



**COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT**

**MARKET CONDUCT  
EXAMINATION REPORT**

**OF**

**OXFORD LIFE INSURANCE COMPANY  
PHOENIX, AZ**

**As of: October 26, 2012  
Issued: December 21, 2012**

**BUREAU OF MARKET ACTIONS  
LIFE AND HEALTH DIVISION**

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 27<sup>th</sup> day of April, 2011, 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 Ronald A. Gallagher, 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 F. Consedine  
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
OXFORD LIFE INSURANCE	:	40 P.S. §323.4
COMPANY	:	
2721 North Central Avenue	:	
Phoenix, AZ 85004-1172	:	
	:	
Respondent.	:	Docket No. MC12-11-025

CONSENT ORDER

AND NOW, this 21<sup>st</sup> day of December, 2012, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania (“the Department”) pursuant to the statute 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.

3. Respondent does not admit the Findings of Fact or Conclusions of Law contained herein and Respondent expressly denies that it violated any Pennsylvania insurance laws.

#### FINDINGS OF FACT

3. The Department finds true and correct each of the following Findings of Fact:

- (a) Respondent is Oxford Life Insurance Company and maintains its address at 2721 North Central Avenue, Phoenix, AZ 85004-1172.

#### The 2010 Examination

- (b) In July of 2010, Respondent submitted 2009 MCAS data to the Department. At that time, Respondent provided a written certification that its submission represented a full and accurate statement of the information required to be provided.

- (c) On November 3, 2010, the Department announced a target market conduct examination on Respondent's activities relating to company operations and management, claims practices and procedures, policy forms and filings and producer licensing to determine compliance with Pennsylvania statutes and regulations for the experience period January 1, 2009 through December 31, 2009.
- (d) During the course of the 2010 target examination, the Department discovered data integrity issues relevant to Respondent's 2009 Market Conduct Annual Statement (MCAS) on whole life insurance claims denied.
- (e) The 2010 target examination was resolved through a final Examination Report and Consent Order dated January 20, 2012. The January, 2012 Market Conduct Examination Report did not address the data integrity issues presented by Respondent's 2009 MCAS data. Instead, the Department decided to conduct a separate review of Respondent's data integrity issues through a subsequent target market conduct examination.

### **The 2012 Examination**

- (f) Accordingly, on February 23, 2012, the Department announced a target market conduct examination relating to Respondent's operations and

management to determine the accuracy and completeness of Respondent's 2010 and 2011 MCAS filings.

(g) Relevant to Respondent's 2010 and 2011 MCAS filings:

(i) In July 2011, Respondent inputted its 2010 MCAS filing, representing 2010 Life and Annuity data. In doing so, Respondent provided a written certification that its submission represented a full and accurate statement of the information required to be provided.

(ii) In May of 2012, Respondent inputted its 2011 MCAS filing, representing 2011 Life and Annuity data. In doing so, Respondent provided a written certification that its submission represented a full and accurate statement of the information required to be provided.

(h) Thereafter, on October 26, 2012, the Department issued its Market Conduct Examination Report ("2012 Exam Report"), which revealed data integrity issues involving Respondent's 2010 and 2011 MCAS data for claims and underwriting information.

(i) On November 21, 2012, Respondent provided the Department with a response to the 2012 Exam Report.

- (j) The 2012 Examination Report notes violations of 40 P.S. Section 323.4, due to findings that Respondent provided the Department with inaccurate MCAS data for calendar years 2010 and 2011.
- (k) Respondent represents that it has implemented additional internal operational safeguards designed to ensure timely and accurate reporting of MCAS data to the Department as necessary for compliance with the Examination Law.
- (l) Respondent cooperated with the Department in its review and resolution of this matter.

#### 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) Under 40 P.S. §323.4, every company or person from whom information is sought must provide the examiners timely, convenient and free access to all books, records, accounts, papers and documents relating to the property, assets, business and affairs of the company being examined.

- (c) Respondent's actions in paragraphs 3(g) and 3(h) constitute a failure to exercise sufficient due diligence to ensure compliance with 40 P.S. §323.4.

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) Should Respondent fail to exercise sufficient due diligence to ensure compliance with 40 P.S. §323.4 in regard to data integrity, Respondent shall be subject to a \$10,000 penalty per violation, as well as any other sanctions or remedies as provided for by law.

6. In addition to potential penalties under paragraph 5(b) above, 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.

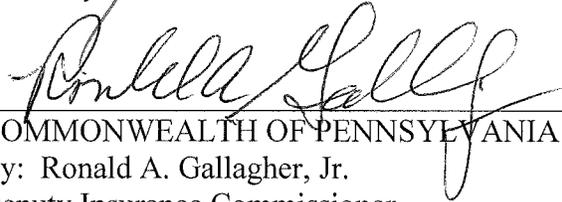
BY: OXFORD LIFE INSURANCE COMPANY,  
Respondent



\_\_\_\_\_  
President / Vice President



\_\_\_\_\_  
Secretary / Treasurer



COMMONWEALTH OF PENNSYLVANIA  
By: Ronald A. Gallagher, Jr.  
Deputy Insurance Commissioner

**OXFORD LIFE INSURANCE COMPANY**  
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## **I. INTRODUCTION**

The Market Conduct Target Examination was conducted on Oxford Life Insurance Company; hereafter referred to as “Company,” at the Company’s office located in Phoenix, AZ from June 4, 2012, through June 8, 2012. The examination team included a Pennsylvania Insurance Department (PID or the Department) market conduct examiner and three engaged market conduct examiners from Risk & Regulatory Consulting, LLC (RRC). Subsequent review and follow-up was conducted at the Harrisburg, Pennsylvania office of RRC and remotely by the examination team.

