COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

AMERICAN GENERAL LIFE INSURANCE COMPANY
HOUSTON, TX

As of: May 15, 2023
Issued: July 10, 2023

BUREAU OF MARKET ACTIONS
PROPERTY AND CASUALTY DIVISION

pennsylvania
INSURANCE DEPARTMENT

PENNSYLVANIA INSURANCE DEPARTMENT
EXAMINATION VERIFICATION

I, Holly Examiner (Name of Examiner), Contract Examiner (Title of Examiner) from

Regulatory Insurance Advisors, LLC (Name of Vendor/Department) certify that I was the Examiner-In-Charge of the Report of

Examination of American General Life Insurance Company (Name of Examined Company) made as of 05/08/2023 (Date).

The last date of examination file review was 04/24/2023 (Date) and the written Report

of Examination was reviewed and accepted by the Paul Towsen (Chief of Market Conduct Examiner)

on 05/10/2023 (Date).

I have reviewed the completed written Report of Examination and certify that the facts and figures recited therein are true and accurate, according to the records, documents and other evidence obtained during the course of the examination.

Holly L Blanchard
(Examiner-in Charge)

Regulatory Insurance Advisors, LLC
(Name of Vendor/Department)

5100 N. 27th ST. STE A-2, Lincoln, NE 68521
(Address of Vendor/Department)

Holly Blanchard
(Examiner in Charge Signature)

5/10/2023
(Date)

IN ORDER TO SATISFY SECTION 40 P.S. § 323.5(b), THAT PROVIDES FOR NO LONGER THAN SIXTY (60) DAYS FROM THE COMPLETION OF THE EXAMINATION, THE EXAMINER IN CHARGE SHALL FILE WITH THE DEPARTMENT A VERIFIED WRITTEN REPORT OF EXAMINATION UNDER OATH.

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

O R D E R

AND NOW, this __3rd___ day of _July___, 2023, 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 David J. Buono, Jr., 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.

Michael Humphreys
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
AMERICAN GENERAL LIFE INSURANCE COMPANY	:	40 P.S. §§310.71(c) and 310.71(f)
2727 A Allen Parkway,3-D1	:	
Houston, TX 77019	:	40 P.S §323.3(a)
	:	
	:	40 P.S §511b(a)
	:	
	:	40 P.S §625-4
	:	:
	:	40 P.S. §§1171.5(a)(10)(ii),
	:	1171.5(a)(10)(x), and 1171.5(a)(10)(x)(iii)
	:	
	:	31 Pa. Code §§146.3, 146.5(d), 146.6, and
	:	146.7(a)(1)
	:	
	:	
	:	
	:	
	:	
Respondent.	:	Docket No. MC23-06-001

CONSENT ORDER

AND NOW, this 10th day of July, 2023, this Order is hereby issued by the Insurance Department 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 Insurance Department finds true and correct each of the following Findings of Fact:

(a) Respondent is American General Life Insurance Company and maintains its address at 2727 A. Allen Parkway 3-D1, Houston, TX 77019.

(b) A market conduct re-examination of Respondent was conducted by the Insurance Department covering the experience period from January 1, 2021, through December 31, 2021.

(c) On May 15, 2023, the Insurance Department issued a Market Conduct Re-Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on June 14, 2023.

(e) The Market Conduct Examination of Respondent revealed violations of the following:

(i) All findings and conclusions in the Examination Report, which is attached hereto, are hereby incorporated into this Consent Order.

CONCLUSIONS OF LAW

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

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

(b) Respondent's violations of Section 40 P.S. §§ 310.71a(a) and 310.71(f) are punishable by the following, under (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 40 P.S. §§510b(a) and 625-4 are punishable 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) Violations of 40 P.S. §§1171.5(a)(10)(ii), 1171.5(a)(10)(x), and 1171.5(a)(10)(x)(iii) are punishable by the following, under Section 9 of the Unfair Insurance Practices Act (40 P.S. §1171.9):

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

(e) In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.1 – 1171.15, the Commissioner may, under (40 P.S. §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 under 40 P.S. 1171.5 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 under 40 P.S. 1171.5 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).

(f) Respondent's violations of 31 Pa. Code §§146.3, 146.5(d), 146.6, and 146.7(a)(1) are punishable under Sections 1 through 5 and Section 9 of the Unfair Insurance Practices Act (40 P.S. §§1171.1 – 1171.5 and 1171.9):

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department 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 pay One Hundred and Sixty Thousand Dollars ($160,000.00) in settlement of all violations contained in the Report.

(c) Payment of this matter shall be made at https://www.bpp.ob.pa.gov/Customer Instructions on how to do this are provided in the attached cover letter to this order. Payment must be made no later than thirty (30) days after the date of this Order.

(d) To determine Respondent's compliance with the full and timely implementation of all recommendations in the Examination Report, the Department may inquire with the Respondent about its implementation of the Recommendations no earlier than twelve (12) months from the date of this Order.

(e) Respondent shall share the Examination Report and this Order with each of its directors and submit affidavits executed by each of its directors, stating under oath that they have received a copy of the Examination Report and this Order. Such affidavits shall be submitted within thirty (30) days of the date of this Order.

(f) Respondent shall comply with all recommendations contained in the attached Report.

6. In the event the Insurance Department 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 Insurance Department 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 Department 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 Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department 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 Insurance Department. Only the Insurance Commissioner or a duly authorized delegee 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 delegee.

BY: AMERICAN GENERAL LIFE INSURANCE COMPANY
Respondent

DocuSigned by:
Tim Heslin
F3AB3220BDD04B6...

Tim Heslin, President, Life U.S.

DocuSigned by:
36CF7D02810347A...

Bryan Pinsky, President, Individual Retirement

DAVID J. BUONO
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION AND METHODOLOGY

The Market Conduct Re-examination (Re-Examination) was conducted as a follow-up to the previous examination conducted in 2017. The Examination was performed through a desktop examination of American General Life Insurance Company (the Company) (NAIC #60488). All reviews were conducted through the offices of the Pennsylvania Insurance Department (the Department) at off-site locations. During the course of the Examination, the examiners reviewed and tested randomly selected samples related to the scope of the Examination, which were approved by the Department. The Examination focused on determining the Company's full and timely implementation and compliance with the Recommendations and Consent Order dated May 18, 2017, which required the Company to comply with the fourteen (14) recommendations included in the examination report and which the Department found necessary as a result of the number of violations, or the nature and severity of other violations, as noted in the report. The Recommendations required the Company to review, revise or implement policies and procedures, internal controls, or general business practices to ensure compliance with Pennsylvania Statutes and Regulations as follows:

1. The Company must review and revise internal control procedures to ensure compliance with the replacement requirements of 31 Pa. Code, Chapter 81.

