1300 A.1 contained the following provision:

"CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy."

Also, the examiner's review revealed that two group policies issued with policy form GBD-1100 and one group policy issued with policy form GBD-1200 contained the following provision:

"Policy Interpretation: Who interprets the terms and conditions of The Policy?

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA)."

In 9 out of the 30 group policies reviewed (30%), the policies contained the above provisions that grant the Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. The Department deemed the above discretionary clause as unfair, unjust, and contrary to the provisions of Sections 3201(c)(2) and (c)(3) of the New York Insurance Law.

The Company violated Sections 3201(c)(2) and (c)(3) of the New York Insurance Law by including a discretionary clause in the policy provisions that gives the Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy. A similar violation was cited in the prior report on examination.

3. Incorrect letterhead in applications for group certificates

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

"(c)(1) The superintendent may disapprove any policy form for delivery or issuance for delivery in this state if he finds that the same contains any provision or has any title, heading, backing or other indication of the contents of any or all of its provisions, which is likely to mislead the policyholder, contract holder or certificate holder."

The examiner's review of a sample of 30 group policies issued revealed that in 10 cases (33.33%), the Company issued the group policies utilizing HLA application forms. The Company was not identified as the insurer on the application forms.

The Company violated Section 3201(c)(1) of the New York Insurance Law by utilizing policy forms that were not approved for use and are misleading as to the identity of the insurer.

4. Information concerning insureds under group policies

Section 226.4(a) of 11 NYCRR 226 (Insurance Regulation 200) states, in part:

> " . . . 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."

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

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this Part A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to Section 243.3(a) of this Part. A policy record shall include: . . .
>
> (ii) The application, including any application form or enrollment form for coverage under any insurance contract or policy . . .
>
> (8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review. . . . "

The examiner's review of a sample of 72 group annuity certificates and 10 group term life certificates issued during the examination period. The review revealed that for 66 group annuity certificates (91.7%) and for 10 group term life certificates (100%), the Company failed to obtain the beneficiary information such as the name, address, date of birth, social security number, and

telephone number of the beneficiaries. Also, in 6 out of 72 group annuity certificates reviewed (8.3%), the examiner noted that the information on the enrollment forms did not include the address, social security number and telephone number of the beneficiaries.

The Company violated Section 226.4(a) of 11 NYCRR 226 (Insurance Regulation 200) for failing to request beneficiary information such as the name, address, date of birth, social security number, and telephone number of every beneficiary of the policy certificates to ensure that all benefits payments are distributed to the appropriate persons upon the death of the insured.

C. Treatment of Policyholders

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

1. Complaints handling procedures

Insurance Circular Letter No. 11 (1978) advises that:

> "As part of its complaint handling function, the company's consumer services department will maintain an ongoing central log to register and monitor all complaint activity. The log should be kept in a columnar form and list the following:
> 1. The date the complaint was received in-house.
> 2. The name of the complainant and the policy or claim file number.
> 3. The New York State Insurance Department file number.
> 4. The responsible internal division, i.e., personal lines underwriting, property damage claims, etc.
> 5. The person in the company with whom the complainant has been dealing.
> 6. The person within the company to whom the matter has been referred for review.
> 7. The date of such referral.
> 8. Bearing in mind the appropriate regulation mandating timely substantive replies, the dates of correspondence to the Insurance Department's Consumer Services Bureau.
>   A) The acknowledgment (if any).
>   B) The date of any substantive response.
>   C) The chronology of further contacts with this Department.
> 9. The subject matter of the complaint.
> 10. The results of the complaint investigation and the action taken.
> 11. Remarks about internal remedial action taken as a result of the investigation."

The examiner's review of the Company's complaint handling procedures revealed that the document did not contain any specific instructions as to how the Company logs, processes, and resolves complaints. More importantly, the complaint procedures did not contain timeframes in which the Company's employees must log, monitor, research, and resolve complaints. In addition, the examiner determined that the Company failed to maintain its complaint log in the format outlined in Insurance Circular Letter No. 11 (1978).

The examiner recommends that the Company amend its complaint handling procedures to ensure that the procedures contain instructions as to how the Company logs, tracks, responds to, and resolves complaints in a timely manner. The examiner further recommends that the Company maintains its complaint log in the manner prescribed by Insurance Circular Letter No. 11 (1978).

2. Complaints - Agent's statement

The examiner reviewed a complaint filed with the Department concerning an increase in life insurance premiums. The complaint was filed on behalf of the insured against an agent of the Company and alleged that the insured was not informed about the increase in premiums. Therefore, the examiner requested that the Company explain why it did not obtain a statement from the agent regarding the complaint. In response, the Company indicated that it is unable to compel a response from the agent.

The examiner recommends that the Company implement procedures that require its agents to respond to any inquiries regarding policyholder complaints and other policyholder related issues.

3. Life insurance policies and annuities surrendered

Section 3227 of the New York Insurance Law states:

> "(a) Interest, at the rate provided for in section three thousand two hundred fourteen of this article, shall be payable by life insurers, fraternal benefit societies, and life insurance departments of savings banks upon: (1) the value of policies surrendered by policyholders for cash values, including the rollover of annuity funds to other entities, and (2) the funds disbursed as policy loans. Such interest payment shall be added to and be a part of the total sum paid or be paid separately at the option of the insurer.
> (b) The interest calculated on amounts described in paragraphs one and two of subsection (a) hereof shall be calculated from the date the documentation necessary to complete the transaction is received by the insurer and shall be payable if the

> funds are not mailed or delivered by the insurer within ten working days of said receipt.
> (c) No interest need be payable pursuant to this section unless the amount of such interest is at least twenty-five dollars or if the payment of benefits by the insurer has been deferred pursuant to other provisions of this chapter.
> (d) Irrespective of the payment of interest in accordance with the above provisions, such life insurers, fraternal benefit societies and life insurance departments of savings banks shall make disbursements under paragraphs one and two of subsection (a) hereof as expeditiously as possible."

A review of a sample of 75 surrendered life insurance policies revealed that in 6 instances (8%), the Company failed to pay interest within ten working days in accordance with Section 3227 of the New York Insurance Law. The Company subsequently paid the required interest on the proceeds to the insureds.

