



STATE OF NEW YORK INSURANCE DEPARTMENT  
REPORT ON EXAMINATION  
OF THE  
COMBINED LIFE INSURANCE COMPANY OF NEW YORK

CONDITION:

DECEMBER 31, 2003

DATE OF REPORT:

AUGUST 20, 2004

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EXAMINER:

EDEN M. SUNDERMAN

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STATE OF NEW YORK  
INSURANCE DEPARTMENT  
25 BEAVER STREET  
NEW YORK, NEW YORK 10004

George E. Pataki  
Governor

Gregory V. Serio  
Superintendent

August 20, 2004

Honorable Gregory V. Serio  
Superintendent of Insurance  
Albany, New York 12257

Sir:

In accordance with instructions contained in Appointment No. 22126, dated January 15, 2004 and annexed hereto, a limited scope examination has been made into the condition and affairs of Combined Life Insurance Company of New York, hereinafter referred to as "the Company," at its home office located at 11 British American Boulevard, Latham, New York 12110.

Wherever "Department" appears in this report, it refers to the State of New York Insurance Department.

The report indicating the results of this examination is respectfully submitted.

## 1. EXECUTIVE SUMMARY

This was a limited scope examination of the Company as of December 31, 2003 which included: (i) a review or audit of certain targeted balance sheet items (bonds, cash, contract loans and reserves) and (ii) a review of the market conduct activities of the Company. The examiner's review of a sample of transactions did not reveal any differences which materially affected the Company's financial condition as presented in its financial statements contained in the December 31, 2003 filed annual statement. (See items 2 and 5 of this report)

The Company violated Section 1505(d)(3) of the New York Insurance Law by failing to notify the superintendent in writing of its intention to enter into an agreement whereby an affiliate renders services to the Company on a regular and systematic basis. (See item 3B of this report)

The Company violated Section 1505(a) of the New York Insurance Law by failing to: 1) reimburse Combined Insurance Company of America ("CICA") a reasonable amount for certain services provided on a regular and systematic basis; and 2) bill or charge CICA a reasonable amount for certain services that were provided on a regular and systematic basis. (See item 3B of this report)

The Company violated Section 1505(d)(3) of the New York Insurance Law by: 1) receiving certain services from CICA on a regular and systematic basis that were not provided for in the filed service agreement between the Company and CICA where CICA is the provider of services; and 2) providing certain services to CICA on a regular and systematic basis that were not provided for in the filed service agreement between the Company and CICA where the Company is the provider of services. (See item 3B of this report)

The Company violated Section 1308(f)(1)(A) of the New York Insurance Law by ceding substantially all or 100% of the net amount at risk for certain blocks of the Company's group accident and health business, referred to as Program Business, during the examination period without obtaining prior written approval of the Superintendent. (See item 3E of this report)

The Company violated Section 2117(a) of the New York Insurance Law when, under the guise of reinsurance, it effectively aided unauthorized insurers to engage in insurance activities that would otherwise require a license under New York Insurance Law. The examiner

recommends that the Company develop a cure for the violation of Section 2117(a) of the New York Insurance Law. (See item 3E of this report)

The Company violated Section 91.4(a)(2) of Department Regulation No. 33 by failing to maintain records with sufficient detail to show fully: (i) the system actually used for allocation of expenses; (ii) the actual basis of allocation; (iii) the actual monetary distribution of the respective items of expense and salaries to annual statement lines of business. (See item 4 of this report)

The Company violated Section 41.3(a) and (b) of Department Regulation No. 143 by failing to disclose in its advertising materials that receipt of accelerated death benefits may affect the insured's eligibility for public assistance programs and may have certain tax consequences. (See item 6A of this report)

The Company violated Section 3203(b)(1)(B) of the New York Insurance Law by using language stating that benefits will be limited if the insured commits suicide "while sane or insane" in its advertising literature for policy form 46002. (See item 6B of this report)

The Company violated Section 3207(b) of the New York Insurance Law by knowingly issuing life insurance on the lives of minors in excess of the limits permitted. (See item 6B of this report)

The Company violated Section 3203(a)(8)(H) of the New York Insurance Law by reducing the credit of additional amounts on certain policies with policy loans in excess of the 2% limit allowed under Section 3203(a)(8)(H) of the New York Insurance Law. (See item 6B of this report)

The Company violated Section 4235(h)(3) of the New York Insurance Law by paying rates of commission to brokers that exceeded the limits on file with the Department in connection with a number of group Employer Medical Stop-Loss ("EMSL") cases produced by BP, Inc. ("BP") during the examination period. (See item 6B of this report)

The Company violated Section 3211(b)(2) of the New York Insurance Law by disseminating premium notices that failed to contain required language pertaining to policy termination or lapse when the premium is not paid on or before the due date shown or within the specified grace period of the policy. (See item 6C of this report)

The Company violated Section 243.2(b) of Department Regulation No. 152 by failing to maintain billing cycle registers or similar documentation for the Life 70 policy administration system in order to demonstrate that the Company complied with Section 3211(a) of the New

York Insurance Law, as well as its own written procedures, with regard to the time frames that reminder notices and lapse or termination notices are generated from the policy administration system and mailed to policyholders. (See item 6C of this report)