2. The Company must review internal control procedures to ensure compliance with disclosure requirements of 31 Pa. Code, Chapter 83.

3. The Company must review and revise internal control procedures to ensure compliance with Unfair Insurance Practices as per 31 Pa. Code, Chapter 146.

4. The Company must review and revise Licensing procedures to ensure compliance with 40 P.S. §§310.71 (a) and 310.71a(a).

5. The Company must review and revise its general business practices to ensure compliance with 40 P.S. §323.3 relative to the authority, scope, and scheduling of examinations.

6. The Company must review and revise its internal controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.4 so that the violations noted in the report do not occur in the future.

7. The Company must implement procedures to ensure compliance with 40 P.S. §477b.

8. The Company must review internal control procedures to ensure compliance with 40 P.S. §510d relative to notice of contract holder's right to examine annuity or pure endowment contracts.

9. The Company must review internal control procedures to ensure compliance with 40 P.S. §512; application for insurance and insurable interest.

10. The Company must review internal control procedures to ensure compliance with 40 P.S. §532.6 relative to standard policy provisions.

11. The Company must review internal control procedures to ensure compliance with 40 P.S. §532.7; notice of conversion provisions.

12. The Company must implement procedures to ensure compliance with the policy delivery receipt requirements of 40 P.S. §625.4

13. The Company must implement procedures to ensure compliance with the requirements of 40 P.S. §1171.5, Insurance Department Act of 1921 "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices."

14. The Company must review 18 Pa. C.S.§4117 (k)(1) to ensure that violations regarding the requirement of a fraud warning on all applications and claim forms, as noted in the report, do not occur in the future.

The review of testing sections was accomplished through the examination of multiple forms of documentation which included, but was not limited to, the Company's policies and procedures associated with life new business, annuity new business, complaint handling, new application

files, licensing and appointment records, complaint files and MCAS documentation, relying on data and related information provided by the Company.

The examiners used Arbutus software to select random samples from the universe of files provided by the Company. During the Examination, thirty-five (35) files were selected from universes that were larger than thirty-five (35). For universes that were smaller than thirty-five (35), all files were reviewed.

Pennsylvania Market Conduct Examination Reports generally note the items that have been reviewed and whether there is a violation of law or regulation. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in an Examination Report may result in imposition of penalties. An Examination Report also includes 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 to determine the potential impact upon Company operations for future compliance. Findings identified in all summaries issued to the Company throughout the Examination process are included in this Examination Report; however, in some instances, the content of multiple summaries may be combined into a single report section. This only applies to sections in which no violations were found.

Throughout the course of the Examination, Company officials were provided status memoranda or summaries, which reference specific policy numbers with citations to each section of law violated. Additional information was requested to clarify apparent violations. Multiple conference calls, status meetings, and an exit conference were conducted with Company officials to discuss the various types of violations identified during the Examination and to review written summaries provided for the violation's examiners identified.

The courtesy and cooperation extended by the officers and employees of the Company during the Examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Examination Report.

PA Insurance Department

Paul Towsen, MCM
Chief Property & Casualty/Life & Annuity Division
PA Insurance Department

David J. Kelly, MCM
Market Conduct Examiner II
PA Insurance Department

Donna Shafer, MCM
Market Conduct Examiner
PA Insurance Department

Holly Blanchard, FLMI, AIE, ACP, CCP, INS, MCM
Contract Market Conduct Examiner

Lindsay Bates, MCM, CFE
Contract Market Conduct Examiner

II. SCOPE OF EXAMINATION

The 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, 2021, through December 31, 2021, unless otherwise noted. The purpose of the Examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The Examination focused on the Company's policies, procedures, and processes in the following areas: Group Certificates Issued, Group Certificate Holders Terminated, Group Certificate Holders Declined, Group Policies Issued, Group Policies Terminated, Group Policies Declined, Group Policies Converted, Individual Annuities Issued, Individual Annuities Terminated, Individual Annuity Replacements, Individual Annuities Surrendered, Individual Life Policies Issued, Individual Life Policies Terminated, Individual Life Policies Declined, Individual Life Replacements, Individual Life Policy Converted, Claims, Market Conduct Annual Statement (MCAS) for Life Underwriting Life Claims, and Annuity Underwriting, Consumer Complaints, and Producer Licensing.

Examiners requested that the Company 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 analysis.

For control purposes, some of the review segments identified in this Examination Report may be broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Examination Report, are included and grouped within the respective categories of the Examination Report. All reviews conducted throughout the Examination included consideration of company responses to examiner requests pursuant to 40 P.S. §§ 323.3 and 323.4. While these statute and regulation sections are included in all reviews completed during the Examination, the Examination Report only notes when examiners found a violation of these sections in a particular sub-category, such as incomplete file documentation or incorrect information provided in response to the requests.

III. COMPANY HISTORY

American General Life Insurance Company (the Company), including its wholly owned subsidiaries, is a wholly owned subsidiary of AGC Life Insurance Company (AGC Life or the Parent), an indirect, wholly owned subsidiary of American International Group, Inc. (AIG Parent).

The Company was incorporated in Delaware on April 11, 1960, and commenced business on August 1, 1960, under the name Knights Life Insurance Company. The Company's name was changed to American General Life Insurance Company of Delaware, on December 31, 1962. On December 31, 1991, the Company, California-Western States Life Insurance Company and American General Life Insurance Company merged, with the Company being the surviving entity. The Company re-domesticated to Texas and changed its name to American General Life Insurance Company.

Effective December 31, 2012, as part of a project that consolidated Seven Sister Life Insurance Companies, the following legal entities merged into American General Life Insurance Company: American General Assurance Company, American General Life and Accident Insurance Company, American General Life Insurance Company of Delaware, Sun America Annuity and Life Assurance Company, Sun America Life Insurance Company, and Western National Life Insurance Company.

