

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

NEW YORK LIFE INSURANCE COMPANY
New York, New York

**AS OF
April 25, 2005**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION**

Issued: June 22, 2005

NEW YORK LIFE INSURANCE COMPANY

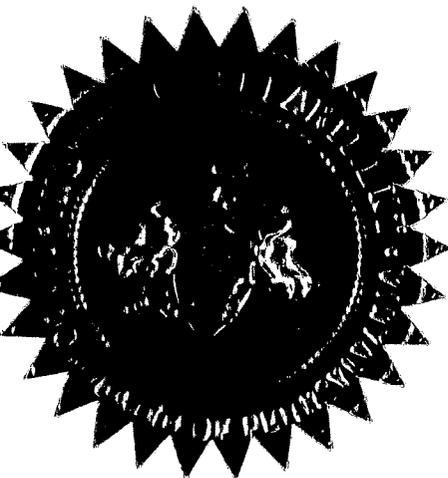
TABLE OF CONTENTS

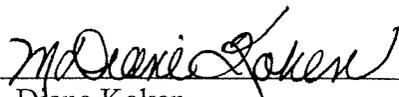
Order	
I. Introduction	3
II. Scope of Examination	6
III. Company History and Licensing	7
IV. Advertising	8
V. Forms	9
VI. Producer Licensing	10
VII. Consumer Complaints	13
VIII. Underwriting	14
A. Underwriting Guidelines	15
B. Group Certificates of Coverage Issued	16
C. Group Long Term Care Certificates Terminated	16
D. Group Certificates Declined	16
E. Long Term Care Policies Issued	17
F. Life Policies Issued	18
G. Annuity Contracts Issued	19
H. Long Term Care Policies Declined	19
I. Life Policies Declined	20
J. Long Term Care Policies Terminated	20
K. Life Policies Terminated	20
L. Annuity Contracts Terminated	21
M. Long Term Care Policies Issued as Replacements	21
N. Life Policies Issued as Replacements	21
O. Long Term Care Policies Not-Taken	23
P. Life Policies Not-Taken	23
Q. Annuity Contracts Not-Taken	23
R. Life Term Conversions	24
IX. Internal Audit and Compliance Procedures	25

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 29 day of April, 2002, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Randolph L. Rohrbaugh, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.





M. Diane Koken
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE: : VIOLATIONS:
: :
NEW YORK LIFE INSURANCE : Section 903(a) of the Insurance
COMPANY : Department Act, Act of May 17, 1921,
51 Madison Avenue : P.L. 789, No. 285 (40 P.S. § 323.3)
New York, NY 10010 : :
: Sections 671-A and 671.1-A of Act
: 147 of 2002 (40 P.S. §§ 310.71)
: :
: Sections 404-A, 408-A(c)(4)(i) and
: (ii), 408-A(e)(2)(iii), and 2166(A) and
: (B) of the Insurance Company Law,
: Act of May 17, 1921, P.L. 682, No.
: 284 (40 P.S. §§ 625-4, 625-8 and
: 991.2166)
: :
: Title 31, Pennsylvania Code, Sections
: 81.6(a)(2)(ii), 83.55b, 89a.113, 146.3
: 146.5, 146.6, 146.7 and 154.18(c)
: :
: Title 18, Pennsylvania Consolidated
: Statutes, Section 4117(k)
: :
Respondent. : Docket No. MC05-06-003

CONSENT ORDER

AND NOW, this 27th day of JUNE, 2005, this Order is hereby
issued by the Deputy Insurance Commissioner of the Commonwealth of
Pennsylvania pursuant to the statutes cited above and in disposition of the matter
captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. § 101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra. or other applicable law.

FINDINGS OF FACT

3. The Deputy Insurance Commissioner finds true and correct each of the following Findings of Fact:

- (a) Respondent is New York Life Insurance Company, and maintains its address at 51 Madison Avenue, New York, New York 10010.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2003 through December 31, 2003.
- (c) On April 25, 2005, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on May 24, 2005.

(e) The Examination Report notes violations of the following:

(i) Section 903(a) of the Insurance Department Act, No. 285 (40 P.S. § 323.3), which requires every company or person subject to examination must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the Department may require, in order that its representatives may ascertain whether the company has complied with the laws of the Commonwealth;

(ii) Section 671-A of Act 147 of 2002, which prohibits producers from transacting business within this Commonwealth without written appointment as required by the Act (40 P.S. § 310.71).

(iii) Section 671.1-A of Act 147 of 2002, which requires (a) an insurer which terminates an appointment shall notify the Department in writing, on a form approved by the Department, or through an electronic process, within 30 days following the effective date of termination; and (d) If the reason for termination was a violation of this act or if the insurer had knowledge that

the licensee was found to have engaged in any activity prohibited by this act, the insurer shall inform the Department in the notification;

(iv) Section 404-A of the Insurance Company Law, No. 284 (40 P.S. §625-4), which requires when the individual policy or annuity is delivered to the policyholder by the producer by hand, a delivery receipt shall be used. This receipt must be in at least a duplicate set and state the date the policy or annuity was received by the policyholder. The receipt date shall be the date on which the policyholder and producer sign the delivery receipt, and such date shall commence any applicable policy or annuity examination period. Copies of the delivery receipt must be provided to the policyholder on the date of policy or annuity delivery and to the issuing insurer. When the individual policy or annuity is delivered to the policyholder by a means other than by hand-delivery by the producer, the insurer shall establish appropriate means of verifying delivery by the producer of the policy or annuity and of establishing the date from which any applicable policy or examination period shall commence;

(v) Section 408-A(c)(4)(i) of the Insurance Company Law, No. 284 (40 P.S. § 625-8), which requires a statement to be signed and dated by the applicant or the policy owner in the case of an illustration provided at time of delivery reading as follows: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to

change and could be either higher or lower. The producer has told me they are non-guaranteed.”

(vi) Section 408-A(c)(4)(ii) of the Insurance Company Law, No. 284, which requires a statement be signed and dated by the producer reading as follows:
“I certify that this illustration has been presented to the applicant or the policy owner and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration.”