The Company violated Section 4221(n-1)(3)(B)(iii) of the New York Insurance Law by failing to provide an option to purchase paid up insurance for its universal life policy form 46002. (See item 6C of this report)

The examiner recommends that the Company establish and maintain an independent, adequately resourced, and competently staffed internal audit function to provide management and the audit committee with ongoing assessments of the Company's risk management processes and the accompanying system of internal control. (See item 7 of this report)

The examiner recommends that the Company continue to develop a disaster recovery plan and a business continuity plan. (See item 8 of this report)

The Company violated Sections 243.2(b)(7) and 243.2(d) of Department Regulation No. 152 by failing to obtain and maintain workpapers and supporting detail records required to support the Company's filed annual statement with regard to the Company's group accident and health operations. (See item 9 of this report)

The examiner recommends that the Company revise its record retention plan to include an index of the records being retained, a description of the types of records being maintained, the method of retention, and the safeguards established to prevent alteration of the records. (See item 11 of this report)

## 2. SCOPE OF EXAMINATION

The prior examination was conducted as of December 31, 2000. This examination covers the period from January 1, 2001 through December 31, 2003. This was a limited scope examination which included: (i) a review or audit of certain targeted balance sheet items considered by this Department to require analysis, verification or description; (ii) a review of the market conduct activities of the Company and; (iii) a review or audit of the items noted in the following paragraph. The balance sheet items targeted for review were bonds, cash, contract loans, and reserves. As necessary, the examiner reviewed transactions occurring subsequent to December 31, 2003 but prior to the date of this report (i.e., the completion date of the examination).

The examiner utilized the National Association of Insurance Commissioners' Examiners Handbook or such other examination procedures, as deemed appropriate, in such review and in the review or audit of the following matters:

- Company history
- Management and control
- Corporate records
- Fidelity bond and other insurance
- Territory and plan of operation
- Market conduct activities
- Growth of Company
- Business in force by states
- Mortality and loss experience
- Reinsurance

The examiner reviewed the corrective actions taken by the Company with respect to violations and recommendations contained in the prior report on examination. The results of the examiner's review are contained in item 12 of this report.

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

### 3. DESCRIPTION OF COMPANY

#### A. History

The Company was incorporated as a stock life insurance company under the laws of New York on November 3, 1964 under the name of James Monroe Life Insurance Company, with authorized capital of \$800,000 consisting of 400,000 shares of stock with a par value of \$2 per share. On February 17, 1965, the Company issued an additional 100,000 shares, with a par value of \$2 per share, which increased the authorized capital to \$1,000,000.

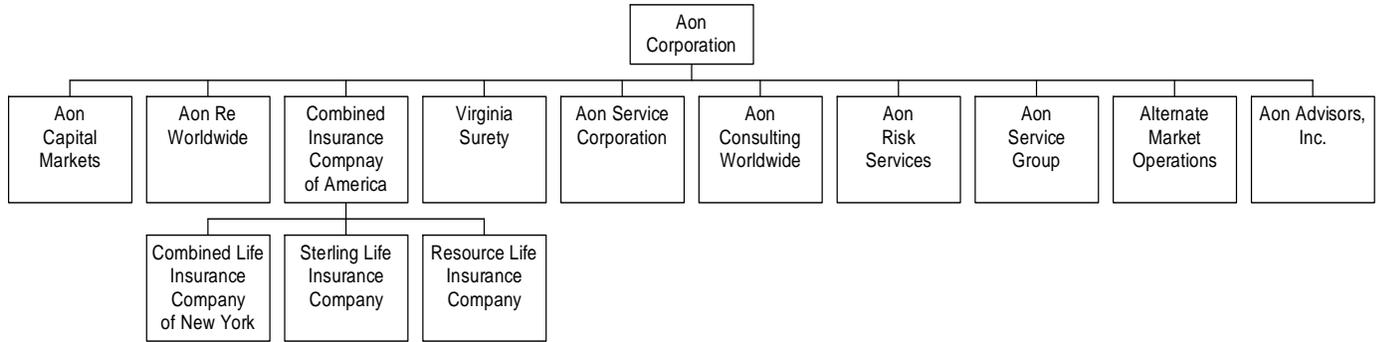
On May 12, 1971, all shares of authorized capital stock were purchased by Combined Insurance Company of America (“CICA”) for \$6.10 per share, for a total consideration of \$3,050,000. Of this amount, \$1,000,000 represented capital and \$2,050,000 represented paid-in and contributed surplus. The present name of the Company was adopted when the Company was purchased by CICA.

On December 9, 1982, the Company amended its charter to increase the par value of all outstanding shares to \$4, thereby increasing capital to \$2,000,000. At the same time, CICA increased the Company’s paid-in and contributed surplus to \$4,050,000. The Company’s gross paid in and contributed surplus at December 31, 2003 was \$4,060,296. This amount is unchanged from the prior examination period.

#### B. Holding Company

The Company is a wholly owned subsidiary of CICA, a specialty accident and health underwriter located in Chicago, Illinois. Effective May 30, 1980, CICA became a wholly owned subsidiary of Aon Corporation (“AC”), formerly Combined International Corporation, a Chicago-based holding company that comprises a family of insurance brokerage, consulting and underwriting subsidiaries.