In its 2021 Annual Statement, the Company reported direct premium for ordinary life insurance and annuities consideration in the amount of $765,378,416 and direct premium for group accident and health in the amount of $4,676,979.

IV. GROUP UNDERWRITING

Concerns were identified in the previous examination regarding group underwriting. For the Re-examination, examiners focused on the areas where previous violations were identified. These areas included: Group Certificate Holders Issued, Group Certificate Holders Terminated, Group Certificate Holders Declined, Group Policies Issued, Group Policies Terminated, Group Policies Declined, and Group Policies Converted.

Unless noted, all documents identified in the universes by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 323.3, 323.4, 40 P.S. §1171.5, and 31 Pa. Code §146.5.

A. Group Certificate Holders Issued

Throughout the course of the previous examination, the following violations were identified:

- **40 P.S. § 323.3(a)**
  1 Violation - In one file, the Company identified a declined contract as an issued contract.
- **18 Pa C.S. § 41117(k)**
  6 Violations - In six files, the master group application did not contain the required fraud statement.

For the Re-examination, the Company was requested to provide a list of all group certificates issued during the examination period. The Company initially identified a universe of group certificates issued for four (4) groups during the examination period. All files were reviewed to determine compliance with issuance, underwriting and replacement statutes and regulations. No violations were noted.

B. Group Certificate Terminated

For the Re-examination, the Company was asked to provide a list of all group certificates terminated during the examination period. The Company advised they did not have any group certificates terminated during the examination period.

C. Group Certificate Declined

For the Re-examination, the Company was asked to provide a list of all group certificates declined during the examination period. The Company advised they did not have any group certificates declined during the examination period.

D. Group Policies Issued

For the Re-examination, the Company was asked to provide a list of all group policies issued during the examination period. The Company advised they did not have any group policies issued during the examination period.

E. Group Policies Terminated

For the Re-examination, the Company was asked to provide a list of all group policies terminated during the experience period. The Company initially identified a universe of seven (7) group policies terminated during the period, however subsequently removed two (2) after identifying only five (5) group policies terminated during the period. All five files were reviewed to determine compliance with issuance, underwriting, and replacement statutes and regulations. Data integrity issues were identified with the files reviewed. These are addressed in the Data Integrity section of the report. No further violations were identified.

F. Group Policies Declined

For the Re-examination, the Company was asked to provide a list of all group policies declined during the examination period. The Company advised they did not have any group policies declined during the examination period.

G. Group Policies Converted

For the Re-examination, the Company was asked to provide a list of all group policies converted during the examination period. The Company advised they did not have any group policies converted during the examination period.

V. INDIVIDUAL UNDERWRITING

Concerns were identified in the previous examination regarding individual underwriting. For the Re-examination, examiners focused on the areas where previous violations were identified. These areas included: (Annuities) Individual Annuities Issued, Individual Annuities Terminated, Individual Annuities Issued as Replacements, Individual Annuities Surrendered, (Life) Individual Life Policies Issued, Individual Life Policies Terminated, Individual Life Policies Declined, Individual Life Policies Replacements and Individual Life Policies Converted.

Unless noted, all documents identified in the universes by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 323.3, 323.4, 40 P.S. §1171.5, and 40 P.S. §§ 477a, 40 P.S. § 625–4, and 31 Pa Code §51.3(a).

A. Individual Annuities Issued

For the Re-examination, examiners requested a list of all individual annuities issued during the experience period. In response, the Company provided a spreadsheet containing 3,457 individual annuities issued during the examination period. The examiners chose a random sample of thirty-five (35) files from the listing for review. The files were provided, and in accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

B. Individual Annuities Terminated

In response to the Re-examination, the Company was asked to provide a list of individual annuities terminated during the experience period. The Company identified a universe of 4,603 individual annuity insurance policies terminated. A random sample of thirty-five individual annuity terminations was requested, received, and reviewed. The files were reviewed to determine compliance with issuance and underwriting statutes and regulations, as well as to ensure previous concerns and violations were corrected. No violations were noted.

C. Individual Annuities Issued as Replacements

The Company was asked to provide a list of all individual annuity policies issued as replacements during the experience period. The Company identified a universe of 1,907 individual annuity policies issued as replacements during the period. A random sampling of 35 individual annuity replacement files was requested, received and reviewed. The files were reviewed to determine compliance with issuance, underwriting, and replacement statutes and regulations, as well as to determine corrective actions implemented for previous findings. No violations were noted.

D. Individual Annuities Surrendered

Throughout the course of the previous examination, the following violations were identified:

- **40 P.S. § 510(a)(1)** - 7 Violations - The required 10-day free look statement was not available.
- **40 P.S. § 1171.5 (a)(1)(i)** - 18 Violations - The option utilized by the Company regarding the contract settlement appears not to be consistent with the available options referenced in the settlement provisions contained in the contract.
- **40 P.S. § 1171.5 (a)(10)(i)** - 4 Violations - The Company did not annuitize the contract at the contract maturity date in accordance with the terms of the contract.
- **40 P.S. § 1171.5 (a)(10)(vi**) - 3 Violations – The Company did not properly annuitize the contract upon the maturity date in accordance with the terms of the contract.

As part of the Re-examination, the Company was asked to provide a list of all individual annuities surrendered during the experience period. The Company presented a spreadsheet containing a listing of 2,617 individual annuities surrendered during the examination period. A random sample of thirty-five (35) individual annuities surrendered was requested, received, and reviewed. The files were reviewed to determine compliance with issuance and underwriting statutes and regulations, as well as to ensure previous concerns and violations were corrected.

The thirty-five (35) Re-examination claim files were also reviewed for compliance with the following:

- **18 Pa. C.S. § 4117(k)(1) –** Insurance fraud
- **40 P.S. § 323.3(a) –** File and record documentation
- **40 P.S. § 1171.5(a) –** Unfair methods of competition and unfair or deceptive acts or practices

The following violations were noted.

2 VIOLATIONS-40 P.S. § 323.3(a) – Authority, scope, and scheduling of examinations.

(a) 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 Company did not provide comprehensive documentation in two (2) files that allowed for the recreation of the surrender transaction.