(vii) Section 408-A(e)(2)(iii) of the Insurance Company Law, No. 284, which states the following applies if no illustration is used by a producer in the sale of a life insurance policy or if a screen illustration is displayed. If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy and signed by the policy owner no later than the time the policy is delivered. A copy shall be provided to the policy owner at the time the policy is delivered and to the insurer;

(viii) Section 2166(A) and (B) of Insurance Company Law, No. 284 (40 P.S. § 991.2166), which provides: (A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of a clean claim, and (B) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (A), interest at 10%

per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than two dollars;

(ix) Title 31, Pennsylvania Code, Section 81.6(a)(2)(ii), which requires an insurer that uses an agent or broker in a life insurance or annuity sale shall, if replacement is involved: Send to each existing insurer a written communication advising of the replacement or proposed replacement and the identification information obtained under subparagraph (I) and in the case of life insurance, the disclosure statement as required by § 83.3, or ledger statement containing comparable policy data on the proposed life insurance. This written communication shall be made within five working days of the date the application is received in the replacing insurer's home or regional office, or the date the proposed policy or contract is issued, whichever is sooner;

(x) Title 31, Pennsylvania Code, Section 89a.113, which requires application forms to include the following questions designed to elicit information as to whether, as of the date of application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace another accident and sickness or long-term care policy or certificate presently in force. A supplementary

application or form to be signed by the applicant and producer, except when the coverage is sold without a producer, containing the questions may be used;

- (xi) Title 31, Pennsylvania Code, Section 146.3, which states the claim files of the insurer shall be subject to examination by the Commissioner or by appointed designees. The files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed;
- (xii) Title 31, Pennsylvania Code, Section 146.5, which requires every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated;
- (xiii) Title 31, Pennsylvania Code, Section 146.6 states that if an investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected;

- (xiv) Title 31, Pennsylvania Code, Section 146.7, which states within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer;

- (xv) Title 31, Pennsylvania Code, Section 154.18(c), which states interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim; and

- (xvi) Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), which requires all applications for insurance and all claim forms shall contain or have attached thereto the following notice: “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 subjects such person to criminal and civil penalties.”

CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Deputy Insurance Commissioner makes the following Conclusions of Law:

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

- (b) Respondent's violations of Sections 671-A and 671.1-A of Act 147 of 2002 are punishable by the following, under Section 691-A of Act 147 of 2002 (40 P.S. § 310.91):
 - (i) suspension, revocation or refusal to issue the certificate of qualification or license;
 - (ii) imposition of a civil penalty not to exceed five thousand dollars (\$5,000.00) for every violation of the Act;
 - (iii) an order to cease and desist; and
 - (iv) any other conditions as the Commissioner deems appropriate.

- (c) Respondent's violations of Sections 404-A and 408-A of the Insurance Company Law, No. 284 (40 P.S. §§625-4 and 625-8) are punishable as detailed in the Report of Examination by the following, under 40 P.S. § 625-10: Upon determination by hearing that this act has been violated, the commissioner may

issue a cease and desist order, suspend, revoke or refuse to renew the license, or impose a civil penalty of not more than \$5,000 per violation.

(d) Respondent's violations of Sections 2166(A) and (B) of the Insurance Company Law of 1921 are punishable by the following, under Section 2182 of the Act (40 P.S. § 991.2182): A violation of this article is subject to a fine not to exceed five thousand dollars (\$5,000.00).

(e) Respondent's violations of Title 31, Pennsylvania Code, Section 81.6(a)(2)(ii) are punishable under Title 31, Pennsylvania Code, Section 81.8(b) and (c), which provide failure to comply, after a hearing, may subject a company to penalties provided in 40 P.S. § 475. Failure to comply shall be considered a separate violation and may not be considered in lieu of a proceeding against the company for a violation of 40 P.S. §§472, 473 or 474. In addition, failure to make the disclosure may be considered a violation of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 to 1171.15);

(f) Respondent's violations of Title 31, Pennsylvania Code, Section 83.55 are punishable under Title 31, Pennsylvania Code, Section 83.6:

(i) For failing to insure adequate disclosure of basic information, after a hearing, a company may be subject to the penalties provided under

40 P.S. § 475, for violations of 40 P.S. §§ 472 through 474. In addition, failure to make the disclosure outlined in this subchapter may be considered a violation of 40 P.S. §§ 1171.1 through 1171.15.

(g) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.3, 146.5, 146.6 and 146.7 are punishable under Sections 9, 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9, 1171.10 and 1171.11):

- (i) cease and desist from engaging in the prohibited activity;
- (ii) suspension or revocation of the license(s) of Respondent.

(h) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

- (i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);

- (ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00).

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Deputy Insurance Commissioner orders and Respondent consents to the following:

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.
- (d) Respondent shall pay Ten Thousand Dollars (\$10,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

(e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Harbert, Administrative Assistant, Bureau of Enforcement, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Deputy Insurance Commissioner finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Deputy Insurance Commissioner may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Deputy Insurance Commissioner may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Deputy Commissioner finds that there has been a breach of any of the provisions of this Order, the Deputy Commissioner may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate

action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Deputy Insurance Commissioner. Only the Insurance Commissioner or a duly authorized Deputy Insurance Commissioner is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent

Order is not effective until executed by the Insurance Commissioner or a duly authorized Deputy Insurance Commissioner.

BY: NEW YORK LIFE INSURANCE
COMPANY, Respondent



Name: Michael G. Gallo
Title: Senior Vice President



Name: Eric S. Rubin
Title: Senior Vice President



RANDOLPH L. ROHRBAUGH
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination was conducted on New York Life Insurance Company, hereafter referred to as “Company,” at the Company’s office located in New York, New York, September 20, 2004, through December 3, 2004.

Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

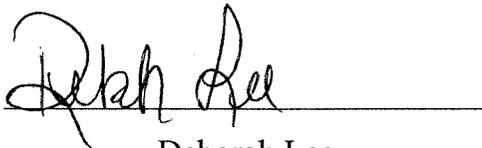
Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

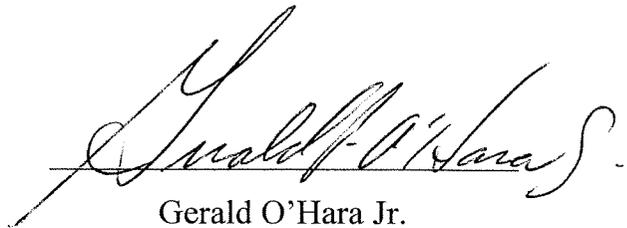
The undersigned participated in the Examination and in the preparation of this Report.



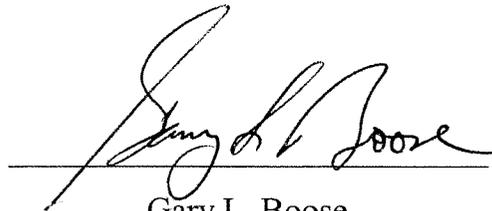
Daniel Stemcosky, AIE, FLMI
Market Conduct Division Chief



Deborah Lee
Market Conduct Examiner



Gerald O'Hara Jr.
Market Conduct Examiner



Gary L. Boose
Market Conduct Examiner

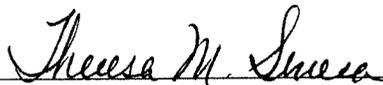
Verification

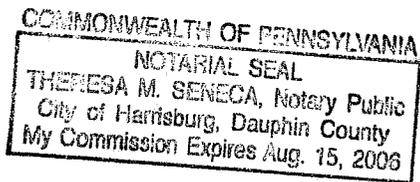
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).


Daniel Stemcosky

Sworn to and Subscribed Before me

This *22* Day of *April*, 2005


Notary Public



II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2003, through December 31, 2003, unless otherwise noted. The purpose of the examination was to determine compliance by the Company with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Advertising, Consumer Complaints, Forms, Producer Licensing, Underwriting Practices and Procedures, and Claim Handling Practices and Procedures.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

III. COMPANY HISTORY AND LICENSING

New York Life Insurance Company was incorporated in the State of New York on May 21, 1841, and commenced business on April 12, 1845. Originally incorporated as Nautilus Insurance Company, the Company adopted its current title in 1849. The Company is licensed in all states, District of Columbia, Puerto Rico, U.S. Virgin Islands and Canada.

In 1951, the Company entered into the group insurance and individual accident and health insurance business.

In 1987, the Company ceased writing individual medical expense insurance products in all fifty states. In the same year, the Company entered into an administrative agreement with Mutual of Omaha, which requires Mutual of Omaha to service the individual medical expense products that remain in force.

In 1995, the Company placed existing disability income policies into a closed block of business and stopped offering new policies for individuals.

As of their 2004 annual statement for Pennsylvania, New York Life Insurance Company reported direct premium for ordinary and group life insurance and annuities in the amount of \$323,942,077; and direct premium for accident and health in the amount of \$14,321,700.

IV. ADVERTISING

Title 31, Pennsylvania Code, Section 51.2(c) provides that “Any advertisements, whether or not actually filed or required to be filed with the Department under the provisions of this Regulation may be reviewed at any time at the discretion of the Department.” The Department, in exercising its discretionary authority for reviewing advertising, requested the Company to provide copies of all advertising materials used for solicitation and sales during the experience period.

The Company provided a list of 402 pieces of advertising utilized in the Commonwealth during the experience period. The advertising consisted of: life marketing materials, long term care marketing materials and annuity marketing materials. A sample of 20 pieces of advertising was requested, received and reviewed. The 20 advertising materials and the Company’s web site were reviewed to ascertain compliance with Act 205, Section 5 (40 P.S. §1171.5), Unfair Methods of Competition and Unfair or Deceptive Acts or Practices and Title 31, Pennsylvania Code, Chapter 51 and Chapter 89. No violations were noted.

V. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy contracts, riders, endorsements and applications used in order to determine compliance with requirements of Insurance Company Law, Chapter 2, Section 354 (40 P.S. §477b), as well as provisions for various mandated benefits. Applications and claim forms were also reviewed to determine compliance with Title 18, Pa. C.S., Section 4117(k). The following violations were noted:

13 Violations - Title 18, Pa. C. S., Section 4117(k)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice:

“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 subjects such person to criminal and civil penalties.”

The following application forms did not contain or have attached the required fraud statement. The application form description and frequency of use is listed in the table below.

Form Number	Descriptive Name	Number
995-585	Annuity Application	1
G29155 0	Group Enrollment Form	3
ILTC-5101(PA)(1001)	LTC Application	8
GPA L29	Group Enrollment Form	1

VI. PRODUCER LICENSING

The Company was requested to provide a list of all producers active and terminated during the experience period. Section 671-A (40 P.S. §310.71) of the Insurance Department Act prohibits agents from doing business on behalf of any entity without a written appointment from that entity. Section 641.1-A (40 P.S. §310.41a) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. Section 671.1 (40 P.S. §310.71a) of the Insurance Department Act requires the Company to report all agent terminations to the Department.

The Company provided a list of 1,534 active producers and 438 terminated producers. A random sample of 150 active producers and 50 terminated producers was compared to departmental records of producers to verify appointments, terminations and licensing. In addition, a comparison was made on the producers identified on applications reviewed in the policy issued sections of the exam. The following violations were noted:

4 Violations – Insurance Department Act, No. 147, Section 671-A (40 P.S. §310.71)

- (a) Representative of the insurer. – An insurance producer shall not act on behalf of or as a representative of the insurer unless the insurance producer is appointed by the insurer. An insurance producer not acting as a representative of an insurer is not required to be appointed.
- (b) Representative of the consumer. – An insurance producer acting on behalf of or representing an insurance consumer shall execute a written agreement with the insurance consumer prior to representing or acting on their behalf that:

- (1) Delineates the services to be provided; and
 - (2) Provides full and complete disclosure of the fee to be paid to the insurance producer by the insurance consumer.
- (c) Notification to department. – An insurer that appoints an insurance producer shall file with the department a notice of appointment. The notice shall state for which companies within the insurer’s holding company system or group the appointment is made.
- (d) Termination of appointment. – Once appointed, an insurance producer shall remain appointed by an insurer until such time as the insurer terminates the appointment in writing to the insurance producer or until the insurance producer’s license is suspended, revoked or otherwise terminated.
- (e) Appointment fee. – An appointment fee of \$12.50 will be billed annually to the insurer for each producer appointed by the insurer during the preceding calendar year regardless of the length of time the producer held the appointment with the insurer. The appointment fee may be modified by regulation.
- (f) Reporting. – An insurer shall, upon request, certify to the department the names of all licensees appointed by the insurer.