An organization chart reflecting the relationship between the Company and significant entities in its holding company system as of December 31, 2003 follows:



The Company had 4 service agreements in effect during the examination period whereby services were either provided by the Company on behalf of affiliates or services were provided by affiliates on behalf of the Company.

<b>Type of Agreement</b>	<b>Effective Date</b>	<b>Provider(s) of Service(s)</b>	<b>Recipient(s) of Service(s)</b>	<b>Specific Service(s) Covered</b>	<b>Income/ (Expense)* For Each Year of the Examination</b>
Investment Management Agreement	June 9, 1992	Aon Advisors, Inc. ("Advisors")	The Company	Investment management and advisory services	2001 \$(441,000) 2002 \$(439,000) 2003 \$(439,000)
Administrative Services Agreement	January 1, 1987	CICA	The Company	Insurance administrative services performed on behalf of each other	2001 \$(1,777,106) 2002 \$(1,799,121) 2003 \$(1,812,998)
Administrative Services Agreement	January 1, 1987	The Company	CICA	Insurance administrative services performed on behalf of each other	2001 \$863,714 2002 \$484,477 2003 \$504,071
Administrative Services Agreement**	October 1, 1998	Aon Service Corporation ("ASC")	The Company	All corporate related services	2001 \$(872,665) 2002 \$(885,709) 2003 \$(896,877)

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

\*\* Agreement not filed with the Department

On January 15, 2004, the Company filed a revised tax allocation agreement between the Company, AC, and AC's subsidiary companies.

Section 1505 of the New York Insurance Law states, in part:

“(a) Transactions within a holding company system to which a controlled insurer is a party shall be subject to the following:

(1) the terms shall be fair and equitable;

(2) charges or fees for services performed shall be reasonable . . .

(d) The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period . . .

(2) reinsurance treaties or agreements;

(3) rendering of services on a regular systematic basis . . .”

The Company provided the examiners with an executed copy of a service agreement between the Company and ASC, effective October 1, 1998. As reflected in the service agreement table above the Company paid ASC \$872,665, \$855,709, and \$896,877 in 2001, 2002, and 2003, respectively, for the services provided. The service agreement between the Company and ASC was not filed with the Department.

The Company violated Section 1505(d)(3) of the New York Insurance Law by failing to notify the Superintendent in writing of its intention to enter into an agreement whereby an affiliate renders services to the Company on a regular and systematic basis.

As indicated in the service agreement table above, the Company has a filed service agreement in effect with CICA that provides for CICA to perform certain administrative insurance services for the Company. However, during the current examination period, certain additional services were transitioned to and are now performed by CICA, on behalf of the Company. Such services are not provided for under the filed service agreement. The Company was not charged by CICA for these services nor did the Company reimburse CICA. The services are enumerated below:

- Underwriting;
- Premium processing for business other than group accident and health;
- Billing services for all business other than group accident and health;

- Administration of group accident and health insurance business acquired from Reliance in addition to all new group accident and health policies written on the Company's paper since 2001;
- Customer service /"Virtual" call center services;
- Surrender processing;
- Contract or policy loan processing; and
- Processing Department Regulation No. 60 requests for information received from other licensees.

Similarly, the Company has a filed service agreement in effect with CICA that provides for the Company to perform certain administrative insurance services for CICA. However, the following additional services were provided by the Company to CICA during the examination period, but were not provided for under the filed service agreement. The Company did not bill CICA or receive reimbursement for the following services:

- Claims processing services for CICA individual accident and health claims;
- Premium processing services for group accident and health and individual high limit disability blocks of business administered by Combined Select Programs ("CSP"), a business unit of CICA that currently administers the Company's group accident and health operations;
- Account reconciliation services for CICA suspense accounts;
- Agent licensing services; and
- Customer service/"Virtual" call center services.

The Company violated Section 1505(a) of the New York Insurance Law by failing to: 1) reimburse CICA a reasonable amount for certain services provided on a regular and systematic basis; and 2) bill or charge CICA a reasonable amount for certain services that were provided on a regular and systematic basis.

The Company violated Section 1505(d)(3) of the New York Insurance Law by: 1) receiving certain services from CICA on a regular and systematic basis that were not provided for in the filed service agreement between the Company and CICA where CICA is the provider of services; and 2) providing certain services to CICA on a regular and systematic basis that were

not provided for in the filed service agreement between the Company and CICA where the Company is the provider of services.

The Company provided a copy of an executed quota share reinsurance agreement between CICA, CICA's affiliates, including the Company, and Security Life Insurance Company of America ("SLICA"), effective January 1, 2002. The agreement states, in part:

"This agreement is made and effective this 1<sup>st</sup> day of January, 2002 by and between Combined Insurance Company of America on behalf of itself and its affiliates and subsidiaries ('Company') and Security Life Insurance Company of America ('Reinsurer'). . ."

The business covered by this agreement is the group vision insurance produced and serviced by Cole Vision Services, Inc. ("CVS"). The agreement was not filed with the Superintendent.

The examiner recommends that the Company enter into a separate reinsurance agreement with CVS that does include any affiliates.