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

Yonise A. Roberts Paige  
Market Conduct Division Chief (PID)

Michael Jones  
Market Conduct Examiner (PID)

Sam Binnun  
Market Conduct Examiner (RRC)

Jo-Anne Fameree  
Market Conduct Examiner (RRC)

Scott Bryson  
Market Conduct Examiner (RRC)

**Verification**

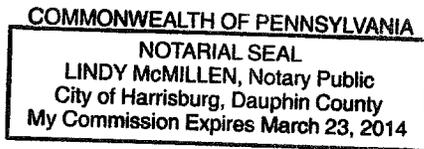
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

*Michaela. Jones*  
\_\_\_\_\_  
Examiner in Charge

Sworn to and Subscribed Before me

This 10<sup>th</sup> Day of October, 2012

*Lindy McMillen*  
\_\_\_\_\_  
Notary Public



## **II. SCOPE OF EXAMINATION**

The Market Conduct Target 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 Market Conduct Annual Statement (MCAS) reporting for 2010 and 2011. The examination included, but was not limited to, the evaluation of the Company's activities surrounding the accuracy and completeness of the mandatory filing of data for the MCAS report which is used by regulators to collect claims and underwriting data.

The examination focused on evaluating if the following Company MCAS reporting activities were compliant with Pennsylvania insurance laws and regulations: the 2010 and 2011 MCAS life report submissions, the 2010 and 2011 MCAS annuity report submissions and the policies, procedures, data extractions and report generation used by the Company in preparing the 2010 and 2011 MCAS report submissions.

The examination team initially requested that the Company provide the following information: 1) policies, procedures and controls related to gathering, analyzing, validating, reporting and revising the MCAS data; 2) audits performed to validate the MCAS data and responses; 3) the source data extracts used by the Company to analyze and compile its response to each MCAS interrogatory; 4) a list of systems along with an explanation of how they are used in the MCAS reporting process; and 5) the actual program queries used by the Company when pulling the MCAS data. Additional information was requested throughout the course of the examination. The examination team conducted walkthroughs of various portions of the MCAS report preparation process as well as conducting interviews with Company personnel responsible for the preparation and submission of the MCAS report submissions. Randomly selected files were reviewed to verify the accuracy of the data included in the Company's 2010 and 2011 MCAS report submissions.

During the course of the examination and for control purposes, some of the review segments identified in this report may have been combined with segments containing like elements for the continuity of the report.

### **III. COMPANY HISTORY AND LICENSING**

Oxford Life was founded in 1965 in Arizona and is a member of AMERCO, a publicly traded financial holding network. AMERCO's other significant holdings include U-Haul International, Inc. and Republic Western Insurance Company. Oxford Life's marketing strategy focused upon providing quality life, annuities and Medicare supplement insurance for the senior market.

In 1997, Oxford Life expanded its services with the acquisition of Encore Financial, Inc., a Wisconsin-based insurance holding company, which owned the stock of North American Insurance Company as a third-party administrator of Medicare supplement insurance programs.

In 2000, Oxford Life expanded its growth and distribution in the Medicare supplement market with the acquisition of Christian Fidelity Life Insurance Company ("Christian Fidelity"). Christian Fidelity is a Medicare supplement and final expense life insurance company.

In 2006, the Company continued their growth in the Texas Medicare supplement market with the acquisition of Dallas General Life Insurance Company ("Dallas General"). Dallas General's business is focused on providing Medicare supplement insurance policies for the senior marketplace.

As of the Annual Statement for year ending December 31, 2010 for Pennsylvania, the Oxford Life Insurance Company reported direct premium for ordinary life insurance and annuity considerations in the amount of \$12,065,746.00; and direct premium earned for accident and health in the amount of \$76,212.00. As of the Annual Statement for year ending December 31, 2011 for Pennsylvania, the Oxford Life Insurance Company reported direct premium for ordinary life insurance and annuity considerations in the amount of \$12,158,429.00; and direct premium earned for accident and health in the amount of \$113,984.00.

## **IV. MARKET CONDUCT ANNUAL STATEMENT REPORT**

In Pennsylvania, insurers are required annually to submit a Market Conduct Annual Statement (MCAS) to the National Association of Insurance Commissioners (NAIC). The MCAS data is submitted in compliance with Pennsylvania Insurance Department Act, Section 903(a) [40 P.S. §323.3] which states in part, “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 MCAS data is submitted, protected and analyzed under the referenced Pennsylvania examination law as a means to validate the continued solvency of an insurer.

The examination team reviewed all of the Company’s 2010 and 2011 MCAS submissions along with documentation regarding the Company’s policies, procedures, controls, and source data extracts used in preparing the MCAS report submissions. The review of MCAS information was twofold: first to determine if the Company had IT and data integrity controls in place along with policies and procedures, to ensure the validity of the MCAS data submissions; and second, to determine if the 2010 and 2011 MCAS data reported was accurate and complete. The MCAS reporting activities listed below were reviewed during the course of the examination.

	<b>SECTION TITLES</b>
<b>A.</b>	<b>The 2010 MCAS Life Report Submission</b>
<b>B.</b>	<b>The 2011 MCAS Life Report Submission</b>
<b>C.</b>	<b>The 2010 MCAS Annuity Report Submission</b>
<b>D.</b>	<b>The 2011 MCAS Annuity Report Submission</b>
<b>E.</b>	<b>The Company’s MCAS Policies, Procedures, Data Extraction and Report Generation Processes</b>

Below are the references used to determine compliance with the Pennsylvania MCAS reporting requirements.

**LEGAL REFERENCE: Pennsylvania Insurance Department Act, Section 904(b) [40 P.S. §323.4]**

Every company or person from whom information is sought, its officers, directors and agents must provide to the examiners appointed under subsection (a) timely convenient and free access at all reasonable hours at its offices to 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 being examined. The officers, directors, employees and agents of the company or person must facilitate such examination and aid in such examination so far as it is in their power to do so. The refusal of any company by its officers, directors, employees or agents to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of or nonrenewal of any license or authority held by the company to engage in insurance or other business subject to the department's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to 2 Pa. C.S. (relating to administrative law and procedure).