E. Individual Life Policies Issued

Throughout the course of the previous examination, the following violations were identified:

- **40 P.S. § 323.3 (a)**

3 Violations-Three files did not contain all documentation as required by 40 P.S. § 323.3 (a)

- **40 P.S. § 625.4**

  4 Violations-In four instances, verification of the date of policy delivery could not be established.

For the Re-examination, the Company was asked to provide a list of individual life policies issued during the experience period. The Company identified a universe of 4,432 individual life policies issued during the period. A random sample of 35 individual life policies issued were requested and received. Of the 35 files reviewed two (2) were identified as not taken, free look cancelations, and two (2) additional files were identified as replacements. The files were reviewed to determine compliance with issuance and underwriting statutes and regulations, as well as to ensure previous concerns and violations were corrected.

The following violations were noted.

2 VIOLATIONS-40 P.S. §625-4 – Delivery of individual policies and annuities.

(a) For purposes of determining the commencement of the period during which the owner of an individual insurance policy or annuity may exercise any statutory right to examine, surrender or return the policy for cancellation, the date of delivery of the policy or annuity shall be:

(1) the date of mailing of the policy or annuity by the insurer if the delivery is by the United States mail or other postal delivery system;

(2) the date the policy or annuity is physically delivered to the owner by a representative of the insurer; or

(3) the date of electronic transmission of the policy or annuity provided the electronic transmission has been effected in accordance with this section and the provisions of section 354.7 1 and any other state or Federal laws governing the electronic transmission of documents and information. The insurer shall retain

evidence of electronic transmittal for the entire period of the insurance policy or annuity.

(b) In the event of a dispute with the owner of a policy or annuity, the burden of proof shall be on the insurer to establish that the policy or annuity was delivered. An insurer or representative of the insurer shall be deemed to have satisfied the burden of proof by showing, to the department's satisfaction, it has sent the policy or annuity in the normal course of business.

Verification of the date of policy delivery could not be established in two (2) files, or the policy was not delivered in the required timeframe, which does not provide proof of the commencement of the policy for establishing the free look period.

F. Individual Life Policies Terminated

Throughout the course of the previous examination, the following violations were identified:

- **40 P.S. § 323.3(a)**

  3 Violations-In three files the policy information was missing.

  1 Violation-The Company provided several incorrect files for this category indicating a documentation issue.

For the Re-Examination, The Company was asked to provide a list of individual life policies terminated during the experience period. The Company identified a universe of 4,603 individual life insurance policies terminated. A random sample of thirty-five (35) individual life terminations was requested, received, and reviewed. The files were reviewed to determine compliance with issuance and underwriting statutes and regulations, as well as to ensure previous concerns and violations were corrected. The thirty-five (35) files were Also reviewed for compliance with 40 PS § 323.3(a).

The following violations were noted.

2 VIOLATIONS-40 PS § 323.3(a) – Authority, scope and scheduling of examinations

(a) 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, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth.

The Company failed to provide accurate documentation in two (2) files.

G. Individual Life Policies Declined

For the Re-examination, the Company was asked to provide a list of all individual life policies declined coverage during the experience period January 01, 2021, to December 31, 2021. The Company identified a total of 522 applications declined during the period. A random sample of 35 files was requested and received. The first 35 files were reviewed. Application files were reviewed for compliance with 31 Pa. Code §81.5(b). No violations were noted.

H. Individual Life Policies Replacements

Throughout the course of the previous examination, the following violations were identified:

- **31 Pa. Code §81.4(b)(l)**
  1 Violation – In one file, the replacement form was dated after the application date.
- **31 Pa. Code §81.6(a)(2)(ii)**
  3 Violations – In three files, the replacement letter to the replaced company was not issued in a timely manner.
- **31 Pa. Code §83.4a and 83.4b**
  1 Violation – In one file, the required producer's certification of disclosure was not made available for review.
- **31 Pa. Code §83.3(a)(4)(i)**

1 Violation-In one file, the producer's telephone number and/or address were absent from the disclosure statement.

- **31 Pa. Code §83.55**

  1 Violation – In one file, the Cost Surrender Comparison Index Disclosure was not made available for review.

- **31 Pa. Code, §83.55a and 83.55b**

  1 Violation – In one file, the producer's certification of the surrender comparison index disclosure delivery was not evident.

- **40 P.S. §625-4**

  1 Violation – In one file, verification of policy delivery could not be established.

For the Re-Examination, the Company was asked to provide a list of all individual life policies issued as replacements during the experience period. The Company identified a universe of 558 individual life policies issued as replacements during the period. A random sampling of 35 individual life replacement files was requested, received, and reviewed. The files were reviewed to determine compliance with issuance, underwriting, and replacement statutes and regulations.

The following violations were noted.

2 VIOLATIONS-40 P.S. §323.3(a) – Authority, scope, and scheduling of examinations.

(a) 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 Company did not provide pertinent information in two (2) files.

1 VIOLATION-40 P.S. §625-4 – Delivery of individual policies and annuities.

(a) For purposes of determining the commencement of the period during which the owner of an individual insurance policy or annuity may exercise any statutory right to examine, surrender or return the policy for cancellation, the date of delivery of the policy or annuity shall be:

(1) the date of mailing of the policy or annuity by the insurer if the delivery is by the United States mail or other postal delivery system;

(2) the date the policy or annuity is physically delivered to the owner by a representative of the insurer; or

(3) the date of electronic transmission of the policy or annuity provided the electronic transmission has been effected in accordance with this section and the provisions of section 354.7 1 and any other state or Federal laws governing the electronic transmission of documents and information. The insurer shall retain evidence of electronic transmittal for the entire period of the insurance policy or annuity.

(b) In the event of a dispute with the owner of a policy or annuity, the burden of proof shall be on the insurer to establish that the policy or annuity was delivered. An insurer or representative of the insurer shall be deemed to have satisfied the burden of proof by showing, to the department's satisfaction, it has sent the policy or annuity in the normal course of business.

The Company failed to provide verification of the policy delivery in one (1) file.

CONCERNS:

The following concern was noted:

CONCERN 1:

It was noted that the digital owner application signature is populating in the Primary Proposed Insured Signature (if other than Owner) block.

I. Individual Life Policies Converted

For the Re-examination, examiners requested a list of all individual life policies converted during the experience period. In response, the Company provided a spreadsheet containing 166 individual life policies converted during the examination period. The examiners chose a random sample of thirty-five (35) files from the listing for review. The files were provided, and in accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

VI. CLAIMS

Concerns were identified in the previous examination regarding claims and claims handling. For the Re-examination, examiners focused on the areas where previous violations were identified. These areas included: Annuity Claims and Life Claims.