The claims servicing agreement between CICA, CICA's affiliates, including the Company, and Administrative Concepts, Inc. states, in part:

"This Claims Servicing Agreement . . . is made and entered into by and between Combined Insurance Company of America, an Illinois insurance company ("Insurer") *on behalf of itself and its affiliated companies* and Administrative Concepts, Inc., a licensed Third Party Administrator . . . this 1<sup>st</sup> day of September, 2001."

The claims servicing agreement covers a number of blanket student accident and sickness policies issued to colleges and universities in New York State by the Company. The claims servicing agreement was not filed with the Superintendent.

The examiner recommends that the Company enter into a separate claims servicing agreement with Administrative Concepts, Inc. that does not include any affiliates.

Schedule C, Part 1 of the filed service agreement among Virginia Life Insurance Company of New York ("VLONY"), the Company (referred to as "CLICNY" in the agreement), CICA and CICA's subsidiary and affiliate companies, effective January 1, 1987 states:

"Within 30 days after the end of each of the first three calendar quarters, CLICNY shall pay to CICA an amount equal to 25% of the total expenses charged under this Part for the preceding calendar year. Within 30 days after the end of the calendar year, CICA will provide CLICNY with a detailed report of the actual

charges to CLICNY for the entire calendar year. The report shall contain a listing of those centers by name which charged expenses to CLICNY, the total expenses of such cost center in the preceding calendar year and the percentage of each cost center's total expenses for the preceding calendar year which is represented by its charge to CLICNY. Within 30 days of receipt of such report, CLICNY shall make such payment as is necessary as to compensate CICA for all expenses charged during the calendar year."

Article 5 of the Investment Management Agreement by and between the Company (referred to as "CLICNY" in the agreement) and Advisors, effective June 9, 1992 states, in part:

"Compensation to ADVISORS. For ADVISORS' performance of the investment advisory services contemplated hereunder, CLICNY shall pay ADVISORS a sum, determined at the beginning of each calendar year during the term of this Agreement, and approved by CLICNY's Board of Directors or Investment Committee, representing a fair and reasonable allocation to CLICNY of ADVISORS' projected calendar-year investment management expenses. This sum shall be determined by ADVISORS by applying to ADVISORS' projected investment advisory expenses a percentage arrived at by taking into account the dollar amount of assets to be managed for CLCNY and all other CLICNY money to be invested for CLLICNY, and such other cost factors as are considered appropriate in determination a fair and reasonable cost allocation in accordance with the provisions of New York Insurance Department Regulation No. 33. The cost allocation hereunder to CLCNY however, shall not include, directly or indirectly, any portion of the investment management fees paid to ADVISORS by Aon Money Market Fund, Inc. or any other fund advised by ADIVORS, with respect to shares of any such fund purchased or sold by CLICNY. This dollar allocation of ADVISORS' investment management expenses to CLICNY shall be submitted at least annually, together with any necessary or appropriate adjustments thereto, for approval by CLICNY's Board of Directors or Investment Committee. CLICNY shall remit to ADVISORS one-fourth of the sum determined in accordance with the provisions of the preceding sentence by the 30<sup>th</sup> day following the close of each calendar quarter in March, June, September, and December in each calendar year during the term of this Agreement."

Article 1.02 of the Services Agreement by and between the Company (referred to as "COMPANY" in the agreement) and ASC (referred to as "PROVIDER" in the agreement) states the following, in part, with respect to payment for services provided under said agreement:

"Payment for Services. COMPANY shall pay PROVIDER a MONTHLY fee for the Services that are provided under Section 1.01 equal to the sum of the total Cost (as defined hereinafter) of PROVIDER providing such Services to COMPANY for the MONTH . . . COMPANY shall pay the MONTHLY fee within thirty (30) days after receipt of a Services invoice from PROVIDER."

A review of the holding company service agreements quoted above and related transactions revealed the following:

- The Company did not receive a detailed report from CICA of the actual charges to the Company at the end of each of the calendar years covered by the examination and the Company did not reimburse CICA for the difference between the actual cost of providing services and the quarterly estimated payments based upon the prior year's actual cost;
- Reimbursements for services provided under the service agreements between the Company and CICA and between the Company and ADVISORS were not made in a timely manner;
- Charges for services provided under the service agreement between the Company and ASC and between the Company and ADVISORS were settled with CICA and not directly with ASC and ADVISORS, respectively;
- The Company did not receive a monthly services invoice in accordance with the provisions of the executed service agreement with ASC; and
- The service agreement between the Company and ASC provides for monthly reimbursement, however, reimbursement was made to CICA on a quarterly basis.

The examiner recommends that the Company review its service agreements and revise them to accurately reflect the manner in which services are billed, how settlements are made and which affiliate is actually providing services. The examiner further recommends that the Company settle amounts due under holding company service agreements in a timely manner.

Note: With regard to the filed service agreement among VLONY, the Company, CICA and CICA's subsidiary and affiliate companies, effective January 1, 1987, a majority of the affiliated companies mentioned in the service agreement, including VLONY, are no longer within the Aon holding company system. Services formerly performed by VLONY are now provided by CICA under the administrative service agreement between the Company and CICA dated January 1, 1987 and indicated in the service agreement table.