**MCAS REFERENCE: The Market Conduct Annual Statement General Filing Information – Company Attestation**

All companies that submit an MCAS filing must attest to the completeness and accuracy of their submission. The attestation is required once per filing period and applies to all submissions for a specific company code. No submissions will be accepted until an attestation is completed for the company.

### A. The 2010 MCAS Life Report Submission

The examination team reviewed the Company’s 2010 MCAS Life submission, the supporting source documents and randomly selected files corresponding to the MCAS data call in order to determine completeness and accuracy of the information attested to by the Company in the MCAS submission. The attestation is required once per filing period and applies to all submissions for a specific company code. No submissions will be accepted until an attestation is completed for the company. Below are the interrogatories that every Pennsylvania insurer was required to complete for the 2010 Life MCAS Report.

LINE	MCAS DATA CALL
<b>0</b>	Does the company have data to report for this product type?
<b>1</b>	Number of new replacement policies applied for during period (include all replacements regardless of whether an insurance policy was actually issued)
<b>2</b>	Number of new replacement policies issued during period (include only the number of replacement insurance policies issued)
<b>3</b>	Do replacement counts provided include internal replacements?
<b>4</b>	Do replacement counts include policies surrendered?
<b>5</b>	Do replacement counts provided include policies/contracts purchased using loan proceeds from existing life policies and/or annuity contracts?
<b>6</b>	Do replacement counts provided include policies/contracts purchased through 1035 exchanges?
<b>7</b>	Does company maintain replacement register?
<b>8</b>	Number of in force policies with loan balance over 25% of maximum loan value as of end of reporting period
<b>9</b>	Number of policies surrendered during period
<b>10</b>	Number of partial surrenders during period
<b>11</b>	Does count of policies surrendered include partial surrenders?
<b>12</b>	Number of new 1035 exchanges coming into company during period
<b>13</b>	Number of new policies issued by the company during period
<b>14</b>	Number of policies in force at end of period (the number of active policies that the company has outstanding at the end of the reporting period)
<b>15</b>	Dollar amount of direct premium during period
<b>16</b>	Dollar amount of insurance issued during period (face amount)
<b>17</b>	Dollar amount of insurance in force at the end of period (face amount)
<b>18</b>	Number of complaints received directly from consumers
<b>19</b>	Number of complaints received directly from the corresponding department of insurance

<b>20</b>	Does the company maintain complaint register?
<b>21</b>	Number of death claims closed with payment, during period, within 60 days from date of due proof of loss (include claims where final decision was payment in full, and was made within 60 days from when date of due proof of loss occurred)
<b>22</b>	Number of death claims closed with payment, during period, beyond 60 days from date of due proof of loss (include claims where final decision was payment in full, and was NOT made within 60 days from when date of due proof of loss occurred)
<b>23</b>	Number of death claims denied, resisted or compromised during period (a claim is considered resisted when in dispute and not resolved on statement date)
<b>24</b>	Total number of death claims received during period (include any claim received during the period as determined by the first date the claim was opened on the company system)

**BACKGROUND ITEM I - 1035 EXCHANGES:**

- 1) Line #12 of the 2010 MCAS life report reads as follows:  

Number of new 1035 exchanges coming into the company during the period.
  
- 2) The 2010 Life & Annuity Market Conduct Annual Statement Life & Annuities Data Call & Definitions contains the following definitions:  

**1035 Exchange** – A provision in the tax code (IRC 1035), which allows for the direct transfer (Rollover) of accumulated funds in a life insurance policy, endowment policy or annuity contract to another life insurance policy, endowment policy or annuity policy, without creating a taxable event.
  
- 3) The MCAS Data File Instruction Guide requires that a numeric value be submitted for line 12 of the 2010 MCAS life report. The MCAS process does not accommodate situations in which the Company does not track the data necessary to respond to this question.

**FACTS - ITEM I:**

- 1) The Company's response to the initial examination data request dated April 20, 2012, contained the name of the source file(s) used by the Company in responding to the MCAS report requests. The Source file(s) for line #12 of the life report did not contain a numeric value.

- 2) The Company's response to *2010 MCAS Life Report Line #12 –New 1035 Exchanges* was inconsistent with the information observed by the Examiners in their source data,
- 3) During the June 5, 2012 onsite interviews, Company personnel confirmed that their response on MCAS was inconsistent with their source data.
- 4) Upon reviewing the sample files selected for 2010 MCAS Life lines it was noted that several files contained 1035 transfer request forms.
- 5) The source data used by the Company in preparing the response to the 2010 MCAS life report line #12 did not conform to the data requirements of the MCAS reports. Therefore, the Company's policies and procedures were insufficient to ensure the accuracy of the MCAS response.
- 6) The Company's response on line #12 of the *2010 MCAS Life* submission regarding New 1035 Exchanges was understated.

**BACKGROUND ITEM II - CLAIMS:**

- 1) Line #24 of the 2010 MCAS Life report reads as follows:

Total number of death claims received during the period (include any claim received during the period as determined by the first date the claim was opened on the company system).
- 2) The 2010 Life & Annuity Market Conduct Annual Statement Life & Annuities Data Call & Definitions contains the following definitions:

**Date Claim Received** – The first date the claim is opened on the Company system.

**Date of Due Proof of Loss** – The date the company received the necessary proof of loss on which to base a claim determination.

**FACTS - ITEM II:**

- 1) The Company stated that the response for Line #24 of the 2010 MCAS Life submission was derived from page 25 of the source document, which reflected the total number of claims paid in 2010; coupled with the data included in a different source document which reflected claims that were incurred in but not paid in 2010 and claims that were incurred in 2009 but paid in 2010.