Unless noted, all documents identified in the universes by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 323.3, 323.4, 40 P.S. §§ 511B, 1171.5 and 31 Pa. Code Ch. 146.

A. Annuity Claims

Throughout the course of the previous examination, the following violations were identified:

- **31 Pa Code §146.5**

  4 Violations-In four files, the Company did not provide evidence that an acknowledgement to the notification was provided within 10 working days as required by **31 Pa Code §146.5**
- **31 Pa Code §146.6**

4 Violations-In four files, the Company failed to provide timely status letters as required by **31 Pa Code §146.6.**

- **40 P.S. §1171.5(a)(10)(x)**,

  1 Violation-One file did not contain the required statement describing the payment.
- **40 P.S. §1171.5(a)(10)(iii)**

  1 Violation-In one file the Company did not implement reasonable standards for the prompt investigation of claim; specifically, regarding the annuitization.
- **40 P.S. §1171.5(a)(10)(iv)**

  1 Violation-In one file, the Company did not investigate the policy annuitization.
- **40 P.S. §1171.5(a)(10)(vi)**

  1 Violation-In one file, the Company did not properly investigate the policy annuitization**.**

For the Re-examination, the Company was asked to provide a list of claims received during the experience period. The Company identified 3,836 individual annuity claims received. A random sample of thirty-five (35) individual annuity claims was requested, received, and reviewed. The files were reviewed to determine compliance with issuance and underwriting statutes and regulations, as well as to ensure previous concerns and violations were corrected. The individual claim files were also reviewed for relevancy to applicable statutes and to verify compliance with the following.

- **18 Pa. Code § 4117. (k)(1) –** Insurance fraud
- **31 Pa. Code § 146.3 –** File and record documentation
- **31 Pa. Code § 146.5 –** Failure to acknowledge pertinent communications
- **31 Pa. Code §146.7 –** Standards for prompt, fair and equitable settlements applicable to insurers
- **40 P.S. § 323.3(a) –** Authority, scope and scheduling of examinations
- **40 P.S. § 511b(a)(a) –** Payment of benefit
- **40 P.S. § 1171.4 –** Unfair methods of competition and unfair or deceptive acts or practices prohibited.
- **40 P.S. § 1171.5(a)(2) –** Unfair Insurance Practices Act – Untrue statements
- **40 P.S. § 1171.5(a)(10) –** Unfair Insurance Practices Act – Business practices

The following violations were noted.

8 VIOLATIONS-31 Pa Code §146.3 – File and record documentation

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 Company failed to provide a complete claim file, or the file presented contained inaccurate information in eight (8) files which prevented the events of the claim from being reconstructed.

1 VIOLATION-31 Pa Code §146.5(d) – Failure to acknowledge pertinent communications

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

The Company failed to provide a response within 10 working days in one (1) file.

4 VIOLATIONS-31 Pa Code § 146.7(a)(1) – Standards for prompt, fair and equitable settlements applicable to insurers

(a) Acceptance or denial of a claim shall comply with the following:

> (1) Within 15 working days after receipt by the insurer of properly executed proof of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

The Company failed to provide prompt, fair, and equitable settlements within 15 days in four (4) files.

1 VIOLATION-40 P.S. § 511b(a) – Payment of benefits

(a) Except as set forth in subsection (b), life insurance death benefits not paid within thirty days after satisfactory proof of death was submitted to the insurer shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest shall accrue from the date of death of the insured to the date the benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than one hundred eighty days after the death of the insured and the death benefits are not paid within thirty days after satisfactory proof of death was submitted to the insurer, interest shall accrue from the date on which satisfactory proof was submitted to the date on which the benefits of the policy are paid.

The Company failed to pay interest upon satisfactory proof of death in one (1) file.

14 VIOLATIONS-40 P.S. § 1171.5(a)(10)(x) – Unfair Insurance Practices Act – Settlement statement

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means:

…

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

…

(x) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

Fourteen (14) of the thirty-four (34) (41% error rate) files did not contain the required settlement statement, which demonstrates a frequency that indicates a standard business practice as outlined in 40 P.S. § 1171.5(a)(10)(x).

4 VIOLATIONS-40 P.S. § 1171.5(a)(10)(xiii) – Unfair Insurance Practices Act - Failing to promptly settle claims

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means:

…

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

…

(xiii) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance.

Four (4) of thirty-four (34) files (12% error rate) failed to incorporate "Standards for prompt, fair and equitable settlements" applicable to insurers as required by 31 PA Code § 146.7(a)(1) - that demonstrates a frequency that indicates a standard business practice as outlined in 40 P.S. § 1171.5(a)(10)(x).

The following concerns were also noted.

CONCERN 1:

One claim file contained documents from an unrelated claim file. Similar issues were addressed in the previous examination. As such, the ongoing issue of file documentation accuracy is being presented as an ongoing concern that the Company should address.

CONCERN 2:

Data integrity issues were an identified concern in the previous exam and continued to be a concern in the Re-examination. The initial submission of the claim files were missing substantially important documentation that allowed for reconstruction of the claim from inception to final disposition. Subsequently, the Company provided supplemental supporting documentation for most of the files. It is unclear why this information was not

provided upon the initial submission of the files and leads to ongoing concerns regarding the file construction at the Company.

B. Life Claims

Throughout the course of the previous examination, the following violations were identified:

- **31 Pa Code §146.5**

  7 Violations - In seven files, the Company failed to acknowledge the notification of claims within 10 working days as required by **31 Pa Code §146.5.**

- **31 Pa Code § 146.6**

  4 Violations - In four files, the Company failed to provide a timely status letter as required by **31 Pa Code § 146.6.**

- **31 Pa Code § 146.7**

  5 Violations - In five files, the Company failed to provide notice of acceptance of denial within 15 working days after proof had been received by the Company as required by **31 Pa Code § 146.7.**

For the Re-examination, the Company was asked to provide a list of life claims received during the experience period. The Company identified 7,355 individual life claims received. A random sample of thirty-five (35) individual life claims was requested, received, and reviewed. The files were reviewed to determine compliance with issuance and underwriting statutes and regulations, as well as to ensure previous concerns and violations were corrected.