### C. Management

The Company's by-laws provide that the board of directors shall be comprised of not less than nine directors. The number of directors will be increased to not less than 13 within one year following the end of the calendar year in which the corporation exceeds one and one-half billion dollars in assets. Directors are elected for a period of one year at the annual meeting of the

stockholders held in February of each year. As of December 31, 2003, the board of directors consisted of nine members. Meetings of the board are held quarterly.

The board members and their principal business affiliation, as of December 31, 2003, were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>	<u>Year First Elected</u>
Leonard A. Dopkins* Williamsville, NY	Certified Public Accountant Dopkins & Company	1993
Henry M. Gridley* Saratoga Springs, NY	Retired	1985
John J. Hogan Wheaton, IL	Controller Combined Life Insurance Company of New York	1999
Michael F. Hurd Clifton Park, NY	Vice President, Treasurer and Chief Administrative Officer Combined Life Insurance Company of New York	1999
Steven E. Lippai Highland Park, IL	Actuary Combined Life Insurance Company of New York	1993
Ronald D. Markovits Northbrook, IL	Vice President, Law and Corporate Secretary Combined Life Insurance Company of New York	1992
Richard F. Purcell* Lebanon, NJ	Retired	1971
Richard M. Ravin Northbrook, IL	Chairman, President and Chief Executive Officer Combined Life Insurance Company of New York	1985
Noel Wilner* Northbrook, IL	President CBIZ Rootberg Business Services, Inc.	2003

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

The examiner's review of the minutes of the meetings of the board of directors and its committees thereof indicated that Director Lippai failed to attend a majority of the meetings. Members of the board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Company.

The examiner recommends that the Company replace those directors who fail to attend a majority of the meetings.

The following is a listing of the principal officers of the Company as of December 31, 2003:

<u>Name</u>	<u>Title</u>
Richard M. Ravin	Chairman, President and Chief Executive Officer
Michael F. Hurd*	Vice President, Treasurer and Chief Administrative Officer
Jerome I. Baer	Vice President – Taxes
Michael A. Conway	Vice President – Investments
Steven E. Lippai	Actuary
Harvey N. Medvin	Vice President
Ronald D. Markovits	Vice President, Law and Corporate Secretary
John J. Hogan	Controller
Leonard Karpowich	Vice President- Security Officer

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

#### D. Territory and Plan of Operation

The Company is authorized to write life insurance, annuities and accident and health insurance as defined in paragraphs 1, 2 and 3 of Section 1113(a) of the New York Insurance Law. The Company has never engaged in writing annuity business.

The Company is licensed to transact business in three states, namely Florida, Illinois, and New York. In 2003, 95.8% of life premiums and 98.7% of accident and health premiums were received from New York. Policies are written on a non-participating basis.

The principal lines of business sold during the examination period were individual life and individual accident and health. The following life products were sold during the examination period:

Life Plus - Issue ages 0-54. A whole life policy which has an accelerated death benefit, guaranteed issue without evidence of insurability and premiums payable for 25 years.

Juvenile Term Life – Issue ages 14 days to 19 years. A single premium continues the policy until the insured reaches age 24.

Golden Advantage – Issue ages 55-70. A limited life insurance benefit is paid if death occurs within two years. Face amount is \$3,000 or \$5,000.

Golden Life Plus - Issue ages 55-75. A whole life insurance policy which has an accelerated death benefit and options to increase the amount of insurance. Face amounts of \$3,000, \$5,000 or \$10,000 are available.

The following accident and health products were sold during the examination period:

Hospital Emergency Recovery and Outpatient – Issue ages 0-69. Pays benefits for hospitalization, intensive care, emergency room and physician’s treatment for accident related injuries.

Sickness Income Policy – Issue ages 16-64. Pays a flat amount per day for disability income protection due to sickness. Policy is guaranteed renewable.

Sickness Hospital Indemnity Plan (“HIP”) - Issue ages 0-64. Pays a flat amount for each day the insured is confined to a hospital due to sickness. Policy is guaranteed renewable.

Long Term Disability – Issue ages 18-59. Benefits are for accident or sickness. Pays a basic and secondary amount. There is an elimination period and a maximum benefit period. Policy is guaranteed renewable.

Cancer Assistance – Issue ages 18-64. Pays benefits for hospitalization, surgery, anesthesia, radiation and chemotherapy treatment for cancer related illnesses and includes a preventative care benefit.

Accidental Death and Dismemberment – Issue ages 0-69. Pays a benefit for certain common carrier accidents and any accident referred to in the policy. The policy is guaranteed renewable.

Long Term Care – Issue ages 18-64. Covers some of the costs of a variety of long-term care options such as nursing home, assisted living facilities, medical home care, non-medical home care and adult day care. It also includes a bed reservation benefit, respite and hospice care, emergency response system, caregiver training, and a cost-of-living option.

The Company focuses on the sale of individual accident and health policies, however, the Company also sells small face life insurance policies. The Company primarily markets its individual life and health products on a general agency basis. The Company’s group accident and health products are sold through managing general agents/underwriters. The targeted market for the Company’s products are lower middle income and working class groups in urban areas and farmers and small business owners throughout New York State. The sales force works off of the existing renewal base while collecting renewal premiums in the field for existing policies and

conducting “cold calls”, particularly for disability income products. Life insurance and sickness policies are sold as follow-up policies to existing disability income policy customers.