The Company failed to file a notice of appointment and submit appointment fees to the Insurance Department for the following 4 producers. The company listed these producers as active; however, department records did not indicate an active appointment.

Agent’s Name	Inactive Date
Dennis M Chant	09/18/2002
Leann G Sprague	No Appt on File
Peter K Stevenson	03/08/2002
Gwendolyn J Tibbals	05/12/2001

5 Violations – Insurance Department Act, No. 147, Section 671.1-A (40 P.S.

§310.71a) Termination of Appointments

(a) Termination. - An insurer which terminates an appointment pursuant to section 671-A(d) shall notify the department in writing on a form approved by the department, or through an electronic process approved by the department, within 30 days following the effective date of the termination.

(b) Reason for termination. – If the reason for the termination was a violation of this act or if the insurer had knowledge that the licensee was found to have engaged in any activity prohibited by this act, the insurer shall inform the department in the notification.

The following 5 producers were listed as terminated by the Company but not reported as terminated to the Department. Department records indicate an active status.

Agent's Name	Term Date	Comments
Zheng, Haokun	20030216	Active Status
Hill, Robert	20030409	Active Status
Kleinsmith, Bruce	20030409	Active Status
Williams, Lakisha	20031006	Active Status
Redic, Patricia	20031229	Active Status

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of their consumer complaint logs for 2000, 2001, 2002 and 2003. The Company identified 43 written consumer complaints and provided complaints logs for 2000, 2001, 2002 and 2003. Of the 43 consumer complaints identified, 25 were forwarded from the Department. All 43 consumer complaint files were requested, received and reviewed.

The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log. The complaint files and the 4 years of complaint logs were reviewed for compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5 (a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with Title 31, Pennsylvania Code, Section 146.5(b) and 146.5(c), Unfair Claims Settlement Practices. No violations were noted.

VIII. UNDERWRITING

The Underwriting review was sorted and conducted in 18 general segments.

- A. Underwriting Guidelines
- B. Group Certificates of Coverage Issued
- C. Group Long Term Care Certificates Terminated
- D. Group Certificates Declined
- E. Long Term Care Policies Issued
- F. Life Policies Issued
- G. Annuity Contracts Issued
- H. Long Term Care Policies Declined
- I. Life Policies Declined
- J. Long Term Care Policies Terminated
- K. Life Policies Terminated
- L. Annuity Contracts Terminated
- M. Long Term Care Policies Issued as Replacements
- N. Life Policies Issued as Replacements
- O. Long Term Care Policies Not-Taken
- P. Life Policies Not-Taken
- Q. Annuity Contracts Not-Taken
- R. Life Term Conversions

Each segment was reviewed for compliance with underwriting practices and included forms identification and agent identification. Issues relating to forms or agent/broker licensing appear in those respective sections of the Report and are not duplicated in the Underwriting portion of the Report.

A. Underwriting Guidelines

The Company was requested to provide copies of all established written underwriting guidelines in use during the experience period. Underwriting guidelines were reviewed to ensure guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place which could possibly be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

The following manuals and guides were provided and reviewed:

Individual Life and Annuity Products

- Underwriting, claims and policyholder service procedures

Group Membership Association Division (GMAD)

- Policyholder service and underwriting – TPA procedure manuals
- Underwriting manuals and guidelines
- Claim procedures and compliance manuals

Long Term Care Division

- Underwriting policies and procedure manuals

B. Group Certificates of Coverage Issued

The Company was requested to provide a list of all group certificates issued during the experience period. The Company provided a list of 3,800 certificates issued. A random sample of 100 certificates issued files was requested, received, and reviewed. Of the 100 certificate issued files reviewed, 38 were guaranteed coverage issued to new group members, 36 were new certificates issued and 26 certificates were issued as the result of the group coverage being transferred from another insurance company. The files were reviewed to ensure compliance with Pennsylvania Consolidated Statutes, Section 4117(k). No violations were noted.

C. Group Long Term Care Certificates Terminated

The company was requested to identify all group certificates terminated during the experience period. The company identified a universe of 7 group long term care certificates terminated. All 7 files were requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. No violations were noted.

D. Group Certificates Declined

The Company was requested to provide a list of all group certificates declined during the experience period. The company identified 345 certificates declined. A random sample of 50 certificates was requested, received and reviewed. The files

were reviewed to ensure declinations were not the result of any discriminatory underwriting practice and any remittance of unearned premium was properly refunded. No violations were noted.

E. Long Term Care Policies Issued

The Company was requested to identify all individual long term care policies issued during the experience period. The Company identified a universe of 498 individual long term care policies issued. A random sample of 75 files was requested, received and reviewed. The applications and policies were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 89a. The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Chapter 89a.113

Requirements for application forms and replacement coverage.

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace another accident and sickness or long-term care policy or certificate presently in force. A supplementary application or form to be signed by the applicant and producer, except when the coverage is sold without a producer, containing the questions may be used. The applicant's replacement question was not answered in the file noted.