Also, a review of a sample of 10 surrendered annuity contracts revealed that in one instance (10%), the Company failed to pay interest within ten working days in accordance with Section 3227 of the New York Insurance Law. The annuity contract surrendered was issued prior to July 1, 1986, but the Company failed to pay the interest on the surrender. The Company cited the Office of General Counsel Opinion No. 85-73 and indicated that the contract contains a deferral provision which states: "We may defer paying any amount under the 'Cash Surrender Value' or 'Partial Surrender' provisions for up to 6 months. If we defer payment for 30 days or more, we will pay interest at the rate of 4% per year on the amount deferred." To date, the Company has not paid the required interest for annuity contracts surrendered that were issued prior to July 1, 1986.

The Company violated Section 3227(c) of the New York Insurance Law by failing to pay the required interest on surrendered policies.

The Company conducted a study to identify the surrendered life policies that it failed to pay the required interest on and initially identified 20 life insurance policies. On September 30, 2020, the Company revised the list from 20 to 29 life insurance policies. The Company provided an additional 21 life insurance policies on February 26, 2021. In total, the Company identified 50 surrendered life insurance policies that it failed to pay the required interest on the benefits.

With respect to surrendered annuity contracts, the Company's study revealed only one surrendered annuity contract that it failed to pay the required interest on the benefit.

The examiner recommends that the Company review all annuity surrenders and pay interest as required under Section 3227 of the New York Insurance Law.

4. Annual privacy notices

   Section 420.5(a)(1) of 11 NYCRR 420 (Insurance Regulation 169) states, in part:

   "... A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of 12 consecutive months during which that relationship exists. A licensee may define the 12-consective-month period, but the licensee must apply it to the customer on a consistent basis."

A review of a sample of 25 in force annuity contracts revealed that in 9 cases (36%), the policy files did not contain evidence that the Company sent the required annual privacy notices to the contract holders.

The Company violated Section 420.5(a)(1) of 11 NYCRR 420 (Insurance Regulation 169) by not providing annual privacy notices to the contract holders.

5. Premium notices for individual life insurance policies

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

   "(b) The notice required by paragraph one of subsection (a) hereof shall . . .
   (2) state the amount of such payment, the date when due, the place where and the person to whom it is payable; and shall also state that unless such payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or nonforfeiture benefit."

The examiner's review of a sample of 60 lapsed policies processed by Prudential revealed that in 51 cases (85%), the notices did not contain the language 'unless such payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or nonforfeiture benefit.'

The Company violated Section 3211(b)(2) of the New York Insurance Law by disseminating premium notices to life insurance policyholders that failed to contain the language "unless such payment is made on or before the date when due or within the specified grace period

thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or nonforfeiture benefit."

6. Correspondence with the letterhead of another entity

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

   "No insurance producer or other person, shall, by any advertisement or public announcement in this state, call attention to any unauthorized insurer or insurers."

   Section 243.2 of 11 NYCRR 243 (Insurance Regulation 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: . . . (8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review. . . . "

The examiner's review of samples of enrollment application forms and policy loan applications revealed several findings as outlined below:

- In 9 out of 60 loan applications (15%) reviewed, the loan applications contained the name of Hartford Life and Annuity Insurance Company, an unauthorized insurer. The Company was not identified as the insurer on the application forms.
- In 4 out of 60 block of TRAC group annuity contracts (i.e., 401k plans) administered by MassMutual on behalf of the Company (6.7%), the enrollment applications contained the name of MassMutual Financial Group with no mention of the Company as the primary issuer of the policies. MassMutual Financial Group provides investment and wealth management solutions, insurance and retirement planning services.
- In 30 out of 60 block of OMNI group annuity contracts (i.e., government 457 plans) administered by MassMutual (50%), the enrollment forms contained the name of MassMutual Financial Group. In one case, the enrollment application contained the header of "The Hartford" which is the name of the group that previously owned the Company.

The Company violated Section 2122(a)(2) of the New York Insurance Law by calling attention to unauthorized insurers in its correspondence with New York policyholders.

The examiner recommends that the Company be clearly identified as the insurer on its policy loan applications and group policy enrollment forms.

7. Group accident and health correspondence with the incorrect insurer in the letterhead

The examiner's review of a sample of 13 group accident and health lapsed or terminated policies administered by Trustmark Insurance Company revealed that in 12 cases (92.31%), the letters sent to the policyholders included the name of Trustmark Insurance Company with no mention of the Company as the primary issuing Company of record.

The examiner recommends that the Company be clearly identified as the insurer on all its premium and lapse notices for accident and health policies administered by Trustmark Insurance Company.

The examiner also recommends that the letters and notices concerning lapses and terminations of group accident and health policies administered by Trustmark Insurance Company clearly identify Trustmark Insurance Company as the administrator.

8. Lost policy finder application

Section 226.5(a)(2)(ii) of 11 NYCRR 226 (Insurance Regulation 200) states, in part:

"(a) An insurer shall: . . .
(2) report to the superintendent through a lost policy finder:
(i) within 30 days of receiving the request, or within 45 days of receiving the request where the insurer contracts with another entity to maintain the insurer's records, the findings of the search; and
(ii) where the search reveals that benefits may be due, within 30 days of the final disposition of the request, the benefit paid and any other information requested by the superintendent . . . "

Section 3240 of the New York Insurance Law states, in part, that:

"(h) Lost policy finder. . . .
(6) When a beneficiary identified in paragraph four of this subsection submits a claim or claims to an insurer, the insurer shall process such claim or claims and make prompt payments and distributions in accordance with all applicable laws, rules, and regulations.

> (7) Within thirty days of the final disposition of the request, an insurer shall report to the superintendent through the lost policy finder any benefits paid and any other information requested by the superintendent. . . ."

The examiner's review of a sample of 35 Lost Policy Finder ("LPF") files revealed that death benefits were paid for 16 policies, but the status of the policies were not updated in the LPF and reported to the Superintendent within thirty days of the final disposition of the request.