Effective August 1, 2000, CICA coinsured and purchased the renewal rights, via a coinsurance agreement, to the Accident & Health Division business of Reliance National Insurance Company (“Reliance”). The policies covered under the coinsurance agreement were primarily blanket policies covering student health and accident risks, business travel and foreign travel accident and health risks, individual disability income, group employer stop loss, individual short-term medical and group association major medical plans. The coinsurance agreement between Reliance and CICA contemplated that over time, the Reliance policies, as they expired, would be renewed or rewritten by CICA or the Company as the direct issuing insurer. However, on October 3, 2001, the Commonwealth Court of Pennsylvania placed Reliance into liquidation before all of the coinsured business was re-written/renewed with CICA and the Company as the issuing insurers.

As a result of the Order of Liquidation placed on Reliance, Reliance, CICA, the Company, and the National Organization of Life and Health Insurance Guaranty Association entered into a settlement agreement on October 31, 2001 for the assumption of the policies covered under the coinsurance agreement which provided for the following:

- CICA and the Company would assume the coinsured business as of October 3, 2001;
- CICA and the Company would issue assumption certificates;
- CICA and the Company would seek necessary regulatory approval for the assumption of the coinsured business; and
- the coinsurance agreement would terminate on the date that CICA’s assumption of all the policies that make up the coinsured business is complete.

Pursuant to CICA purchasing renewal rights and acquiring blocks of group student accident and health business from Reliance in 2000, the Company sought and later obtained approval from the Department for blanket student accident and sickness insurance policy forms on August 17, 2001. After August 2001, all New York blanket student accident and sickness policyholders, for the 2001-2002 academic year and forward, were issued a Company policy. The insurance is marketed to colleges and universities in New York State solely through insurance brokers. The coverage is designed to supplement parents’ major medical coverage and to provide coverage for students with no health insurance. Colleges and universities can purchase their coverage on an accident only or combined accident and sickness basis. The

blanket student accident and health block is the core business for Combined Select Programs (“CSP”), a business unit of CICA that currently administers the Company’s group accident and health operations. The Company retains all of the risk for this block of group accident and health business. The maximum policy limit for the blanket student accident and sickness business written in New York is \$250,000 per insured. The Company had approximately \$18.5 million of annualized in-force premiums through 49 colleges in New York for the 2003-2004 academic year. The Company predicts modest growth of 15% annually for this block of business.

In 2001, the Company commenced writing a block of K-12 student accident only insurance business through a managing general underwriter (“MGU”), Professional Underwriters. The policy provides accident insurance for insureds while attending a primary, elementary, secondary or collegiate school or involved in a school sponsored activity. Travel associated with attending the school or attending school-sponsored activities is also covered. The policy is marketed through licensed agents and brokers. The risk for this small block of business is also retained entirely by the Company. The maximum exposure written per insured life is \$25,000.

The remainder of the Company’s group accident and health business is referred to as “Program Business”. The Program Business is produced and maintained by a number of MGUs. The Program Business includes:

1. Employer Medical Stop-Loss (“EMSL”) – Beginning in 2002, the Company wrote EMSL (excess loss) insurance through two MGUs, Elite Brokerage Services, Inc. (“Elite”) and BP, Inc. (“BP”). The coverage is designed to offer insurance to employer groups who self fund their employee medical plan in order to protect themselves from catastrophic losses. Benefits under the plan are payable to the employer. A strategic corporate business decision was made in 2002 to discontinue (non-renew) all EMSL business as the Company’s investment analysts felt that the business was too volatile. The Company ceased writing new business with Elite effective January 1, 2003; this business is currently in runoff. Business produced by Elite is ceded (100%) to a number of reinsurers through a pooled participation agreement. However, the Company allowed BP to continue writing policies after January 1, 2003. BP is a member of the Fiserv, Inc. holding company system that

- owns its own captive insurer, Sheridan Re. The Company cedes 100% of the risk on business produced by BP to Sheridan Re, an unauthorized reinsurer.
2. Individual High Limit Disability (“HLD”) – Beginning in 2001, the Company started writing individual single premium HLD policies in New York through Hanleigh Management Inc. and Hanleigh General Agency, collectively the MGU (“Hanleigh”). These were weekly disability policies issued to individuals that were not covered by workers compensation insurance from employers. The Company ceased writing new HLD business effective January 1, 2003 and the line of business remains in runoff until all policies are expired, the last policy expires in 2006. The Company cedes 100% of the risk associated with this block of business to a number of Lloyds’ Syndicates.
  3. Group Vision Care Insurance – In 2002, the Company started writing group vision care insurance which is produced and administered by Cole Vision Services, Inc. (“CVS”), a vision service and products supplier that owns a number of vision service and product stores throughout the United States. The Company cedes 100% of the risk for its group vision care insurance to Security Life Insurance Company of America (“SLICA”), an unauthorized reinsurer.

#### E. Reinsurance

As of December 31, 2003, the Company had reinsurance treaties in effect with 21 companies, of which 16 were authorized or accredited. The Company’s life business is reinsured on a coinsurance basis and the accident and health business is reinsured on a yearly renewable term basis. Reinsurance is provided on an automatic basis.