F. Life Policies Issued

The Company identified a universe of 9,429 life policies issued during the experience period. A sample of 125 files was requested, received, and reviewed. Life issued policy files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

5 Violations – Title 31, Pennsylvania Code, Section 83.55b

The insurer shall maintain the agent's certification of surrender comparison index disclosure delivery in its appropriate files for at least 3 years or until the conclusion of the next succeeding regular examination by the insurance department of its domicile, whichever is later. The absence of the agent's certification from the appropriate files of the insurer shall constitute prima facie evidence that no surrender comparison index disclosure was provided to the prospective purchaser of life insurance. The 5 files noted did not contain the agent's certification of surrender comparison index disclosure delivery.

7 Violations – Insurance Company Law, Section 408-A(c)(4)(i) (40 P.S. §625-8)

A statement to be signed and dated by the applicant or the policy owner in the case of an illustration provided at time of delivery reading as follows: "I have received a copy of this illustration and understand that any non guaranteed elements illustrated are subject to change and could be either higher or lower. The producer has told me they are non-guaranteed." Of the 7 files noted, the applicant or the policy owner did not sign an illustration delivery receipt at the time of the policy delivery in 6 files and the illustration was dated after the policy delivery date in the remaining file.

6 Violations – Insurance Company Law, Section 408-A(c)(4)(ii)

(40 P.S. §625-8)

A statement to be signed and dated by the producer reading as follows: “I certify that this illustration has been presented to the applicant or the policy owner and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration.” The writing agent did not sign the certification upon delivery of illustration in the 6 files noted.

G. Annuity Contracts Issued

The Company identified a universe of 114 Annuity Contracts issued during the experience period. A random sampling of 50 annuity files was requested, received, and reviewed. The annuity files were reviewed to determine compliance to issuance, and replacement statutes and regulations. No violations were noted.

H. Long Term Care Policies Declined

The Company was requested to identify all policies declined during the experience period. The Company identified a universe of 122 individual long term care policies declined. A random sample of 25 files was requested, received, and reviewed. The files were reviewed to ensure declinations were not the result of any discriminatory underwriting practices and the proper return of any unearned premium. No violations were noted.

I. Life Policies Declined

The Company was requested to identify all policies declined during the experience period. The Company identified a universe of 553 individual life policies declined. A Sample of 50 files was requested, received, and reviewed. The files were reviewed to ensure declinations were not the result of any discriminatory underwriting practices and the proper return of any unearned premium. No violations were noted.

J. Long Term Care Policies Terminated

The Company was requested to identify all policies terminated during the experience period. The Company identified a universe of 43 individual long term care policies terminated. A random sample of 25 files was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. No violations were noted.

K. Life Policies Terminated

The Company was requested to identify all policies terminated during the experience period. The Company identified a universe of 8,960 individual life policies terminated. A random sample of 50 files was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. No violations were noted.

L. Annuity Contracts Terminated

The Company was requested to identify all policies terminated during the experience period. The Company identified a total of 9 individual annuity contracts terminated. All 9 files were requested for review. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. No violations were noted.

M. Long Term Care Policies Issued as Replacements

The Company identified a universe of 9 long term care policies that were issued as replacements during the experience period. All 9 files were requested, received, and reviewed. The long term care replacement files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. No violations were noted.

N. Life Policies Issued as Replacements

The Company identified a universe of 536 life policies issued as replacements during the experience period. A random sample of 100 files was requested, received, and reviewed. The policy files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violations were noted:

1 Violation - Insurance Department Act, Section 903 (40 P.S. § 323.3)

Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily ascertain whether the Company or person has complied with the laws of this Commonwealth. The file noted was missing the application and replacement information.

4 Violations - Title 31, Pennsylvania Code, Section 81.6 (a)(2)(ii)

An insurer that uses an agent or broker in a life insurance or annuity sale shall, if replacement is involved: Send to each existing insurer a written communication advising of the replacement or proposed replacement and the identification information obtained under subparagraph (I) and in the case of life insurance, the disclosure statement as required by §83.3 (relating to disclosure statement) or ledger statement containing comparable policy data on the proposed life insurance. This written communication shall be made within 5 working days of the date the application is received in the replacing insurer's home or regional office, or the date the proposed policy or contract is issued, whichever is sooner. The replacement letter to the replaced company was not documented in the 4 files noted.

**1 Violation – Insurance Company Law, Section 408-A(e)(2)(iii)
(40 P.S. §625-8)**

The following applies if no illustration is used by a producer in the sale of a life insurance policy or if a screen illustration is displayed. If the policy is issued, a basic illustration conforming to the policy as issued shall be sent with the policy

and signed by the policy owner no later than the time the policy is delivered. A copy shall be provided to the policy owner at the time the policy is delivered and to the insurer. The file noted did not contain the signed certification and acknowledgement of the delivery of an illustration.

O. Long Term Care Policies Not-Taken

The Company was requested to identify all individual policies not-taken during the experience period. The Company identified a universe of 47 individual long term care policies not-taken. All 47 files were requested, received and reviewed. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

P. Life Policies Not-Taken

The Company was requested to identify all individual policies not-taken during the experience period. The Company identified a universe of 880 individual life policies not- taken. A sample of 50 files was requested, received, and reviewed. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

Q. Annuity Contracts Not-Taken

The Company was requested to identify all individual contracts not-taken during the experience period. The Company identified a universe of 8 individual annuity

contracts not-taken. All 8 files were requested for review. The files were reviewed to ensure compliance with the free look provisions of the contract. No violations were noted.

R. Life Term Conversions

The Company identified 64 individuals converting term coverage during the experience period. A random sample of 25 conversion files was requested, received and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. The following violation was noted.

1 Violation - Insurance Company Law, Section 404-A (40 P.S. §625-4)

When the individual policy or annuity is delivered to the policyholder by the producer by hand, a delivery receipt shall be used. This receipt must be in at least a duplicate set and state the date the policy or annuity was received by the policyholder. The receipt date shall be the date on which the policyholder and producer sign the delivery receipt, and such date shall commence any applicable policy or annuity examination period. Copies of the delivery receipt must be provided to the policyholder on the date of policy or annuity delivery and to the issuing insurer. When the individual policy or annuity is delivered by the producer, the insurer shall establish appropriate means of verifying delivery by the producer of the policy or annuity and of establishing the date from which any applicable policy or examination period shall commence. The file noted did not contain a policy delivery receipt.