The Company stated that the data was based on the claims incurred date; however, the data fields in the source documents do not capture a *claims incurred* field.

- 2) The MCAS instructions requires that the response to Line 24 be based on the date the claim was received (opened on the company system) but the data fields in the source documents does not contain a *claims received* field. Instead the source documents contain data fields for the day, month and year of death.
- 3) The source data fields used by the Company to prepare the response to the 2010 MCAS Life Report Line #24 did not conform to the data as defined by the 2010 Life & Annuity Market Conduct Annual Statement Life & Annuities Data Call & Definitions. Therefore, the Company's policies and procedures were insufficient to ensure that accuracy of the MCAS response.

**THE 2010 MCAS LIFE REPORT SUBMISSION VIOLATIONS:**

**The Company provided an inaccurate response on line #12 of the 2010 MCAS Life submission regarding New 1035 Exchanges. Additionally, the source documents provided by the Company were insufficient to allow for the independent verification of the accuracy of the Company's response to the 2010 MCAS Life Report Lines #12 and #24 regarding claims.**

## B. The 2011 MCAS Life Report Submission

The examination team reviewed the Company’s 2011 MCAS Life submissions, the supporting source documents and randomly selected files corresponding to the MCAS data call in order to determine the completeness and accuracy of the information attested to by the Company in the MCAS submission. All companies that submit an MCAS filing must attest to the completeness and accuracy of their submission. The attestation is required once per filing period and applies to all submissions for a specific company code. No submissions will be accepted until an attestation is completed for the company. Below are the interrogatories that every Pennsylvania insurer was required to complete for the 2011 Life MCAS Report.

Line	INTERROGATORIES
<b>0</b>	Does the company have data to report for this product type?
<b>1</b>	Number of new replacement policies applied for during the period (include all replacements regardless of whether an insurance policy was actually issued)
<b>2</b>	Number of new replacement policies issued during the period (include only the number of replacement insurance policies issued)
<b>3</b>	Do the replacement counts provided include internal replacements?
<b>4</b>	Do the replacement counts provided include policies surrendered?
<b>5</b>	Do the replacement counts provided include policies/contracts purchased using loan proceeds from existing life insurance policies and/or annuity contracts?
<b>6</b>	Do the replacement counts provided include policies/contracts purchased through 1035 exchanges?
<b>7</b>	Does the company maintain a replacement register?
<b>8</b>	Number of in force policies with a loan balance over 25% of the maximum loan value as of the end of the reporting period
<b>9</b>	Number of replacement policies issued during period
<b>10</b>	Number of internal replacements issued during period
<b>11</b>	Number of external replacements issued during the period.
<b>12</b>	Number of policies replaced where age of insured at replacement was < 65
<b>13</b>	Number of policies replaced where age of insured at replacement was age 65 and over
<b>14</b>	Number of policies surrendered under 2 years from policy issue
<b>15</b>	Number of policies surrendered between 2 years and 5 years from policy issue
<b>16</b>	Number of policies surrendered between 6 years and 10 years from policy issue

17	Number of policies surrendered during the period
18	Number of new policies issued during the period where age of insured at issue was <65
19	Number of new policies issued during the period where age of insured at issue was age 65 and over
20	Number of new policies issued during the period
21	Number of policies in force at the end of the period
22	Dollar amount of direct written premium during the period
23	Face amount of insurance issued during the period
24	Face amount of insurance in force at the end of the period
25	Number of complaints received directly from consumers
26	Number of death claims closed with payment, during the period, within 60 days from the date of due proof of loss (include only claims where the final decision was payment in full)
27	Number of death claims closed with payment, during the period, beyond 60 days from the date of due proof of loss (include only claims where the final decision was payment in full)
28	Number of death claims denied, resisted or compromised during the period
29	Number of death claims received during the period

**BACKGROUND - ITEM I: SURRENDERS**

1) The 2011 MCAS life report lines #14-16 – surrenders by years, read as follows:

Line #14 - Number of policies surrendered under 2 years from policy issue.

Line #15 - Number of policies surrendered between 2 years and 5 years from policy issue.

Line #16 - Number of policies surrendered between 6 years and 10 years from policy issue.

2) The 2011 Life & Annuities Data Call & Definitions contains the following:

**Surrendered Policy/Contract** – A life insurance policy or annuity contract terminated at the request of the policy owner. It does not include life insurance policies or annuity contracts not taken or cancelled during the free look period. For annuities, systematic withdrawals (the withdrawal of a certain amount on a predetermined periodic basis for deferred annuities) and partial withdrawals should not be reported as “surrenders” for this statement.

- 3) The MCAS Data File Instruction Guide requires that a numeric value be submitted for each of the referenced lines.
- 4) The MCAS Data Call & Definitions (Instructions) do not specifically address how to determine the duration for these questions. The MCAS instructions indicate that the Financial Annual Statement Instructions (FAS) definitions and methodologies should be used whenever possible in completing the MCAS reports. The FAS instructions and state page instructions do not address this issue.
- 5) Question 28 in the document linked to “[FAQ](#)” on the NAIC MCAS website; which was internally titled Market Conduct Annual Statement (MCAS) Frequently Asked Questions, Updated – 03/27/2012, addresses the 2011 MCAS Life Report Lines #14-16, and reads as follows:

28. The life and annuity policy/contract surrender data elements now request that surrenders be split according to the date of issuance. It is not clear where surrenders should be reported if the policy/contract is 2, 5 or 10 years old. How should these be reported? The life and annuity policy/contract surrender data element date of issuance splits should be interpreted as follows:

<b>Data element wording</b>	<b>Clarification</b>
Under 2 years	< 2 years
Between 2 years and 5 years	>=2 years and < 6 years
Between 6 years and 10 years	>=6 years and < 11 years

**FACTS - ITEM I:**

- 1) The Company provided an internal document that identifies the source document for the 2011 MCAS life report lines #14-16.
- 2) The internal document contains a summary of data supported by the information contained on the source document tab.