The maximum retention limit for individual life contracts is \$100,000. The total face amount of life insurance ceded as of December 31, 2003, was \$76,805,000, which represents 8.9% of the total face amount of life insurance in force. Reserve credit taken for reinsurance ceded to unauthorized companies, totaling \$27,613,638, was supported by trust agreements.

The Company entered into the following new reinsurance agreements during the examination period:

1. Effective January 1, 2001, the Company entered into a quota share reinsurance contract with a number of reinsurers whereby the Company cedes, on an

automatic basis, 87.5% of the Company's gross liability for all specific and aggregate EMSL plans produced and serviced by Elite and Elite Underwriting Services.

2. In addition to the aforementioned agreement, effective January 1, 2001, the Company entered into a second quota share reinsurance contract with QBE Reassurance Corporation, whereby the Company cedes 100% of the liability in excess of \$1 million to a maximum of \$10 million for each covered person not covered under the participation agreement described above, for all specific and aggregate EMSL plans produced and serviced by Elite and Elite Underwriting Services.
3. Effective June 2001, the Company entered into a reinsurance agreement with Reassure America Life Insurance Company ("Reassure America") whereby the Company ceded, on a 100% coinsurance basis, a closed block of individual universal life business issued by Life of Virginia and assumed by the Company, and a closed block of individual adjustable life policies issued by the Company. The business relates to New York risks only and represents less than 15% of the Company's total reserves. Reassure America also administers the business on behalf of the Company. This agreement was approved by the Department.
4. Effective June 2001, the Company entered into 3 reinsurance agreements with certain underwriting members of Lloyds, whereby the Company cedes 100% of the risks under certain HLD policies produced and serviced by Hanleigh. These accident and sickness policies include personal accident and sickness contingency coverage. Hanleigh has binding authority with regard to the reinsurance contract. Reinsurance is provided on an automatic basis. Glenrand Limited acts as the reinsurance intermediary for all business covered under the agreement. This business was originally acquired from Reliance Insurance Company and is currently in runoff.
5. Effective January 1, 2002, the Company entered into an EMSL insurance quota share reinsurance contract with Sheridan Re, an unauthorized reinsurer, whereby the Company cedes 100% quota share participation of the Company's gross

liability for all EMSL insurance produced and serviced by BP. Reinsurance is provided on an automatic basis.

6. Effective January 1, 2002, the Company entered into a group vision quota share reinsurance contract with SLICA, an unauthorized reinsurer, whereby the Company cedes 100% quota share of the Company's gross liability for all group vision insurance produced and serviced by CVS, Inc. Reinsurance is provided on an automatic basis.

Section 1308(f)(1) of the New York Insurance Law states, in part:

“Unless the superintendent permits:

(A) No domestic life insurance company shall (i) reinsure its whole risk on any individual life or joint lives, or (ii) reinsure a substantial portion of its life insurance in force. . . .”

The examiner's review of the aforementioned reinsurance agreements revealed that during the examination period the Company ceded substantially all or 100% of the net amount at risk for certain blocks of the Company's group accident and health business, referred to as Program Business, under the reinsurance agreements described in items 4, 5 and 6 above. The Company did not submit nor receive the prior written approval of the Superintendent for these agreements.

The Company violated Section 1308(f)(1)(A) of the New York Insurance Law by ceding substantially all or 100% of the net amount at risk for certain blocks of the Company's group accident and health business, referred to as Program Business, during the examination period without obtaining prior written approval of the Superintendent.

Section 2117(a) of the New York Insurance Law states:

“No person, firm, association or corporation shall in this state act as agent for any insurer . . . which is not licensed or authorized to do an insurance . . . business in this state, in the doing of any insurance . . . business in this state or in soliciting, negotiating or effectuating any insurance . . . or shall in this state act as insurance broker in soliciting, negotiating or in any way effectuating any insurance . . . or in placing risks with, any such insurer . . . or shall in this state in any way or manner aid any such insurer . . . in effecting any insurance . . .”

The policies reinsured under the aforementioned reinsurance treaties described in items 5 and 6 above, were issued with the understanding that 100% of the risk would be reinsured with unauthorized insurers. The business is being produced and serviced by a third party MGU. The Company does not retain any of the risk for the policies nor does it participate in the servicing of any of the policies. Such actions constitute acting as an agent for an unauthorized insurer in the doing of an insurance business and aiding an unauthorized insurer in the effectuating of insurance and the placement of risks.

The Company violated Section 2117(a) of the New York Insurance Law when, under the guise of reinsurance, it effectively aided unauthorized insurers to engage in insurance activities that would otherwise require a license under New York Insurance Law. The examiner recommends that the Company develop a plan to cure the violation of Section 2117(a) of the New York Insurance Law.

#### 4. SIGNIFICANT OPERATING RESULTS

Indicated below is significant information concerning the operations of the Company during the period under examination as extracted from its filed annual statements. The information has been subjected to a limited audit or review as indicated in this report's Scope of Examination. Failure of items to add to the totals shown in any table in this report is due to rounding.