The thirty-five (35) Re-examination claim files were also reviewed for compliance with the following:

- **31 Pa. Code § 146.3 –** File and record documentation
- **31 Pa. Code § 146.5 –** Failure to acknowledge pertinent communications
- **31 Pa. Code §146.6 –** Standards for prompt investigation of claims

- **31 Pa. Code §146.7 –** Standards for prompt, fair and equitable settlements
- **40 P.S. §323.3(a) –** Authority, scope and scheduling of examinations
- **40 P.S. § 511b –** Payment of benefits
- **40 P.S. §1171.4 –** Unfair methods of competition and unfair or deceptive acts or practices prohibited.
- **40 P.S. §1171.5(a)(2) –** Unfair Insurance Practices Act – Untrue statements
- **40 P.S. §1171.5(a)(10) –** Unfair Insurance Practices Act – Business practices

The following violations were noted.

3 VIOLATIONS-31 Pa. Code §146.3 – File and record documentation

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 Company failed to provide a complete claim file in three (3) files which prevented the events of the claim from being reconstruction.

4 VIOLATIONS-31 Pa. Code §146.5(d) – Failure to send claim forms within 10 working days

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

The Company failed to send claim forms within 10 working days in four (4) files.

2 VIOLATIONS-31 Pa. Code §146.6 – Standards for prompt investigation of claims

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 a timely status letter in two (2) files.

5 VIOLATIONS-31 Pa. Code §146.7(a)(1) – Standards for prompt, fair, and equitable settlements applicable to insurers within 15 working days.

(a) Acceptance or denial of a claim shall comply with the following:

(1)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 of denial of the claim within 15 working days in five (5) files.

2 VIOLATIONS-40 P.S. §323.3(a) – Authority, scope and scheduling of examinations

(a) 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, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth.

The Company failed to provide complete and accurate documentation in two (2) files that allowed for the recreation of the claim.

3 VIOLATIONS-40 P.S. §511b(a) – Payment of benefits not paid within 30 days

(a) Life insurance death benefits not paid within thirty days after satisfactory proof of death was submitted to the insurer shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest shall accrue from the date of death of the insured to the date benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than one hundred eighty days after the death of the insured, and the death benefits are not paid within thirty days after the

satisfactory proof of death was submitted to the insurer, interest shall accrue from the date on which satisfactory proof was submitted to the date on which the benefits of the policy are paid.

The Death Benefits were not paid withing 30 days as required by 40 P.S. §511(a), or the proof of the required interest was not provided in three (3) files.

9 VIOLATIONS-40 P.S. §1171.5. (a)(10)(ii) –Unfair Insurance Practices Act – Failing to act promptly.

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means:

…

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

…

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

Five (5) of thirty-five (35) files (or 14% error rate) failed to incorporate "Standards for prompt, fair, and equitable settlements" as required by 31 PA Code § 146.7(a)(1) which presents at a frequency that indicates a business practice.

Four (4) of thirty-five (35) files (or 11% error rate) documented failure to send claim forms within 10 days as required by 31 PA Code § 146.5(d) which presents a frequency that indicates a business practice.

VII. MCAS

Concerns were identified in the previous examination regarding information presented in the MCAS data. For the Re-examination, examiners requested life and annuity underwriting data listings that supported the 2020 MCAS filing for underwriting and claims. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company

did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 310.1 et seq, 40 P.S. §310.41, 40 P.S. §310.71. No violations were noted.

VIII. CONSUMER COMPLAINTS

The Company was asked to identify all consumer complaints received during the experience period of January 1, 2021, through December 31, 2021, and provide copies of internal and external Pennsylvania Insurance Department (Department) consumer complaint logs. The Company identified forty-nine (49) internal consumer complaints received. Of the forty-nine (49) complaints identified, a random sample of fifteen (15) complaint files were requested, received, and reviewed. The Company identified 74 complaints received by the Company from the Department. The Department selected a random sample of thirty-five (35) complaint files which were requested, received, and reviewed. The Company also provided complaint logs for the preceding four years. The logs were reviewed to verify compliance with Unfair Insurance Practices Act (40 §P.S. 1171.1 - 1171.5). The individual complaint files were reviewed for the relevancy to applicable statutes and to verify compliance with 31 Pa. Code §146.5(b)(c). No Violations were noted.

The following concern was noted:

CONCERN:

The Company failed to maintain a complete complaint log. Recommendations were made to the Company for additional elements that should be included in the log for internal reference.

IX. PRODUCER LICENSING

Throughout the course of the previous examination, the following violations were identified:

- **40 P.S. §310.71(a)**

3 Violations-Three producers were identified as not being in the Department records as being appointed by the Company.

- **40 P.S. §310.71(d)**

  6 Violations-Six records showed a termination that occurred outside the calendar year experience period.

- **40 P.S. §310.71a(a)**

  11 Violations-11 Department records showed an active license during the experience period where the producer was terminated from the Company.

For the Re-examination, the Company was asked to provide a list of all producers active and terminated during the experience period. A random sample of 50 active and 50 terminated producers were selected and reviewed. The sampled list was compared to Departmental records of producers to verify appointments, terminations, and licensing to ensure compliance with the statutes and regulations and to confirm that previously identified issues have been corrected. The following violations were identified.

3 VIOLATIONS- 40 P.S. §310.71a(a)

(a) Termination-An insurer which terminates an appointment pursuant to Section 671A(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.

The Company presented inaccurate information regarding the termination of producers in three (3) instances.

11 VIOLATIONS-40 P.S. §310.71(f) – Appointments.

(f) Reporting. – An insurer shall, upon request, certify to the department the names of all licensees appointed by the insurer.

In eleven (11) instances, the Company listed producers as active; however, department records their appointment as terminated during the examination period.

X. DATA INTEGRITY

Throughout the course of the previous examination, the following violations were identified.

Individual Life Policies Issued:

- **40 P.S. § 323.3(a)**

  3 Violations-Three files did not contain all documentation as required by 40 P.S. § 323.3 (a)

Individual Life policies Terminated:

- **40 P.S. § 323.3(a)**

  3 Violations-In three files the policy information was missing.

  1 Violation-The Company provided several incorrect files for this category indicating document issue.

Individual Life Conversions:

- **40 P.S. § 323.3(a)**

  2 Violations- Incorrect file information was provided by the Company**.**

Individual Annuity Contracts Issued:

- **40 P.S. § 323.3(a)**

  1 Violation-The Company provided multiple files that were not a part of the requested criteria.

Group Certificates issued:

- **40 P.S. § 323.3(a)**

  1 Violation-In one file the Company identified a declined contract as an issued contract.

As part of the Re-examination, the Company was sent a preliminary examination packet in accordance with NAIC uniformity standards and provided specific information relative to the exam. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure its accuracy and completeness to determine compliance with Insurance Department Act, Section 904(b) [40 P.S. §323.4].