- 3) In the Company's June 27, 2012 email response to the Examiners' question, the Company stated:
- a. *"The "Duration" is calculated in the source document query which has a duration function that calculates a difference between two dates. It gives you a serial number that contains years, months, and days between the dates. I pull the year out and add one to get the duration.*
  - b. *You can also calculate it in Excel. I would subtract the two dates to get the number of days between them. Divide that by 365. Take the integer of that result and add one. This will give you the duration or policy year of the surrender."*
- 4) In the Company's June 27, 2012 email response to the Examiner's question, the Company confirmed inconsistencies in the data contained in the source document tab. The inconsistencies were the result of an error in transferring data from the source document 1 system into the secondary source document; specifically the data in the effective and transaction date columns was off by one row.
- 5) Based on the examination team's understanding of the Company's data in the source document 2 tab, column "N", which is labeled "Effective Date", column "O", which is labeled "Transaction Date Policy" and column "P" labeled "Duration" was data that was pulled out of source document 2 with a query and used as the basis of the MCAS response. The comparable data in the fields in source document 1 does not match the data fields in source documents 2.

Based on the **query** data in column "N", "O", and "P" of the source document 2 tab, the policy durations (number of days between the Effective Date and Trans Date) that the Company's reported on the 2011 MCAS life report lines #14-16 were inaccurate. The Company's responses were understated or overstated as documented below:

14	Number of policies surrendered less than 2 years from policy issue.	PA	Understated by 100%
15	Number of policies surrendered between 2 years and 5 years from policy issue.	PA	Overstated by 7%
16	Number of policies surrendered between 6 years and 10 years from policy issue.	PA	Overstated by 60%

- 6) The Company employs a methodology for calculating the policy duration which does not conform to the data requirements of the MCAS reports; the duration function calculates a difference between two dates and then the Company pulls the year out of the calculation results and adds one to the year in order to get the duration. In essence the Company is rounding the policy duration up to the next closest year. This methodology would result in the inaccurate reporting by year, for example if a policy was in effect for 1 year and 5 months the Company would consider the duration 2 years and therefore this policy would not be reported in the under 2 year category. Therefore, the procedures adopted by the Company are inconsistent with the MCAS reporting requirements.
- 7) Based on the fact that the source documents were inconsistent, and those inconsistencies were not identified or addressed by the Company during the MCAS reporting process, it appears the Company's validation process is insufficient to ensure that accuracy of the data used to prepare the MCAS responses.

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**BACKGROUND - ITEM II: CLAIMS**

- 1) Line #29 of the 2011 MCAS Life Interrogatories reads as follows:  
Number of death claims received during the period.
- 2) The 2011 Life & Annuities Data Call & Definitions contains the following definitions:  
**Date Claim Received** – The first date the claim is opened on the company system.

**Date of Due Proof of Loss** – The date the company received the necessary proof of loss on which to base a claim determination, including where necessary, proof of unencumbered interest of the beneficiary and documentation required to legally make payment (such as completed claim forms, W-9's, estate dispute settlements, proof of age, police investigation reports, etc.).

**FACTS - ITEM II:**

- 1) According to the June 14, 2012 email from Company representatives, the source documents for the Company's 2011 MCAS Life line #29-Number of death claims received during the period, are source document and the source document report.
- 2) On June 19, 2012, the Company provided further clarification via email, indicating the data used to respond to line #29 was derived from the same data source used for MCAS Life Line 26 (number of death claims closed with payment, during the period, within 60 days from the date of due proof of loss (include only claims where the final decision was payment in full)) and MCAS Life Line 28 (Number of death claims denied, resisted or compromised during the period).
- 3) The source document report does not contain a claims received date field; instead it contains an "All Info Received Date" field. The source document does not contain any data fields containing claim dates received but contains fields labeled claim type, claim number and "for Death or Disability". The data in the "for Death or Disability" field is strictly a year or is blank. Therefore, it appears the data reported from the source document report was based on the date all information was received instead of the date the claim was received (opened on the company system) as defined by MCAS and it is unclear what date is used as the basis of the data reported from the source document report.
- 4) The source data fields used by the Company in preparing the response to the 2011 MCAS Life Report Line #29 – Claims Received did not conform to the data as defined by the 2011 Life & Annuities Data Call & Definitions. Therefore, the Company's policies and procedures were insufficient to ensure that accuracy of the MCAS response.

5) The source documents provided by the Company were inadequate to allow for the independent verification of the accuracy of the Company’s response to the 2011 MCAS Life Report Line #29.

**THE 2011 MCAS LIFE REPORT SUBMISSION VIOLATION(S):**

**The methodology employed by the Company for calculating policy duration was found not to conform to data requirements needed for MCAS reporting. Therefore, line # 14-16 of the 2011 MCAS Life submission report was determined as inaccurate. Additionally, the source documents provided by the Company were insufficient to allow for the independent verification of the accuracy of the Company’s response to the 2010 MCAS Life Report Line #29 regarding claims.**

**C. The 2010 MCAS Annuity Report Submission**

The examination team reviewed the Company’s 2010 MCAS annuity submissions, the supporting source documents and randomly selected files corresponding to the MCAS interrogatories in order to determine completeness and accuracy of the information attested to by the Company in the MCAS submission. All companies that submit an MCAS filing must attest to the completeness and accuracy of their submission. The attestation is required once per filing period and applies to all submissions for a specific company code. No submissions will be accepted until an attestation is completed for the company. Below are the interrogatories that every Pennsylvania insurer was required to complete for the 2010 Annuity MCAS Report.