The Company violated Section 226.5(a)(2)(ii) of 11 NYCRR 226 (Insurance Regulation 200) and Section 3240(h)(7) of the New York Insurance Law by failing to report to the Superintendent through the lost policy finder the benefits paid within thirty days of the final disposition of the request.

The Company violated Section 226.5(a)(2)(ii) of 11 NYCRR 226 (Insurance Regulation 200) and Section 3240(h)(7) of the New York Insurance Law by failing to, within thirty days of the final disposition of the request, report to the Superintendent through the lost policy finder the benefits paid on 16 policies.

9. Renewal provisions for group annuity contracts

The examiner reviewed a copy of the renewal notice the Company sent to a CRC Select group annuity contract certificate holder in 2016 and noted that the renewal notice did not explicitly state the contract options available to the certificate holder as required under the provisions of the contract.

The examiner recommends that the Company amend its CRC Select annuity contract renewal notices to include the options available to the certificate holders as required under provisions of the contracts.

10. Accelerated death benefits claims

Section 3230 of the New York Insurance Law states, in part:

> "(a) The application for a life insurance policy or policy rider which provides for accelerated payment of death benefits or a special surrender value shall:
> (1) contain a notice, prominently displayed, to read as follows: 'Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.' . . .
> (b) The application to accelerate benefits shall: . . .

(2) contain a notice, prominently displayed, to read as follows: 'Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (medicaid), family assistance and supplemental security income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, policyowners should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.'
(3) contain a notice, prominently displayed, to read as follows: 'Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, policy owners should seek assistance from a qualified tax adviser.';
(4) contain a statement by the policy owner that such application is voluntary and without coercion on the part of any third party; and
(5) contain a statement of the remaining death benefit available to the beneficiary. . . .
(d) Within five days of receipt of an application to accelerate benefits an insurer must provide the policy owner with the following:
(1) an illustration demonstrating the effect of the accelerated benefit on the policy's cash value and policy loans;
(2) a numerical computation of the amount of the death benefit which would be payable upon death;
(3) a numerical computation of the amount of the death benefit that would be payable upon acceleration; and
(4) a notice that other means may be available to achieve the intended goal, including a policy loan."

The examiner's review of a sample of seven (7) accelerated death benefit claims revealed the following:

- For all seven claim files reviewed, the claim form utilized by the Company did not contain the disclosure that receipt of accelerated death benefits may be taxable, receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum, and prior to applying for such benefits, policy owners should seek assistance from a qualified tax adviser.
- For all seven claim files reviewed, the claim form utilized by the Company did not contain the required language under Sections 3230(b)(4) and (b)(5) of the New York Insurance Law.

- For one claim, the Company received the application on July 15, 2014, and sent the disclosure information on July 23, 2014, a total of 8 days later. However, the first payment of the accelerated benefit was issued on March 19, 2015.

The Company violated Section 3230(d) of the New York Insurance Law by failing to provide certificate holders with the required disclosure information within five days of receipt of the applications to accelerate benefits.

The Company violated Section 3230(b)(3) of the New York Insurance Law by failing to include the entire notice required by such section on its accelerated death claim forms.

The Company violated Sections 3230(b)(4) and 3230(b)(5) of the New York Insurance Law by failing to include the notice required by such sections on its accelerated death claim forms.

11. Interest on matured life insurance policies

Section 3214 of the New York Insurance Law states, in part:

> (c) 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’s review of a sample of 50 matured life insurance policies administered by Prudential on behalf of the Company revealed that in five (5) cases (10%), the Company did not pay the total interest due from the date of maturity of the life insurance policy to the date of payment to the beneficiary.

The Company violated Section 3214(c) of the New York Insurance Law by failing to pay the interest required on five matured life insurance policies during the examination period.

12. Annual notification to policyholders with policies with cash surrender value

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

> “In the case of life insurance policies to which this section is applicable and which contain a cash surrender value, the insurer must provide an annual notification that the policy contains a cash surrender value and that further information, including the amount thereof, is available from the insurer upon written request from the

> policyowner . . . Any notice or statement which informs a policyowner of the policy's cash surrender value at least annually shall be deemed to comply with the requirements of this subsection."

The examiner's review of a sample of 52 individual life in force policies administered by Prudential on behalf of the Company revealed that in 7 (13.46%) cases, the Company failed to provide an annual notification to policyholders.

The Company violated Section 3211(g) of the New York Insurance Law by failing to provide an annual notification to policyholders that the policy contains a cash surrender value and that further information, including the amount thereof, is available from the insurer upon written request from the policyowner.

13. Audits of TPAs

During the examination period, the Company did not conduct any audits of its outsourced functions provided by six TPAs. Also, for two TPAs, Trustmark Insurance Company and HLA, the Company was unable to provide independent Statement on Standards for Attestation Engagements No. 16 ("SSAE 16") reviews that were performed during the examination period.

The examiner recommends that the Company perform audits of the functions provided by its TPAs. The examiner also recommends that the Company ensure that the TPAs perform audits on their own processes and internal controls, and each TPA should engage with an external firm to perform, annually, an SSAE 16 review.

14. Annual notice to non-qualified fixed annuities contract holders

Section 4223(k)(1) of the New York Insurance Law states, in part:

> "At least once in each contract year, the company shall mail to each holder of a contract subject to this section under which benefit payments have not yet commenced a statement as of a date during such year as to any paid-up annuity benefit or the amount available under each account to provide a paid-up annuity benefit, any cash surrender benefit and any death benefit, under the contract. If the minimum annual effective rate of interest is subject to redetermination, then the statement shall include the current minimum annual effective rate of interest and the next redetermination date. For contracts containing an equity index account, the statement shall identify the minimum accumulation value, the equity index value, any changes in the participation rate, margin, cap, floor or other factor used in the equity index formula. The statement shall be addressed to the last post-office address of the contractholder known to the company."

In response to examination correspondence concerning the Company's in force annuity contracts from its ILD administrative system, the Company indicated that it did not send annual statements to non-qualified fixed annuity contract holders.

The Company violated Section 4223(k)(1) of the New York Insurance Law by failing to send annual statements to non-qualified fixed annuity contract holders.

The examiner recommends that the Company implement controls to ensure that annual statements are mailed to contract holders of non-qualified fixed annuity contracts.