IX. INTERNAL AUDIT AND COMPLIANCE PROCEDURES

The Company was requested to provide copies of their internal audit and compliance procedures. The audits and procedures were reviewed to ensure compliance with Insurance Company Law, Section 405-A (40 P.S. §625-5). Section 405-A provides for the establishment and maintenance of internal audit and compliance procedures, which provides for the evaluation of compliance with all statutes and regulations dealing with sales methods, advertising, and filing and approval requirements for life insurance and annuities. The procedures shall also provide for the following:

- (1) Periodic reviews of consumer complaints in order to determine patterns of improper practices.
- (2) Regular reporting to senior officers and the board of directors or an appropriate committee thereof with respect to any significant findings.
- (3) The establishment of lines of communication, control and responsibility over the dissemination of advertising and promotional materials, including illustrations and illustration explanations, with the requirement that such materials shall not be used without the approval by company employees whose compensation, other than generally applicable company bonus or incentive plans, is not directly linked to marketing or sales.

No violations were noted.

X. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The claim manuals and procedures were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The Claim file review consisted of 12 areas:

- A. Life Claims
- B. Annuity Claims
- C. Insured-Submitted Medical and Medicare Supplement Claims
- D. Provider-Submitted Medical and Medicare Supplement Claims
- E. Long Term Care Claims
- F. Group Medical Claims
- G. Claims Group Disability (Harrington)
- H. Group Disability JLT Claims
- I. Group Disability Claims (Professional Member Association)
- J. Group Life Claims
- K. Group Accidental Death and Dismemberment Claims
- L. Group Waiver of Premium Claims

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). The insured submitted claims were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices and the provider submitted claims were reviewed for compliance with Insurance Company Law, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims. The life claims were additionally reviewed for compliance with Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b).

A. Life Claims

The Company was requested to provide a list of all claims received during the experience period. The company identified 3,297 individual life claims. A random sample of 100 claim files was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

11 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for the 11 claims noted.

B. Annuity Claims

The Company was requested to provide a list of all claims received during the experience period. The company identified 46 individual annuity claims. All 46 claim files were requested, received and reviewed. The policy files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

5 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for the 5 claims noted.

C. Insured-Submitted Medical and Medicare Supplement Claims

The Company was requested to provide a list of all insured-submitted claims received during the experience period. The Company provided the following lists of medicare supplement claims and other medical claims submitted by the Insured. The claims on this closed block of business are administered and processed through an agreement with Mutual of Omaha. The number of claims listed for each claim status and selected for review is outlined in the following table.

Claim Status	Universe	Sample
Medicare Supplement Claims Paid	31	25
Medicare Supplement Claims Denied	98	25
Medical Claims Paid	97	25
Medical Claims Denied	42	25
Totals	268	100

The following violations were noted:

1 Violation – Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The claim noted was missing pertinent information.

52 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the 52 claims noted within 10 working days.

9 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for the 9 claims noted.

10 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within 15 working days for the 10 claims noted.

D. Provider-Submitted Medical and Medicare Supplement Claims

The Company was requested to provide a list of all provider-submitted claims received during the experience period. The Company provided the following lists of medicare supplement claims and other medical claims submitted by the Provider. The claims on this closed block of business are administered and processed through an agreement with Mutual of Omaha. The number of claims listed for each claim status and selected for review is outlined in the following table.

Claim Status	Universe	Sample
Medicare Supplement Claims Paid	2593	50
Medicare Supplement Claims Denied	647	25
Medical Claims Paid	145	50
Medical Claims Denied	61	25
Totals	3446	150

The following violations were noted:

13 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of Provider Claims (A)

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

Claim files for the 50 sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The 13 claims noted were not paid within the 45 day requirement.

2 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of Provider Claims (B)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two (\$2) dollars. The Company failed to pay the interest due (\$16.00) on the 2 claims noted.

2 Violations – Title 31, Pennsylvania Code, Section 154.18(c)

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim. The interest was not paid within 30 days on the 2 claims noted.

E. Long Term Care Claims

The Company was requested to provide a list of all Claims received during the experience period. The company identified 22 Long Term Care Claims. All 22 Long Term Care claim files were requested, received, and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violation was noted.

1 Violation – Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The claim file noted was missing a date stamp or a computer notation to establish the actual date of claim notice to the company.

F. Group Medical Claims

The Company was requested to provide a list of all claims received during the experience period. The company identified 498 group medical claims. A random sampling of 50 group medical claims was requested, received, and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted.

8 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such

period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the 8 claims noted within 10 working days.

3 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for the 3 claims noted.

2 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within 15 working days in the 2 claims noted.

G. Claims Group Disability (Harrington)

The Company was requested to provide a list of all claims received during the experience period. The company identified 70 Group Disability Claims (Harrington). A random sampling of 20 claim files was requested, received, and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

H. Group Disability JLT Claims

The Company was requested to provide a list of all claims received during the experience period. The company identified 22 Group Disability JLT Claims. A random sampling of 5 group disability claims was requested, received, and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

I. Group Disability Claims (Professional Member Association)

The Company was requested to provide a list of all claims received during the experience period. The company identified 8 Group Disability Claims within their Professional Member Association. All 8 claim files were reviewed on the company's DMS computer system. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

J. Group Life Claims

The Company was requested to provide a list of claims received during the experience period. The company identified 116 group life claims. A random sampling of 25 group life claims was requested, received, and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b). The following violations were noted:

3 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for the 3 claims noted.

K. Group Accidental Death and Dismemberment Claims

The Company was requested to provide a list of all claims received during the experience period. The Company identified 2 Group AD&D claims received. The two claims were selected, received, and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b). No violations were noted.

L. Group Waiver of Premium Claims

The Company was requested to provide a list of all claims received during the experience period. The company identified 6 group waiver of premium claims received. The six claims were requested, received, and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted.

5 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for the 5 claims noted.