<b>Line</b>	<b>INTERROGATORIES</b>
<b>0</b>	Does the company have data to report for this product type?
<b>1</b>	Number of new replacement contracts applied for during the period (include all replacements regardless of whether an annuity contract was actually issued)
<b>2</b>	Number of new replacement contracts issued during the period (include only the number of replacement contracts issued)
<b>3</b>	Do replacement counts include internal replacements?
<b>4</b>	Do replacement counts provided include policies/contracts purchased using loan proceeds from existing life policies and/or annuity contracts?

5	Do replacement counts provided include policies/contracts purchased through 1035 exchanges?
6	Does the company maintain a replacement register?
7	Number of contracts surrendered during the period
8	Number of new 1035 exchanges coming into company during period
9	Number of new contracts issued by the company during period
10	Number of contracts in force at the end of the period (the number of active contracts that the company has outstanding at the end of the reporting period)
11	Dollar amount of annuity considerations during the period
12	Number of complaints received directly from consumers
13	Number of complaints received directly from corresponding department of insurance
14	Does company maintain complaint register?

**BACKGROUND – 1035 EXCHANGES:**

- 1) Line #8 of the 2010 MCAS annuity report reads as follows:  
Number of new 1035 exchanges coming into the company during the period.
  
- 2) The 2010 Life & Annuity Market Conduct Annual Statement Life & Annuities Data Call & Definitions contains the following definitions:  
**1035 Exchange** – A provision in the tax code (IRC 1035), which allows for the direct transfer (Rollover) of accumulated funds in a life insurance policy, endowment policy or annuity contract to another life insurance policy, endowment policy or annuity policy, without creating a taxable event.
  
- 3) The MCAS Data File Instruction Guide requires that a numeric value be submitted for line #8 of the 2010 MCAS annuity report. The MCAS process does not accommodate situations in which the Company does not track the data necessary to respond to this question.

**FACTS:**

- 1) The Company’s response to the initial examination data request dated April 20, 2012, contained a document which contained the name of the source file(s) used by the Company in responding to the MCAS report requests. The source file(s) for line 8 of the annuity report was not a numeric value and inconsistent with the MCAS requirements.

- 2) The Company's response to line #8 of the annuity report was underreported.
- 3) During the June 5, 2012 onsite interviews, Company personnel confirmed their response to the question on line #8 was limited.
- 4) The source data used by the Company in preparing the response to the 2010 MCAS annuity report line #8 did not conform to the data requirements of the MCAS reports. Therefore, the Company's policies and procedures were insufficient to ensure that accuracy of the MCAS response.
- 5) The source documents provided by the Company were insufficient to allow for the independent verification of the accuracy of the Company's response to the 2010 MCAS annuity report line #8.

**THE 2010 MCAS ANNUITY REPORT SUBMISSION VIOLATION(S):**

**The source data used by the Company in preparing the response to the 2010 MCAS annuity report line #8 did not conform to the data requirements of the MCAS reports. The Company's policies and procedures were insufficient to ensure that accuracy of the MCAS response.**

**D. The 2011 MCAS Annuity Report Submission**

The examination team reviewed the Company's 2011 MCAS Annuity submissions, the supporting source documents and randomly selected files corresponding to the MCAS interrogatories 9-26 in order to determine completeness and accuracy of the information attested to by the Company in the MCAS submission. The attestation is required once per filing period and applies to all submissions for a specific company code. No submissions will be accepted until an attestation is completed for the company. Below are the interrogatories that every Pennsylvania insurer was required to complete for the 2011 Annuity MCAS Report.

<b>Line</b>	<b>INTERROGATORIES</b>
<b>1</b>	Individual Fixed Annuities - Does the company have data to report for this product type?
<b>2</b>	Individual Variable Annuities - Does the company have data to report for this product type?
<b>3 / 4</b>	Is there a reason that the reported Individual Fixed Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc)?
<b>5 / 6</b>	Is there a reason that the reported Individual Variable Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc)?
<b>7</b>	Additional state specific Individual Fixed Annuities comments (optional)
<b>8</b>	Additional state specific Individual Variable Annuities comments (optional):
<b>9</b>	Number of replacement contracts issued during the period
<b>10</b>	Number of internal replacement contracts issued during the period
<b>11</b>	Number of external replacement contracts issued during the period
<b>12</b>	Number of contracts replaced where age of annuitant at replacement was < 65
<b>13</b>	Number of contracts replaced where age of annuitant at replacement was age 65 to 80
<b>14</b>	Number of contracts replaced where age of annuitant at replacement was > 80
<b>15</b>	Number of new immediate contracts issued during the period
<b>16</b>	Number of new deferred contracts issued during the period where age of annuitant was > 65
<b>17</b>	Number of new deferred contracts issued during the period where age of annuitant was 65 to 80
<b>18</b>	Number of new deferred contracts issued during the period where age of annuitant was > 80
<b>19</b>	Number of new deferred contracts issued during the period
<b>20</b>	Number of contracts surrendered under 2 years from policy issue
<b>21</b>	Number of contracts surrendered between 2 years and 5 years from policy issue
<b>22</b>	Number of contracts surrendered 6 years and 10 years from policy issue
<b>23</b>	Number of contracts surrendered during the period
<b>24</b>	Number of contracts in force at the end of the period
<b>25</b>	Dollar amount of annuity considerations during the period
<b>26</b>	Number of complaints received directly from consumers

**BACKGROUND - SURRENDERS:**

- 1) The 2011 MCAS annuity report lines #20-22 – surrenders by years, read as follows:
  - Line #20 - Number of contracts surrendered under 2 years from policy issue.
  - Line #21 - Number of contracts surrendered between 2 years and 5 years from policy issue.
  - Line #22 - Numbers of contracts surrendered between 6 years and 10 years from policy issue.
  