15. Section 86.4(a) of 11 NYCRR 86 (Insurance Regulation 95) states:

> "Except with respect to automobile insurance, all claim forms for insurance, and all applications for commercial insurance and accident and health insurance, provided to any person residing or located in this State in connection with insurance policies for issuance or issuance for delivery in this State, shall contain the following statement:
> 'Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.'"

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

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

The examiner's review of a sample of 248 accident and health ("A&H") claims (145 paid and 103 denied) revealed that in 101 out of 145 A&H paid claims (69.66%) and in 80 out of 103 A&H denied claims (77.67%) reviewed, the claim forms consist of five pages. Page 1 was the actual claim form, and the remaining four pages contained the fraud warning statements for all the states in which the Company is licensed, including New York. The New York fraud warning

statement was not located above the signature of the person executing the claims as required by Section 86.4(d) of Insurance Regulation 95.

The Company violated Section 86.4(d) of 11 NYCRR 86 (Insurance Regulation 95) by failing to place the required fraud warning statement immediately above the space provided for the signature of the person executing the claim form.

16. Section 3224-a(a) of the New York Insurance Law states:

> "Except 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 submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

In 2 out of 25 TPA-administered A&H paid claims reviewed (8%), the Company did not pay the claim within 45 days of receipt of the claims.

The Company violated Section 3224-a(a) of the New York Insurance Law by failing to make payment on A&H claims within 45 days of receipt of the claims.

17. 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. . . . "

In 6 out of 52 TPA-administered blanket A&H denied claims (11.54%) reviewed, the Company failed to deny the claims within 30 calendar days of the receipt of the claims.

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

The Company violated Section 3224-a(b) of the New York Insurance Law by failing to provide written notification to the policyholder, covered person or health care provider, within 30 days of the receipt of the claims, stating the reasons why it is not obligated to pay such claims.

18. Section 3234 of the New York Insurance Law states, in part:

"(a) Every insurer, including health maintenance organizations operating under article forty-four of the public health law or article forty-three of this chapter and any other corporation operating under article forty-three of this chapter, is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expense or home care expense benefits.
(b) The explanation of benefits form must include at least the following:

(1) the name of the provider of service the admission or financial control number, if applicable;
(2) the date of service;
(3) an identification of the service for which the claim is made;
(4) the provider's charge or rate;
(5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
(6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

In all 25 TPA-administered hospital medical expense paid claims (100%) and in 54 out of 94 A&H denied claims (57.45%) reviewed, the Company failed to issue explanation of benefits ("EOB") to policyholders as required under Sections 3234(a) and (b) of the New York Insurance Law.

The Company violated Sections 3234(a) and (b) of New York Insurance Law by failing to provide EOBs to policyholders that included a description of the time limit, place, and manner in which an appeal of a denial of benefits must be brought under the policy and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection.

19. Section 420.18(b) of 11 NYCRR 420 (Insurance Regulation 169) states:

> "An authorization shall specify a length of time, for which the authorization shall remain valid, which in no event shall be for more than 24 months."

In all five Solar blanket A&H denied claims reviewed (100%), the signed authorization forms did not contain the required notification specifying the length of time for which the authorization shall remain valid, which in no event shall be for more than 24 months.

The Company violated Section 420.18 of 11 NYCRR 420 (Insurance Regulation 169) by failing to specify a length of time for which the authorization shall remain valid, which in no event shall be for more than 24 months.

The examiner's review of a sample of 49 life insurance policy reinstatements administered by Prudential revealed that in 18 cases (36.73%), the reinstatement applications contain authorization forms that permit the Company to disclose nonpublic personal health information for more than 24 months, which is the maximum length of time permitted by Insurance Regulation 169.

The Company violated Section 420.18(b) of 11 NYCRR 420 (Insurance Regulation 169) by obtaining an authorization to disclose nonpublic personal health information for more than 24 months.

20. Section 216.6(c) of 11 NYCRR 216 (Insurance Regulation 64) states, in part:

> "(c) Within 15 business days after receipt by the insurer of a properly executed proof of loss and/or receipt of all items, statements and forms which the insurer

> requested from the claimant, the claimant, or the claimant's authorized representative, shall be advised in writing of the acceptance or rejection of the claim by the insurer. . . . If the insurer needs more time to determine whether the claim should be accepted or rejected, it shall so notify the claimant, or the claimant's authorized representative, within 15 business days after receipt of such proof of loss, or requested information. . . . "

In 3 out of 20 Disability Claims System ("DCS") appealed disability claims (15%) and in 1 out of 15 Pyramid accidental death and dismemberment denied claims (6.67%) reviewed, the Company did not reject the claim within 15 business days after receipt of the claim.

The Company violated Section 216.6(c) of 11 NYCRR 216 (Insurance Regulation 64) by failing to advise the claimant in writing of the rejection of a claim within 15 business days after receipt of the proof of loss or requested information.

D. <u>Record retention</u>

Section 243.2 of 11 NYCRR 243 (Insurance Regulation 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:
> (1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this Part A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to Section 243.3(a) of this Part. A policy record shall include: . . .
> (iii) The contract or policy forms issued including the declaration pages, endorsements, riders, and termination notices of the contract or policy. Binders shall be retained if a contract or policy was not issued; . . .
> (2) An application where no policy or contract was issued for six calendar years or until after the filing of the report on examination in which the record was subject to review, whichever is longer. . . .
> (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. . . .

(6) A complaint record required to be maintained under Chapter IX of this Title for six calendar years after all elements of the complaint are resolved and the file is closed.
(7) A financial record necessary to verify the financial condition of an insurer, including ledgers, journals, trial balances, annual and quarterly statement workpapers, evidence of asset ownership, and source documents, for six calendar years from its creation or until after the filing of the report on examination in which the record was subject to review, whichever is longer.
(8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review. . . . "

Section 243.3(c) of 11 NYCRR 243 (Insurance Regulation 152) states, in part:

"(c) An insurer shall establish and maintain a records retention plan. The plan shall include a description of the types of records being retained, the method of retention, and the safeguards established to prevent alteration of the records. Such plan shall be provided to the superintendent upon request. The insurer shall certify the accuracy of any records that are provided in accordance with its record retention plan. . . . "

A. The examiner's review of the Company's record retention policy revealed that the Company has a "Current Year + 3 Years" retention period for Grievance/Complaint Records, Complaint Log or Register, Policyholder Services, Underwriting, Ratings Complaint/Grievance Handling, and Claims Practices. Thus, the Company's record retention policy did not require retention of records for six calendar years or until after the filing of the report on examination in which the record was subject to review, whichever is longer, as required under Section 243.2(b) of 11 NYCRR 243 (Insurance Regulation 152).