Throughout the course of the examination the Company struggled to provide accurate, comprehensive data. This was detailed in multiple violations as presented above but was also presented in the missing information provided on the data universes. This concern was identified in the previous exam and continued to be an ongoing issue throughout the Re-examination. Upon Re-examination, several similar data integrity issues were identified during the review. The data integrity issue of each area is identified below.

10 VIOLATIONS: 40 P.S. §323.3(a)-Conduct of examinations

(a) 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 related to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that is authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth.

The Company presented incorrect information in response to the Group Policies Terminated in four (4) instances where they presented two files incorrectly and presented agent information incompletely in two instances.

Additionally, the Company failed to provide comprehensive data in six (6) instances that was required by the Department resulting in incomplete information being presented.

XI. PREVIOUS EXAM RECOMMENDATIONS

The examiners requested that the Company identify and provide documentation to support all actions taken by the Company to ensure compliance with the Recommendations and Consent Order dated May 18, 2017. The examiners also requested, received and reviewed sample files for compliance with Pennsylvania Statutes and Regulations for sections identified in the Consent order. Instances where the Company did not identify or provide documentation to support specific actions taken to comply with the Recommendations and Consent Order on the Re-examination were determined to be a violation and are identified below along with the applicable Statute or Regulation.

A. Recommendation 1:

The Company must review and revise internal control procedures to ensure compliance with the replacement requirements of 31 Pa. Code, Chapter 81. No violations were noted.

B. Recommendation 2:

The Company must review internal control procedures to ensure compliance with disclosure requirements of 31 Pa. Code, Chapter 83. No violations were noted.

C. Recommendation 3:

The Company must review and revise internal control procedures to ensure compliance with Unfair Insurance Practices as per 31 Pa. Code, Chapter 146. The following violations were identified during the Re-examination.

12 VIOLATIONS (8 Annuity claims and 4 Life claims)-31 Pa Code §146.3 (a)– File and record documentation

(a) 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.

4 VIOLATIONS-31 Pa Code § 146.7(a)(1) – Standards for prompt, fair and equitable settlements applicable to insurers

(a) Acceptance or denial of a claim shall comply with the following:

> (1) Within 15 working days after receipt by the insurer of properly executed proof of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

4 VIOLATIONS-31 Pa. Code §146.3 (a) – File and record documentation

(a) 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.

4 VIOLATIONS-31 Pa. Code §146.5(d) – Failure to send claim forms within 10 working days.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

2 VIOLATIONS-31 Pa. Code §146.6 – Standards for prompt investigation of claims

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.

5 VIOLATIONS-31 Pa. Code §146.7(a)(1) – Standards for prompt, fair, and equitable settlements applicable to insurers within 15 working days.

(a) Acceptance or denial of a claim shall comply with the following:

(1) Within 15 working days after receipt by the insurer of properly executed proof of loss, the first- party claimant shall be advised of the acceptance or denial of the claim by the insurer.

D. Recommendation 4:

The Company must review and revise Licensing procedures to ensure compliance with 40 P.S. §§310.71 (a) and 310.71 (a). The following violations were identified during the Re-examination.

3 VIOLATIONS- 40 P.S. §310.71(a)

(a) Termination-An insurer which terminates an appointment pursuant to Section 671A(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.

11 VIOLATIONS-40 P.S. §310.71(f) – Appointments.

(f) Reporting. – An insurer shall, upon request, certify to the department the names of all licensees appointed by the insurer.

E. Recommendation 5:

The Company must review and revise its general business practices to ensure compliance with 40 P.S. §323.3 relative to the authority, scope, and scheduling of examinations. The following violations were identified during the Re-examination.

40 P.S. § 323.3(a) – Authority, scope, and scheduling of examinations.

(a) 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.

a. Individual Annuities Surrendered (2 Violations)

i. **2 Violations:** The Company did not provide comprehensive documentation that allowed for the recreation of the surrender transaction in two (2) files.

b. Individual Life Policies Terminated (2 Violations)

i. **2 Violations:** The Company did not provide accurate documentation in two (2) files.

c. Individual Life Policies Replacement (2 Violations)

i. **2 Violations:** The Company did not provide pertinent information in two (2) files.

d. Life Claims (2 Violations)

i. **2 Violations**: The Company did not provide complete and accurate documentation in two (2) files.

e. Data Integrity (10) Violations)

i. **4 Violations**: The Company presented incorrect information in response to the Group Policies Terminated in four instances where they presented two files incorrectly and presented agent information incompletely in two instances.

ii. 6 Violations: The Company failed to provide all requested information on the universes for: Individual Annuities Issued, Individual Annuities Terminated, Individual Annuities Surrendered, Individual Life Terminated, Individual Annuity Claims, and Individual Life Claims

F. Recommendation 6:

The Company must review and revise its internal controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.4 so that the violations noted in the report do not occur in the future. The violations identified during the Re-examination in the data call section for 40 P.S. §323.4 were moved to be combined into 40 P.S. §323.3(a). No further violations were noted.

G. Recommendation 7:

The Company must implement procedures to ensure compliance with 40 P.S. §477b. No violations were noted.

H. Recommendation 8:

The Company must review internal control procedures to ensure compliance with 40 P.S. §510d relative to notice of contract holder's right to examine annuity or pure endowment contracts. No violations were noted.

I. Recommendation 9:

The Company must review internal control procedures to ensure compliance with 40 P.S. §512; application for insurance and insurable interest. No violations were noted.

J. Recommendation 10:

The Company must review internal control procedures to ensure compliance with 40 P.S. §532.6 relative to standard policy provisions. No violations noted.

K. Recommendation 11:

The Company must review internal control procedures to ensure compliance with 40 P.S. §532.7; notice of conversion provisions. No violations noted.

L. Recommendation 12:

The Company must implement procedures to ensure compliance with the policy delivery receipt requirements of 40 P.S. §625.4. The following violations were identified during the Re-Examination.