XI. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must implement procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.
2. The Company must revise control procedures to ensure interest is added to the claim amount as required by Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166). The Company must provide to the Insurance Department within 30 days of the Report issue date proof of interest payment on the claims noted in the examination.
3. The Company must implement procedures to ensure compliance with the fraud statement notice requirements of Title 18, Pennsylvania Consolidated Statutes Section 4117(k).
4. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.
5. The Company must review and revise Licensing procedures to ensure compliance with Sections 641.1-A, Section 671-A and Section 671.1-A of the Insurance Department Act of 1921 (40 P.S. §§310.41a, 310.71 and 310.71a).
6. The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a) of the Insurance Department Act of 1921 (40 P.S. §323.3).

7. The Company must review and revise internal control procedures to ensure compliance with the replacement requirements of Title 31, Pennsylvania Code, Section 81.
8. The Company must review internal control procedures to ensure compliance with disclosure requirements of Title 31, Pennsylvania Code, Chapter 83.
9. The Company must review and revise internal control procedures to ensure compliance with the filing, suitability and disclosure requirements of Title 31, Pennsylvania Code, Chapter 89a. Long-Term Care Model Regulation
10. Deleted
11. The Company must implement procedures to ensure compliance with the policy delivery receipt requirements of Section 404-A of the Insurance Company Law of 1921 (40 P.S. §625-4).
12. The Company must review internal control procedures to ensure compliance with illustration certification and delivery requirements of Section 408-A of the Insurance Company Law of 1921 (40 P.S. §625-8).

XII. COMPANY RESPONSE



New York Life Insurance Company
51 Madison Avenue, New York, NY 10010
www.newyorklife.com
212-576-6735 Fax: 212-447-4268
Randi_Bader@NewYorkLife.com

Randi J. Bader
Associate General Counsel

May 24, 2005

VIA DHL

Mr. Daniel Stemcosky
Chief Market Conduct Examiner
Pennsylvania Insurance Department
Bureau of Enforcement
1321 Strawberry Square
Harrisburg, Pennsylvania 17120

Re: Market Conduct Examination of New York Life Insurance Company
Rebuttal to Examination Report dated April 25, 2005
Examination Warrant No: 04-M12-007

Dear Mr. Stemcosky:

The Company's Rebuttal to the above-referenced Examination Report is enclosed. We respectfully request that the Department consider our Rebuttal and that the Final Report be revised accordingly.

The courtesy of a meeting or conference call is requested before the Examination Report is finalized.

Please do not hesitate to contact me at (212) 576-6735 with any questions or concerns.

Very truly yours,

A handwritten signature in black ink that reads "Randi J. Bader".

Enclosure

REBUTTAL OF
NEW YORK LIFE INSURANCE COMPANY
TO THE
DRAFT REPORT ON
MARKET CONDUCT EXAMINATION
OF
NEW YORK LIFE INSURANCE COMPANY
EXAMINATION WARRANT #04-M12-007
BY THE
COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
FOR THE PERIOD
JANUARY 1, 2003 - DECEMBER 31, 2003

New York Life Insurance Company ("the Company") responds to the draft Report on Market Conduct Examination ("the Report"), #04-M12-007, as set forth herein.

VIII. UNDERWRITING

F. Life Policies Issued

The violations noted in this Section occurred in 9 different policies out of a sample of 125 policies reviewed. Corrective action has been taken to enhance compliance where warranted.

X. CLAIMS

A. Life Claims

Finding: Eleven claims were in violation of Title 31, Pennsylvania Code, Section 146.6 because timely status letters were not provided.

Response: See response below.

B. Annuity Claims

Finding: Five claims were in violation of Title 31, Pennsylvania Code, Section 146.6 because timely status letters were not provided.

Response to Life Claims and Annuity Claims: Four of the violations of Title 31, Pennsylvania Code, Section 146.6 cited were the result of a different interpretation than the PA DOI with regard to what constitutes an investigation. The Company defines an investigation as an inquiry or follow up request that occurs after we receive the claimant's initial proof of loss documentation. In these cases, it has been our practice to communicate with the claimants every thirty days if there are outstanding requirements which we requested after we received the initial proof of loss.

Although an investigation is not defined in Title 31, Pennsylvania Code, Section 146.6, the Company's interpretation of an investigation is consistent with the definition of an investigation in Title 31, Pennsylvania Code, Section 146.7 (c) (1), the following section of PA's Unfair Claims Settlement Practices statute. In this section, an investigation is defined as the actions taken by the insurer to review a claim after the receipt of proofs of loss.

Based on this examination, we understand that the PA DOI examiners interpret the term investigation more broadly to include the time when initial routine proofs of loss documents are outstanding. In these cases, where the initial proof of loss documents had not been received, it was our practice to communicate with the claimants every 45 days to advise them of their outstanding requirements. This interpretation is consistent with the definition of an investigation in Section 146.7 (c)(1). Accordingly, the Company should not be considered to be in violation of PA law for adhering to this interpretation.

Going forward, we will follow the PA DOI examiners' interpretation of investigation. Accordingly, we will communicate with all PA claimants every 30 days if there are any outstanding requirements, whether the outstanding requirements are the initial proof of loss documentation or documents subsequently requested after initial proof of loss documents were received. However, the Company's prior interpretation of an investigation is consistent with PA's Unfair Claims Settlement Practices statute and should not be the basis for findings of violations of Title 31, Pennsylvania Code, Section 146.6.

C. Insured-Submitted Medical and Medicare Supplement Claims

Corrective Action on Insured-Submitted and Provider-Submitted Medical and Medicare Supplement Claims: Mutual of Omaha Insurance Company ("Mutual of Omaha") administers these types of claims for the Company pursuant to a long-standing administrative services agreement between the parties. Prior to this examination, Mutual of Omaha's processing of these claims was examined on a number of occasions in market conduct examinations and found to be satisfactory. Nonetheless, based on the findings for this examination, the following corrective action has been taken by Mutual of Omaha to enhance compliance with PA's laws going forward. In addition, New York Life will more closely monitor Mutual of Omaha's processing of these types of claims.