The examiner recommends that the Company amend its record retention policy to comply with the record retention timeframes required under 11 NYCRR 243 (Insurance Regulation 152).

The Company amended its record retention policy in July 2020.

B. The examiner's review of a sample of 25 group policies terminated or lapsed revealed that in 14 cases (64%), the Company did not maintain a copy of the termination notice that was sent to group policyholders.

The Company violated Section 243.2(b)(1)(iii) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain copies of the termination notices of group policies.

C. In 5 out of 60 DCS LTD paid claims reviewed (8.33%), the Company was unable to provide documents relating to the paid claims.

The Company violated Section 243.2(b)(4) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain copies of all records pertaining to LTD paid claims.

D. The examiner performed reconciliations of the Company's data files to the corresponding policy count information reported in the Company's filed annual statements for the period under examination. As part of the review, the examiner requested the reconciliations for surrenders and terminations data files for life insurance and annuities. The Company responded that it was unable to balance totals for 2015 due to lack of reporting from 2014 due to conversion of business administration to a third-party administrator in 2015.

In addition, there were several instances during the examination in which the examiner determined that the underlying policies for the data files provided by the Company in response to examination requests were issued by a different company. The examiner's review of the data files and the underlying policies revealed the following:

i. A review of a sample of 25 TPA administered A&H paid claims revealed that the policies were issued by HLA, not the Company. The TPA is the Plan Administrator for the Company's A&H claims. In its response to the examiner's request for an explanation, the Company indicated that the TPA confirmed that the paid and denied claims data file was provided in error because the policies were not issued by the Company.

ii. For one complaint reviewed, the Company indicated that the policy pertains to HLA, not the Company.

Also, a review of a sample of 47 reinstated policies administered by Prudential revealed that in 17 cases (36.17%), the files did not contain documents evidencing that the policies were reinstated. The examiner's review revealed the following:

- In three cases, the requests for reinstatement were declined.
- In 14 cases, the reinstatements were not considered as formal reinstatements, but as administrative or informal reinstatements.

Although the Company included the 17 policies above in its reinstatement data file for the examination period, the examiner's review revealed that the Company incorrectly reported the 17 policies as reinstatements.

The examiner recommends that the Company implement enhanced procedures and controls, to ensure that the Company maintain accurate data files to support the amounts reported in the exhibits in the annual statements and that its data files for life insurance and annuities surrenders and terminated reconcile to the information reported in its filed annual statement.

The examiner recommends that the Company conduct periodic audits of its TPAs to ensure the correct number of policies are reported, its records and files are not commingled with that of other insurers, and that the numbers reflected in its annual statements are accurate.

E. The examiner reviewed a sample of 25 annuities with subsequent premium payments and requested that the Company provide copies of the letters requesting the release of the funds under the annuities from the other insurers listed in the Disclosure Statements. In its response, the Company only provided screenshots of the policy file comments showing when the Letter of Acceptance was faxed to the other carrier. In the same response, the Company stated: ". . . Once the Letter of Acceptance is signed by Talcott and faxed to the other carrier, our administrative practice has been to retain it for 90 days."

The Company violated Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain complete records of subsequent annuity premium payments for six calendar years from its creation or until after the filing of the report on examination.

F. The examiner's review of a sample of 60 TRAC group annuity certificates administered by MassMutual revealed that in 23 cases (38%), the Company did not maintain copies of the completed enrollment forms.

Also, for a sample of five TPA-administered group term life insurance certificates issued, the examiner requested that the Company provide enrollment information for the named insured and beneficiary. In response to this request, the Company stated that the TPA was unable to locate evidence that it sent the required form to the named insureds.

The Company violated Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain the completed group annuity enrollment applications for its group annuity contracts and for its certificates issued.

5. EXPERIENCE MONITORING

Section 59.7(a) of 11 NYCRR 59 (Insurance Regulation 123) states, in part:

"(a) Life insurance. (1) By July 1, 1987 each insurer, which has issued certificates subject to this Part, shall submit for approval a plan for the monitoring of experience of these certificates. Such monitoring plan shall include:
(i) Provision for the combining of the experience of similar certificates. This may include, subject to the approval of the superintendent, the use of nationwide experience. Each such grouping shall be considered a monitoring unit. No monitoring unit shall be less than 5,000 lives, unless it is the only unit.
(ii) Provision for demonstrating that the minimum benefit ratio requirements of section 59.5 of this Part are being satisfied. Such demonstration shall compare as a ratio the actual experience to the expected experience as anticipated by the filing memorandum required by section 59.5 of this Part.

(2) Starting in calendar year 1988, by July first each year, each insurer shall submit to the Actuarial Valuation Bureau:
(i) any changes to a monitoring plan approved under paragraph (1) of this subdivision, or in the case of an insurer issuing certificates subject to this Part without an appropriate plan submitted or approved under paragraph (1), a plan should be submitted for approval; (ii) notice of any monitoring unit for which the actual to expected ratio produced by the monitoring plan approved under paragraph (1) of this subdivision is less than the percentages in the following table:

Total incurred claims	Ratio indicating insurer action is necessary
1,000 or more	.90 or less
100 – 999	.80 or less
25 – 99	.65 or less
0 – 24	0 or less

(iii) an adjustment plan, subject to the approval of the superintendent, which can be expected to bring the certificates into compliance with the minimum benefit ratio standards or an explanation, satisfactory to the superintendent, that the minimum benefit ratio is still expected to be met. . . . "

In response to examination correspondence, the Company indicated that it was unable to locate the original filing documents for the experience filings required under Insurance Regulation 123. The review of the Company's filings for life insurance experience for 2015 through 2018 revealed discrepancies regarding the Company's monitoring threshold. In each determination, the monitoring threshold was based on the claims from the last year of experience over the period as opposed to the entire period. Similarly, the Company provided nationwide experience for Annual

Renewable Term Insurance, but it was measuring its threshold based on the claims from the last year of experience. The Department reached the same conclusion in reviewing the life experience for the 5 and 10-Year Level Term Life Insurance plan.