- 2) The 2011 Life & Annuities Data Call & Definitions contains the following:

**Surrendered Policy/Contract** – A life insurance policy or annuity contract terminated at the request of the policy owner. It does not include life insurance policies or annuity contracts not taken or cancelled during the free look period. For annuities, systematic withdrawals (the withdrawal of a certain amount on a predetermined periodic basis for deferred annuities) and partial withdrawals should not be reported as “surrenders” for this statement.
  
- 3) The MCAS Data File Instruction Guide requires that a numeric value be submitted for each of the lines referenced above.
  
- 4) The MCAS Data Call & Definitions (Instructions) do not specifically address how to determine the duration for these questions. The MCAS instructions indicate that the Financial Annual Statement Instructions (FAS) definitions and methodologies should be used whenever possible in completing the MCAS reports. The FAS instructions and state page instructions do not address this issue.
  
- 5) Question 28 in the document linked to “[FAQ](#)” on the NAIC MCAS website; which was internally titled Market Conduct Annual Statement (MCAS) Frequently Asked Questions, Updated – 03/27/2012. addresses the 2011 MCAS Life Report Lines #14-16, and reads as follows:
  - 28. The life and annuity policy/contract surrender data elements now request that surrenders be split according to the date of issuance. It is not clear where

surrenders should be reported if the policy/contract is 2, 5 or 10 years old. How should these be reported?

The life and annuity policy/contract surrender data element date of issuance splits should be interpreted as follows:

<b>Data element wording</b>	<b>Clarification</b>
Under 2 years	< 2 years
Between 2 years and 5 years	>=2 years and < 6 years
Between 6 years and 10 years	>=6 years and < 11 years

**FACTS:**

- 1) The Company's internal document identifies the source document for the 2011 MCAS annuity report lines #20-22.
  
- 2) The source document tab contains a summary of data supported by the information contained on the source document tab.
  
- 3) In a June 27, 2012, email communication to the examination team, the Company stated:  
*"The "Duration" is calculated in the source document query which has a duration function that calculates a difference between two dates. It gives you a serial number that contains years, months, and days between two dates. I pull the year out and add one to get the duration.*  
  
*You can also calculate it in Excel. I would subtract the two dates to get the number of days between them. Divide that by 365. Take the integer of that result and add one. This will give you the duration or policy year of the surrender."*
  
- 5) The data contained on the source document tab corresponds with the MCAS response. However, the source data to support the MCAS response could not have produced the results on the source document tab.

- 6) A review of the file documentation for the Company's response to the 2011 MCAS annuity report lines #22, reveals that the data contained in the source document is inaccurate, but the figures contained in the MCAS response are correct.
- 7) The Company employs a methodology for calculating the policy duration which does not conform to the data requirements of the MCAS reports; the duration function calculates a difference between two dates and then the Company pulls the year out of the calculation results and adds one to the year in order to get the duration. In essence the Company is rounding the policy duration up to the next closest year. This methodology would result in the inaccurate reporting by year, for example if a policy was in effect for 1 year and 5 months the Company would consider the duration 2 years and therefore this policy would not be reported in the under 2 year category. Therefore, the procedures adopted by the Company are inconsistent with the MCAS reporting requirements.
- 8) The source documents provided by the Company do not support the Company's 2011 MCAS response to annuity report lines #20-22.
- 9) The Company's validation process was insufficient to ensure that accuracy of the data used to prepare the MCAS responses.

**THE 2011 MCAS ANNUITY REPORT SUBMISSION VIOLATION(S):**

**The methodology employed by the Company for calculating policy duration was found not to conform to data requirements needed for MCAS reporting. Additionally the source documents provided by the Company do not support the Company's 2011 MCAS annuity response to annuity report lines #20-22. Also, the Company's validation process is insufficient to ensure that accuracy of the data used to prepare the MCAS responses.**

**E. The Company's MCAS Policies, Procedures,  
Data Extraction and Report Generation processes**

The examination team reviewed the Company's 2010 and 2011 MCAS IT and data integrity controls, source documents and its general MCAS policies and procedures to determine if the

Company had policies and procedures in place to ensure its compliance with the MCAS reporting requirements.

**BACKGROUND ITEM I: POLICY AND PROCEDURES**

The Company's response to the initial examination data request dated April 20, 2012, contained three (3) documents that were the basis of the Company's policies and procedures related to the MCAS reporting process. Additionally, during the course of the examination process the Company realized that the data contained in the procedure document did not accurately reflect the source documents used in the MCAS report process, so they provided a revised procedure document.

Below is an excerpt from the Company's response to IDR-001:

2. a. through f. iii. The document labeled source document was created specifically for the purposes of responding to the examination request to outline in writing the Market Conduct Annual Statement (MCAS) process we used. As indicated during the interview process, our process for reviewing and submitting data pursuant to the MCAS data call has been an informal process.

The process of obtaining the data submitted for the data call uses parameters previously established and modified since the inception of the MCAS data call. Please reference the source document as previously provided for 2010 and 2011, which supplements the above-referenced procedure document. Preparation, validation and submission of the MCAS data is a collaborative effort by various areas within the company, including Compliance, Information Systems and the appropriate Business Units.

Attached for your reference is a summary of the evolution of Oxford Life's Market Conduct Annual Statement Policies and Procedures since reporting the 2009 data. During your visit, you asked us to include plans for future revisions to the MCAS process. We are developing a more formalized process for reporting MCAS data, which we intend to implement for the upcoming reporting year; attached is a draft for your reference.