In order to improve response time on claims, Mutual of Omaha implemented several corrective actions subsequent to 2003 and, in most cases, prior to the onset of this examination. Additionally, Mutual of Omaha's current claims management team, which was not in existence during 2003, has dedicated resources to address time service issues, further automate the claims handling process, and monitor claims handling. Specific corrective actions are listed below.

- Staffing - By the end of 2003, the number of claims processing staff levels were increased. In anticipation of potential future staffing issues, Mutual of Omaha is in the process of moving the non-Medicare supplement claims processing function to Aberdeen, South Dakota. At this location, there will be a unit dedicated to handling these claims.

- Conversion of Paper Claims to an Electronic Format - Optical Character Recognition Process (OCR) - The process to convert paper claims into electronic claims has been successful. Staffing and hardware adjustments have been made to further improve the process. Currently, most bills are converted and delivered to the claim system within three working days. Conversion to this process was gradual and fully implemented in the fall of 2003.
- Electronic Data Interchange (EDI) - Since 2003, Mutual of Omaha has developed capabilities to acknowledge claims submitted from a health care clearinghouse back to the submitter. Under this process, Mutual of Omaha's clearinghouses advise of the numbers of claims that were transmitted on a particular day. Mutual of Omaha then reconciles that number to the number of claims received that day. This process will help identify any instances where electronic claims were transmitted, but not received.
- Time Service – Mutual of Omaha recently adjusted time service goals with an objective of handling Pennsylvania claims within five working days from receipt to facilitate timely claims processing in compliance with PA's requirements.
- Verification of corrective action - In order to ensure that these corrective actions are working, Mutual of Omaha recently conducted an audit of claims handled during the period of December 1, 2004 through February 28, 2005. The audit confirmed that Mutual of Omaha met NAIC standards for claims handling in most cases. To further enhance compliance, Mutual of Omaha's Claims Department is currently working with its internal audit area to schedule monthly audits of claims. These audits will begin in June of 2005 and cover claims handled March through May of 2005. These audits will continue throughout the year. Dependent upon the results of these audits, Mutual of Omaha will adjust processes where required. In the interim, Mutual of Omaha will continue to monitor all claims processing both in its Home Office and in the Aberdeen facility to ensure compliance with Pennsylvania requirements.

J. Group Life Claims

Finding: Three claims were in violation of Title 31, Pennsylvania Code, Section 146.6 because timely status letters were not provided.

Response: All of the alleged violations of Title 31, Pennsylvania Code, Section 146.6 cited were the result of a different interpretation than the PA DOI with regard to what constitutes an investigation. The Company defines an investigation as an inquiry or follow up request that occurs after we receive the

claimant's initial proof of loss documentation. In these cases, it has been our practice to communicate with the claimants every thirty days if there are outstanding requirements which we requested after we received the initial proof of loss.

Although an investigation is not defined in Title 31, Pennsylvania Code, Section 146.6, the Company's interpretation of an investigation is consistent with the definition of an investigation in Title 31, Pennsylvania Code, Section 146.7 (c) (1). In this section of PA's Unfair Claims Settlement Practices statute, an investigation is defined as the actions taken by the insurer to review a claim after the receipt of proofs of loss.

Based on this examination, we understand that the PA DOI examiners interpret the term investigation more broadly to include the time when initial routine proofs of loss documents are outstanding. In these cases, where the initial proof of loss documents had not been received, it was our practice to communicate with the claimants every 45 days to advise them of their outstanding requirements. This interpretation is consistent with the definition of an investigation in Section 146.7 (c)(1). Accordingly, the Company should not be considered to be in violation of PA law for adhering to this interpretation.

Going forward, we will follow the PA DOI examiners' interpretation of investigation. Accordingly, we will communicate with all PA claimants every 30 days if there are any outstanding requirements, whether the outstanding requirements are the initial proof of loss documentation or documents subsequently requested after initial proof of loss documents were received. However, the Company's prior interpretation of an investigation is consistent with PA's Unfair Claims Settlement Practices statutes and should not be the basis for findings of violations of Title 31, Pennsylvania Code, Section 146.6.

L. Group Waiver of Premium Claims

Finding: Five claims were in violation of Title 31, Pennsylvania Code, Section 146.6 because timely status letters were not provided.

Response: Three of the alleged violations of Title 31, Pennsylvania Code, Section 146.6 cited were the result of a different interpretation than the PA DOI with regard to what constitutes an investigation. The Company defines an investigation as an inquiry or follow up request that occurs after we receive the claimant's initial proof of loss documentation. In these cases, it has been our practice to communicate with the claimants every thirty days if there are outstanding requirements which we requested after we received the initial proof of loss.

Although an investigation is not defined in Title 31, Pennsylvania Code, Section 146.6, the Company's interpretation of an investigation is consistent with the definition of an investigation in Title 31, Pennsylvania Code, Section 146.7(c)(1). In this section of PA's Unfair Claims Settlement Practices statute, an investigation is defined as the actions taken by the insurer to review a claim after the receipt of proofs of loss.

Based on this examination, we understand that the PA DOI examiners interpret the term investigation more broadly to include the time when initial routine proofs of loss documents are outstanding. In these cases, where the initial proof of loss documents had not been received, it was our practice to communicate with the claimants every 45 days to advise them of their outstanding requirements. This interpretation is consistent with the definition of an investigation in Section 146.7(c)(1). Accordingly, the Company should not be considered to be in violation of PA law for adhering to this interpretation.

Going forward, we will follow the PA DOI examiners' interpretation of investigation. Accordingly, we will communicate with all PA claimants every 30 days if there are any outstanding requirements, whether the outstanding requirements are the initial proof of loss documentation or documents subsequently requested after initial proof of loss documents were received. However, the Company's prior interpretation of an investigation is consistent with PA's Unfair Claims Settlement Practices statutes and should not be the basis for findings of violations of Title 31, Pennsylvania Code, Section 146.6.

CONCLUSION

Based on the foregoing, the Company respectfully requests that the Report be revised as indicated.

Dated: May 24, 2005
New York, New York

PA REBUTTAL TO FINAL REPORT_#216886