For the filings for 2015 through 2018, the Company did not use the correct threshold in determining whether the monitoring unit's actual to expected ratio meets the requirements of Section 59.7(a)(2) of 11 NYCRR 59 (Insurance Regulation 123). Furthermore, when using the correct threshold, the Department determined that the Company would have failed to meet the monitoring threshold for the Annual Renewable Term Insurance under both New York and nationwide experience for each monitoring year 2015 to 2018. Also, the Company would have failed to meet the monitoring threshold for the 5 and 10-Year Level Term Life Insurance under for nationwide experience for 2015. Each such instance would not only require an annual filing when the ratios have not been met but would also require an adjustment plan which can be expected to bring the certificate into compliance per Section 59.7(a)(2)(iii) of 11 NYCRR 59 (Insurance Regulation 123). The Department confirmed that it received the revised filings on August 31, 2020.

The Company violated Section 59.7(a)(1) of 11 NYCRR 59 (Insurance Regulation 123) by failing to submit for the Superintendent's approval a plan for the monitoring of experience of life insurance certificates.

The Company also violated Section 59.7(a)(2) of 11 NYCRR 59 (Insurance Regulation 123) by failing to annually submit to the Department any changes to a monitoring plan approved, a plan to be submitted for approval, notice of any monitoring unit for which the actual to expected ratio produced by the monitoring plan approved by the Department is less than the percentages in the table in Section 59.7(a)(2), and an adjustment plan, subject to the approval of the superintendent, which can be expected to bring the certificates into compliance with the minimum benefit ratio standards or an explanation, satisfactory to the superintendent, that the minimum benefit ratio is still expected to be met.

The examiner recommends that the Company submit, for each year under examination, an adjustment plan, subject to the approval of the superintendent, which can be expected to bring the certificates into compliance with the minimum benefit ratio standards or an explanation, satisfactory to the superintendent, that the minimum benefit ratio is still expected to be met.

6. 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 51.6(b)(2) of Department Regulation No. 60 by not obtaining fully completed Disclosure Statements. The Company ceased new sales of individual annuity contracts in the state of New York effective April 27, 2012 and individual life insurance policies effective December 31, 2013.
B	The Company violated Section 51.6(b)(3) of Department Regulation No. 60 by not ascertaining that statements made on the Disclosure Statement were accurate in the cases where the advantages of the existing policy were described as "none" and in the cases where the Company could not verify that statements made on the Disclosure Statement were accurate. The Company ceased new sales of individual annuity contracts in the state of New York effective April 27, 2012 and individual life insurance policies effective December 31, 2013.
C	The Company violated Section 51.6(b)(9) of Department Regulation No. 60 by failing to provide a Revised Disclosure Statement in those cases where the annuity contract applied for differed from the annuity contract issued. The Company ceased new sales of individual annuity contracts in the state of New York effective April 27, 2012 and individual life insurance policies effective December 31, 2013.
D	The Company violated Section 51.6(b)(7) of Department Regulation No. 60, because where the required forms did not meet the requirements of the Regulation or were not accurate, the Company failed to, within ten days from the date of receipt of the application, either have any deficiencies corrected or reject the application and so notify the applicant of such rejection and the reason therefore. The Company ceased new sales of individual annuity contracts in the state of New York effective April 27, 2012 and individual life insurance policies effective December 31, 2013.

Item	Description
E	The Company violated Section 4226(b) of the New York Insurance Law and Section 51.6(b)(3) of Department Regulation No. 60 by failing to use comparisons that conform to all the requirements established by the Superintendent by regulation, reduce the surrender values and death benefit values for the hypothetical rates of return on the Appendix 10B Disclosure Statements by investment fund level charges and examine Appendix 10B Disclosure Statements for the variable annuity replacements and ascertain that they were accurate and met the requirements of the New York Insurance Law and Department Regulation No. 60. The Company ceased new sales of individual annuity contracts in the state of New York effective April 27, 2012 and individual life insurance policies effective December 31, 2013.
F	The examiner recommended that the Company develop and implement an audit plan designed to review, test and monitor compliance with Department Regulation No. 60. Such plan should be approved by the Company's board of directors and its audit committee. Also, the results of audits performed should be reviewed by the board of directors and the audit committee. The Company adopted an Individual Annuity Regulation 60 Audit Plan effective May 1, 2011. The Audit Plan was amended on April 12, 2012 and approved by the Board. The Company conducted monthly monitoring through December 2012 and then was adjusted to semi-annual thereafter because new sales were discontinued. The Company ceased new sales of individual annuity contracts in the state of New York effective April 27, 2012 and individual life insurance policies effective December 31, 2013. As a result, the Company reported limited incoming replacement activity due to subsequent premium payments in existing annuity contracts from another annuity contract. Outgoing replacements are monitored annually. The examiner's review of surrenders revealed instances in which the Company's life insurance policies and annuity contracts were replaced by other insurers and are subject to the requirements of Regulation 60.
G	The Company violated Section 51.6(b)(5) of Department Regulation No. 60 by failing to file the quarterly report required when an existing insurer failed to provide the information necessary to complete the Disclosure Statement. The Company has been filing the quarterly reports required under Insurance Regulation 60 when an existing insurer failed to provide the information necessary to complete the Disclosure Statement.