40 P.S. §625-4 – Delivery of individual policies and annuities.

(a) For purposes of determining the commencement of the period during which the owner of an individual insurance policy or annuity may exercise any statutory right to examine, surrender or return the policy for cancellation, the date of delivery of the policy or annuity shall be:

(1) the date of mailing of the policy or annuity by the insurer if the delivery is by the United States mail or other postal delivery system;

(2) the date the policy or annuity is physically delivered to the owner by a representative of the insurer; or

(3) the date of electronic transmission of the policy or annuity provided the electronic transmission has been effected in accordance with this section and the provisions of section 354.7 1 and any other state or Federal laws governing the electronic transmission of documents and information. The insurer shall retain evidence of electronic transmittal for the entire period of the insurance policy or annuity.

(b) In the event of a dispute with the owner of a policy or annuity, the burden of proof shall be on the insurer to establish that the policy or annuity was delivered. An insurer or representative of the insurer shall be deemed to have satisfied the burden of proof by showing, to the department's satisfaction, it has sent the policy or annuity in the normal course of business.

a. Individual Life Policies Issued (2 Violations)

i. **2 Violations:** The Company failed to provide documentation for proof of delivery in two (2) files.

c. Individual Life Policies Replacements (1 Violation)

i. **1 Violation:** The Company failed to provide documentation for proof of delivery in one (1) file.

M. Recommendation 13:

The Company must implement procedures to ensure compliance with the requirements of 40 P.S. §1171.5, Insurance Department Act of 1921 "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices." The following violations were identified during the Re-examination.

40 P.S. § 1171.5(a)(10)(x) – Unfair Insurance Practices Act – Settlement statement

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means:

…

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

…

(x) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

a. Annuity Claims (14 Violations):

i. **14 Violations:** Fourteen (14) of the thirty-four (34) (41% error rate) files did not contain the required settlement statement, which demonstrates a frequency that indicates a standard business practice as outlined in 40 P.S. § 1171.5(a)(10)(x).

40 P.S. § 1171.5(a)(10)(xiii) – Unfair Insurance Practices Act - Failing to promptly settle claims.

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means:

…

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

…

(xiii) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance.

a. Annuity Claims (4 Violations)

i. **4 Violations-** Four (4) of thirty-four (34) files (12% error rate) were in violation of 31 PA Code § 146.7(a)(1) – Standards for prompt, fair and equitable settlements applicable to insurers - that demonstrates a frequency that indicates a standard business practice as outlined in 40 P.S. § 1171.5(a)(10)(x).

40 P.S. §1171.5. (a)(10)(ii) –Unfair Insurance Practices Act – Failing to act promptly.

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means:

…

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

…

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

a. Life Claims (9 Violations)

i. **4 Violations-** Four (4) of thirty-five (35) files (or 11% error rate) were in violation of 31 PA Code § 146.5(d) – Failure to send claim forms within 10 working days – at a frequency that indicates a business practice.

ii. **5 Violations-** Five (5) of thirty-five (35) files (or 14% error rate) of 31 PA Code § 146.7(a)(1) – Standards for prompt, fair, and equitable settlements – at a frequency that indicates a business practice.

N. Recommendation 14:

The Company must review 18 Pa. C.S.§4117 (k)(1) to ensure that violations regarding the requirement of a fraud warning on all applications and claim forms, as noted in the report, do not occur in the future. Violations were noted on the Group Policies Issued, however it was determined that the policies were issued outside the State of Pennsylvania. No additional violations were noted.

XII. RE-EXAMINATION RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary due to the number, nature or severity of violations noted in this Examination Report.

1. The Company must review and revise internal control procedures to ensure compliance with Unfair Insurance Practices as per 31 Pa. Code, Chapter 146.

2. The Company must review and revise Licensing procedures to ensure compliance with 40 P.S. §§310.71a(a) and 310.71 (f).

3. The Company must review and revise its general business practices to ensure compliance with 40 P.S. §323.3(a) relative to the authority, scope, and scheduling of examinations, including ensuring ongoing data integrity issues are addressed and resolved.

4. The Company must implement procedures to ensure compliance with the policy delivery receipt requirements of 40 P.S. §625.4.

5. The Company must implement procedures to ensure prompt payments meeting the requirements of 40 P.S. §1171.5(a)(10)(x)(iii), Insurance Department Act of 1921 "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices."

6. The Company must incorporate measures to ensure all claims payments are accompanied by a statement which clearly outlines and sets forth the coverage under which payments are being made as required by 40 PS § 1171.5(a)(10)(x).

7. The Company must incorporate measures to ensure that they acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies as required by 40 P.S. §1171.5. (a)(10)(ii).

8. The Company must ensure that payment of benefits are made timely, and that interest is incorporated into payments not made within 30 days as required by 40 P.S. §511b(a). Additionally, the Company must incorporate measures to identify claims that were not paid in a timely manner and ensure that the correct interest was paid. If interest was not paid, the Company should remediate payments of interest to the claimant.

XIII. COMPANY RESPONSE

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June 14, 2023

Via Email

Paul E. Towsen III
P&C/Life & Annuities Division Chief
Pennsylvania Insurance Department
Bureau of Market Actions
1321 Strawberry Square
Harrisburg, PA 17120
ptowsen@pa.gov

RE: Pennsylvania Report of Market Conduct Re-Examination
American General Life Insurance Company (NAIC #60488)

Dear Mr. Towsen:

The Company is in receipt of the Report of the Market Conduct Re-Examination of American General Life Insurance Company for the period of January 1, 2021 through December 31, 2021. The Company accepts the report with the understanding that the following changes will be reflected on the Final Report based upon the Company's submission of applicable documentation on May 19, 2023:

- **Life Claims**
  - **31 Pa. Code §146.3 – File and record documentation** number of violations from 4 to 3
  - **40 P.S. §1171.5. (a)(10)(ii) – Unfair Insurance Practices Act – Failing to act promptly** number of violations from 12 to 9

The Company takes its compliance responsibilities seriously and its goal is to be in compliance with all laws and regulations. We wish to thank the Department for its cooperation throughout the course of the examination.

Please contact me at (818) 737-3987 or via email at RegulatoryEventManagement@aig.com if you have any questions or concerns.

Sincerely,

Hope Lim