### **FACTS ITEM I:**

- 1) During the examination period the Company did not have formalized policies and procedures in place related to the MCAS reporting process.
  - 2) The Company acknowledged that its MCAS reporting process is evolving and that as a result of the 2011 process and the current market conduct examination, they have identified the following issues and potential resolutions:
    - a. **Issue 1:** Multiple reports used to capture data; **Possible Resolution 1:** Incorporate remaining elements into base report
    - b. **Issue 2:** Multiple manual elements to data reporting process; **Possible Resolution 2:** Add additional automation to reporting process (automatically write source data to database)
    - c. **Issue 3:** Formal validation process; **Possible Resolution 3:** Formalize meetings between departments to review data; create 2-stage review (initial review by business unit, secondary review by Compliance prior to filing)
  - 3) The Company stated that they are in the process of developing more formalized procedures that it intends to implement for the upcoming reporting year.
  - 4) The Company informal policies and procedures related to MCAS reporting process during the examination period did not provide the Company the ability to ensure the accuracy of the data reported in the 2010 and 2011 MCAS submissions.
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### **BACKGROUND DATA EXTRACTION AND REPORT GENERATION - ITEM II:**

The data used for MCAS reporting resides within the source data application. A system generated report is run on the source data 1 to produce the MCAS data for the current year that is stored within the source data report. This report provides most of the detail required for MCAS reporting. The report is first “imported” into MS Excel. The “import” is a manual process that involves converting plain text into columnar format as well as removing headers and footers that existed on the initial system generated report. Individual tabs are created within the spreadsheet

for the various MCAS items and interrogatories. As previously indicated, some data required for MCAS reporting is not provided on the system generated report from the source data.

To obtain this data, custom queries of the source data applications are run. The query output is in text format which gets pasted into the MS Excel spreadsheet. Once all the data is in the correct format, pivot tables are created in MS Excel to allow the Compliance department to obtain the data at the level it is needed for MCAS reporting. The final MS Excel report is called the source data 2.

The examination team has reviewed the data within the source data report and has concerns regarding the accuracy of the data within the report. The issues appear to be occurring during the manual process to “import” the data from the system generated report source data 1 to the MS Excel spreadsheet though in some cases, the actual values entered onto the MCAS form may still be accurate; the examination team cannot rely on the source data 2 as the data source for their testing procedures. The examination team obtained the MCAS data directly from the source system.

**FACTS - ITEM II:**

The examination team identified several errors in the data reports used by the Company in preparing the MCAS report submissions.

First, various date values for records within the reports do not match what is in the Company’s operating system and therefore cannot be accurate. This was validated by comparing the values on the reports to screenshots of the record detail within the actual source system. In one case, it was evident that MS Excel converted the data incorrectly during the process to import the data from the source report. In another case, a manual copy and paste error by the report preparer caused the date values to all be off by one row.

Additionally, the data on one of the Company reports changed because the wrong column was pulled for the detail report. The “Duration” column is what was being pulled in error and was represented as the “Transaction Date Policy” in the initial response. Though this was identified and resolved prior to submitting the MCAS data, it is an example of issues that occurred during

the manual generation of the source document used to prepare the Company's MCAS submission

**THE COMPANY'S MCAS POLICIES, PROCEDURES, DATA EXTRACTION AND REPORT GENERATION PROCESSES VIOLATION(S):**

**The Company's informal policies and procedures related to MCAS reporting process during the examination period did not provide the Company the ability to ensure the accuracy of the data reported in the 2010 and 2011 MCAS submissions. Additionally, the source documents provided by the Company were inadequate to allow for the independent verification of the accuracy of the Company's response to the 2011 MCAS interrogatories.**

## **V. 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 should finalize and implement formal standardized policies and procedures for preparing and for validating the MCAS submission data.
- 2) The Company should take the necessary steps to resolve the issues listed below, which they have identified as issues that impact its ability to produce complete and accurate MCAS report submissions.
  - The use of multiple reports to capture the data necessary to produce the MCAS report response.
  - The necessity for multiple manual elements in the data reporting process.
  - The lack of a formal validation process.

**VI. COMPANY RESPONSE**

November 21, 2012

Ms. Yonise Roberts Paige, Chief  
Life, Accident and Health Division  
Market Actions Bureau  
Pennsylvania Insurance Department  
Office of Market Regulation  
1321 Strawberry Square  
Harrisburg, PA 17120

Re: Market Conduct Examination/Examination Warrant No. 12-M25-015

Dear Ms. Paige,

Oxford Life Insurance Company (“Oxford Life”) received your letter dated October 26, 2012 together with the Report of Examination of Oxford Life (the “Report”). Oxford Life appreciates the opportunity to provide this response to the Report, and notes that the company has complied with all recommendations in the Report.

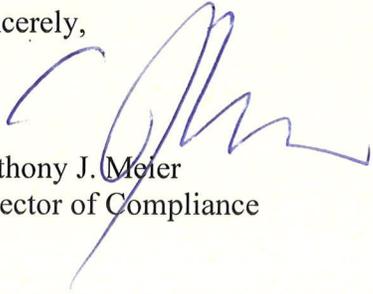
Specifically, pursuant to the Department’s recommendations, Oxford Life finalized and implemented updated formal standardized policies and procedures for preparing and validating Market Conduct Annual Statement (“MCAS”) report data. The updated procedures, incorporating the Department’s comments, were accepted by the Department on November 9, 2012.

Oxford Life respectfully submits that it provided timely, convenient and free access to 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, and maintained records sufficient to permit verification of the company’s financial condition and compliance with Pennsylvania law. At no time did Oxford Life ever refuse to submit to the Department’s examination or to comply with the Department’s reasonable requests. Further, although the company’s 2010 and 2011 MCAS data did contain some inaccuracies, the Department’s review of Oxford Life’s MCAS submissions and procedures did not identify any underlying violations of the insurance code.



Oxford Life appreciates the Department's efforts in reviewing and helping to enhance the company's MCAS reporting procedures. Thank you to you and your examiners for the guidance, courtesy and cooperation extended to us during the examination.

Sincerely,



Anthony J. Meier  
Director of Compliance