Item	Description
H	The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms that were not filed with and approved by the Superintendent and by using policy forms that had been modified from the version filed with and approved by the Department. A repeat violation is contained in this report.
I	The examiner recommended that the Company review the process for reconstructing group policy forms for issue to determine what, if any, role it may have played in the violations of Section 3201(b)(1) and make any necessary changes to the process to prevent future violations. A similar finding is contained in this report.
J	The Company violated Section 3201(c)(2) of the New York Insurance Law by including a discretionary clause in the policy provisions that gives the Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy. A repeat violation is contained in this report.
K	The Company violated Section 3220(a)(2) of the New York Insurance Law by failing to include standard provisions protecting the rights of policyholder from provisions not contained in the policy. The Company also violated Section 3220(a)(2) of the New York Insurance Law by including a provision in the policy that allows the Company to make changes to the policy without the policyholder's signature. A review of a sample of group policies issued did not reveal instances in which policies failed to include standard provisions protecting the rights of policyholder from provisions not contained in the policy. In addition, a review of a sample group policies issued did not reveal instances in which the policies included a provision in the policy that allows the Company to make changes to the policy without the policyholder's consent.
L	The Company violated Section 3220(a)(6) of the New York Insurance Law by failing to include standard provisions entitling the policyholder to a conversion life policy should they be terminated due to a permanent disability. A review of a sample of group policies issued did not reveal instances in which group policies issued failed to include standard provisions entitling the policyholder to a conversion life policy should they be terminated due to a permanent disability.

Item	Description
M	The Company violated Section 3204(a)(3) of the New York Insurance Law by unilaterally modifying life insurance policies such that policyholders could be adversely affected. A review of a sample of group life policies issued did not reveal instances in which the Company unilaterally modified life insurance policies such that policyholders could be adversely affected.
N	The Company violated Section 403(d) of the New York Insurance Law and Section 86.4 of Department Regulation No. 95 by utilizing unapproved fraud warning statements on its claim forms. A similar violation is contained in this report.

7. SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in this report:

Item	Description	Page No(s).
A	The Company violated Section 4224(c) of the New York Insurance Law by offering inducements in the form of non-insurance services in connection with group insurance without the inducements being specified in such group policy and group certificates.	10
B	The Company violated Section 224.4(f) of 11 NYCRR 224 (Insurance Regulation 187) by failing to establish a supervision system to ensure that its agents and brokers obtain each consumers' suitability information for annuities subsequent deposits whose proceeds are derived from replaced annuity contracts.	11
C	The Company violated Sections 224.4(a)(1) and 224.4(c) of 11 NYCRR 224 (Insurance Regulation 187) by failing to inform consumers of all the various features of the annuity contracts.	12
D	The Company violated Section 51.6(c)(2) of 11 NYCRR 51 (Insurance Regulation 60) by failing to provide the replacing insurer with the existing policy information necessary to complete the Disclosure Statement within 20 days of receipt of the request.	12
E	The Company violated Section 51.6(c)(2) of 11 NYCRR 51 (Insurance Regulation 60, Third Amendment) by failing to provide the external replacing insurers with the information necessary for the completion of the Disclosure Statement within 20 days of receipt of the request from the replacing insurer.	13
F	The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms that were not filed with and approved by the Superintendent.	13
G	The examiner recommends that the Company properly identify the use of TPAs prominently on its application forms and policy forms. This means, as a best practice, the Company should include the name of the TPA on the first page of any application or policy.	14
H	The Company violated Section 3201(b)(1) of the New York Insurance Law by using policy forms that had been modified from the version filed with and approved by the Superintendent.	14

Item	Description	Page No(s).
I	The Company violated Sections 3201(c)(2) and (c)(3) of the New York Insurance Law by including a discretionary clause in the policy provisions that gives the Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy. A similar violation was cited in the prior report on examination.	15
J	The Company violated Section 3201(c)(1) of the New York Insurance Law by utilizing policy forms that were not approved for use and are misleading as to the identity of the insurer.	16
K	The Company violated Section 226.4(a) of 11 NYCRR 226 (Insurance Regulation 200) for failing to request beneficiary information such as the name, address, date of birth, social security number, and telephone number of every beneficiary of the policy certificates to ensure that all benefits payments are distributed to the appropriate persons upon the death of the insured.	17
L	The examiner recommends that the Company amend its complaint handling procedures to ensure that the procedures contain instructions as to how the Company logs, tracks, responds to, and resolves complaints in a timely manner. The examiner further recommends that the Company maintains its complaint log in the manner prescribed by Insurance Circular Letter No. 11 (1978).	18
M	The examiner recommends that the Company implement procedures that require its agents to respond to any inquiries regarding policyholder complaints and other policyholder related issues.	18
N	The Company violated Section 3227(c) of the New York Insurance Law by failing to pay the required interest on surrendered policies.	19
O	The examiner recommends that the Company review all annuity surrenders and pay interest as required under Section 3227 of the New York Insurance Law.	20
P	The Company violated Section 420.5(a)(1) of 11 NYCRR 420 (Insurance Regulation 169) by not providing annual privacy notices to the contract holders.	20

Item	Description	Page No(s).
Q	The Company violated Section 3211(b)(2) of the New York Insurance Law by disseminating premium notices to life insurance policyholders that failed to contain the language "unless such payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or nonforfeiture benefit."	20
R	The Company violated Section 2122(a)(2) of the New York Insurance Law by calling attention to unauthorized insurers in its correspondence with New York policyholders.	22
S	The examiner recommends that the Company be clearly identified as the insurer on its policy loan applications and group policy enrollment forms.	22
T	The examiner recommends that the Company be clearly identified as the insurer on all its premium and lapse notices for accident and health policies administered by Trustmark Insurance Company.	22
U	The examiner also recommends that the letters and notices concerning lapses and terminations of group accident and health policies administered by Trustmark Insurance Company clearly identify Trustmark Insurance Company as the administrator.	22
V	The Company violated Section 226.5(a)(2)(ii) of 11 NYCRR 226 (Insurance Regulation 200) and Section 3240(h)(7) of the New York Insurance Law by failing to report to the Superintendent through the lost policy finder the benefits paid within thirty days of the final disposition of the request.	23
W	The Company violated Section 226.5(a)(2)(ii) of 11 NYCRR 226 (Insurance Regulation 200) and Section 3240(h)(7) of the New York Insurance Law by failing to, within thirty days of the final disposition of the request, report to the Superintendent through the lost policy finder the benefits paid on 16 policies.	23
X	The examiner recommends that the Company amend its CRC Select annuity contract renewal notices to include the options available to the certificate holders as required under provisions of the contracts.	23
Y	The Company violated Section 3230(d) of the New York Insurance Law by failing to provide certificate holders with the required disclosure information within five days of receipt of the applications to accelerate benefits.	25

Item	Description	Page No(s).
Z	The Company violated Section 3230(b)(3) of the New York Insurance Law by failing to include the entire notice required by such section on its accelerated death claim forms.	25
AA	The Company violated Sections 3230(b)(4) and 3230(b)(5) of the New York Insurance Law by failing to include the notice required by such sections on its accelerated death claim forms.	25
BB	The Company violated Section 3214(c) of the New York Insurance Law by failing to pay the interest required on five matured life insurance policies during the examination period.	25
CC	The Company violated Section 3211(g) of the New York Insurance Law by failing to provide an annual notification to policyholders that the policy contains a cash surrender value and that further information, including the amount thereof, is available from the insurer upon written request from the policyowner.	26
DD	The examiner recommends that the Company perform audits of the functions provided by its TPAs. The examiner also recommends that the Company ensure that the TPAs perform audits on their own processes and internal controls, and each TPA should engage with an external firm to perform, annually, an SSAE 16 review.	26
EE	The Company violated Section 4223(k)(1) of the New York Insurance Law by failing to send annual statements to non-qualified fixed annuity contract holders.	27
FF	The examiner recommends that the Company implement controls to ensure that annual statements are mailed to contract holders of non-qualified fixed annuity contracts.	27
GG	The Company violated Section 86.4(d) of 11 NYCRR 86 (Insurance Regulation 95) by failing to place the required fraud warning statement immediately above the space provided for the signature of the person executing the claim form.	28
HH	The Company violated Section 3224-a(a) of the New York Insurance Law by failing to make payment on A&H claims within 45 days of receipt of the claims.	28

Item	Description	Page No(s).
II	The Company violated Section 3224-a(b) of the New York Insurance Law by failing to deny all or part of the claims in writing to the policyholder, covered person or health care provider within 30 calendar days of the date of receipt of the claim.	29
JJ	The Company violated Section 3224-a(b) of the New York Insurance Law by failing to provide written notification to the policyholder, covered person or health care provider, within 30 days of the receipt of the claims, stating the reasons why it is not obligated to pay such claims.	29
KK	The Company violated Sections 3234(a) and (b) of New York Insurance Law by failing to provide EOBs to policyholders that included a description of the time limit, place, and manner in which an appeal of a denial of benefits must be brought under the policy and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection.	30
LL	The Company violated Section 420.18 of 11 NYCRR 420 (Insurance Regulation 169) by failing to specify a length of time for which the authorization shall remain valid, which in no event shall be for more than 24 months.	30
MM	The Company violated Section 420.18(b) of 11 NYCRR 420 (Insurance Regulation 169) by obtaining an authorization to disclose nonpublic personal health information for more than 24 months.	30
NN	The Company violated Section 216.6(c) of 11 NYCRR 216 (Insurance Regulation 64) by failing to advise the claimant in writing of the rejection of a claim within 15 business days after receipt of the proof of loss or requested information.	31
OO	The examiner recommends that the Company amend its record retention policy to comply with the record retention timeframes required under 11 NYCRR 243 (Insurance Regulation 152).	32
PP	The Company violated Section 243.2(b)(1)(iii) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain copies of the termination notices of group policies.	32
QQ	The Company violated Section 243.2(b)(4) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain copies of all records pertaining to LTD paid claims.	33

Item	Description	Page No(s).
RR	The examiner recommends that the Company implement enhanced procedures and controls, to ensure that the Company maintain accurate data files to support the amounts reported in the exhibits in the annual statements and that its data files for life insurance and annuities surrenders and terminated reconcile to the information reported in its filed annual statement.	34
SS	The examiner recommends that the Company conduct periodic audits of its TPAs to ensure the correct number of policies are reported, its records and files are not commingled with that of other insurers, and that the numbers reflected in its annual statements are accurate.	34
TT	The Company violated Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain complete records of subsequent annuity premium payments for six calendar years from its creation or until after the filing of the report on examination.	34
UU	The Company violated Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain the completed group annuity enrollment applications for its group annuity contracts and for its certificates issued.	35
VV	The Company violated Section 59.7(a)(1) of 11 NYCRR 59 (Insurance Regulation 123) by failing to submit for the Superintendent's approval a plan for the monitoring of experience of life insurance certificates.	37
WW	The Company also violated Section 59.7(a)(2) of 11 NYCRR 59 (Insurance Regulation 123) by failing to annually submit to the Department any changes to a monitoring plan approved, a plan to be submitted for approval, notice of any monitoring unit for which the actual to expected ratio produced by the monitoring plan approved by the Department is less than the percentages in the table in Section 59.7(a)(2), and an adjustment plan, subject to the approval of the superintendent, which can be expected to bring the certificates into compliance with the minimum benefit ratio standards or an explanation, satisfactory to the superintendent, that the minimum benefit ratio is still expected to be met.	37
XX	The examiner recommends that the Company submit, for each year under examination, an adjustment plan, subject to the approval of the superintendent, which can be expected to bring the certificates into compliance with the minimum benefit ratio standards or an explanation, satisfactory to the superintendent, that the minimum benefit ratio is still expected to be met.	37

Respectfully submitted,

Pablo Ramos
Financial Services Examiner 3

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

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

Pablo Ramos

Subscribed and sworn to before me
this 29th day of September, 2023

Audrey Hall

AUDREY HALL
Notary Public, State of New York
No. 01HA6274900
Qualified in Kings County
Commission Expires January 28, 2025

APPOINTMENT NO. 32090

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

*I, **LINDA A. LACEWELL**, 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:*

PABLO RAMOS

as a proper person to examine the affairs of the

TALCOTT RESOLUTION LIFE INSURANCE COMPANY

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 14th day of May 2020

LINDA A. LACEWELL
Superintendent of Financial Services

By: Mark McLeod

MARK MCLEOD
DEPUTY CHIEF - LIFE BUREAU