The following table indicates the Company's financial growth (decline) during the period under review:

	December 31, <u>2000</u>	December 31, <u>2003</u>	Increase (Decrease)
Admitted assets	<u>\$289,984,873</u>	<u>\$286,082,065</u>	<u>\$(3,902,808)</u>
Liabilities	<u>\$239,622,646</u>	<u>\$238,285,498</u>	<u>\$(1,337,148)</u>
Common capital stock	\$ 2,000,000	\$ 2,000,000	\$ 0
Gross paid in and contributed surplus	4,060,296	4,060,296	0
Unassigned funds (surplus)	<u>44,301,931</u>	<u>41,736,272</u>	<u>(2,565,659)</u>
Total capital and surplus	<u>\$ 50,362,227</u>	<u>\$ 47,796,568</u>	<u>\$(2,565,659)</u>
Total liabilities, capital and surplus	<u>\$289,984,873</u>	<u>\$286,082,066</u>	<u>\$(3,902,807)</u>

The Company's invested assets as of December 31, 2003 were mainly comprised of bonds (79.8%) and cash and short-term investments (12.7%).

The Company's entire bond portfolio, as of December 31, 2003, was comprised of investment grade obligations.

During 2001, the Company changed its method of calculating the accident and health additional policy reserve from the net level method to the two-year preliminary term reserve method. The impact of the change to the Company's surplus was an increase of \$26,758,000. Accident and health reserves decreased by approximately the same amount.

Also in 2001, policy liabilities decreased by approximately \$29 million and policy loan assets decreased by approximately \$5 million as a result of the 100% coinsurance agreement

with Reassure America for a closed block of individual universal life and individual adjustable life policies.

The following is the net gain (loss) from operations by line of business after federal income taxes but before realized capital gains (losses) reported for each of the years under examination in the Company's filed annual statements:

	<u>2001</u>	<u>2002</u>	<u>2003</u>
Ordinary life insurance:	\$ <u>4,808,912</u>	\$ <u>4,300,661</u>	\$ <u>3,489,146</u>
Credit life	\$ <u>3,341</u>	\$ <u>31,111</u>	\$ <u>0</u>
Accident and health:			
Group	\$ (31,928)	\$ 931,331	\$ 1,954,101
Credit	(6,574)	80,244	0
Other	<u>11,069,724</u>	<u>4,529,515</u>	<u>8,042,156</u>
Total accident and health	<u>\$11,031,222</u>	<u>\$5,541,090</u>	<u>\$ 9,996,257</u>
Total	<u>\$15,843,475</u>	<u>\$9,872,862</u>	<u>\$13,485,403</u>

The credit life and credit accident and health lines of business were closed blocks of business that ran off the Company's books in 2001.

The Company started writing group accident and health business in late 2001. Premium that was collected by the Company in 2001 was not booked until 2002 due to the World Trade Center disaster on September 11, 2001. At that time the Company's group operations were headquartered in one of the World Trade Center tower buildings. Key personnel as well as a significant amount data were lost during the disaster.

Between 2001 and 2002, the significant decrease in net gains from operations for the individual accident and health – other line of business was primarily attributable to an \$8.8 million increase in policy related benefits in 2002 as compared to 2001 and a \$3.2 million increase in additional reserves that were established by the Company for potential deficiencies related to its failure to meet minimum loss ratio standards associated with Department Regulation No. 62 with regard to its HIP product and its HERO product.

Between 2002 and 2003, the significant increase in the net gains from operations for the individual accident and health – other line of business was primarily attributable to increased

revenue or sales of the Company's cancer indemnity and sickness income policies, a decrease in policyholder related benefits, a \$1 million decrease in general expenses, and a \$1.7 million decrease in additional reserves related to minimum loss ratio standards.

Section 91.4(a) of Department Regulation No. 33 states, in part:

“ . . . (2) Each life insurer shall maintain records with sufficient detail to show fully:

- (i) the system actually used for allocation of income and expenses;
- (ii) the actual bases of allocation;
- (iii) the actual monetary distribution of the respective items of income, salaries, wages, expenses, and taxes to . . .
- (c) annual statement lines of business,
- (d) companies, and
- (e) a recapitulation and reconciliation of items (a), (b), (c), and (d) with the insurer's books of account and annual statement.

(3) Such records shall be classified and indexed in such form as to permit ready identification between the item allocated and the basis upon which it was allocated, and shall be maintained in such a manner as to be readily accessible for examination . . .”

Schedule C, Part I and Schedule D, Part II of the filed service agreement among Virginia Life Insurance Company of New York, the Company, and CICA and their subsidiary and affiliate companies, effective January 1, 1987, describes the basis of allocation to be used for services provided between CICA and the Company where direct reimbursement is not appropriate. The Company was unable to provide documentation to support the basis or method of allocation for each type of expense between lines of business or members in the holding company system during the examination period.

The Company violated Section 91.4(a)(2) of Department Regulation No. 33 by failing to maintain records with sufficient detail to show fully: (i) the system actually used for allocation of expenses; (ii) the actual basis of allocation; and (iii) the actual monetary distribution of the respective items of expense and salaries to annual statement lines of business and companies.

## 5. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, capital, surplus and other funds as of December 31, 2003, as contained in the Company's 2003 filed annual statement, a condensed summary of operations and a reconciliation of the capital and surplus account for each of the years under review. These financial statements have been subjected to a limited audit or review as indicated in this report's Scope of Examination.

### A. ASSETS, LIABILITIES, CAPITAL, SURPLUS AND OTHER FUNDS AS OF DECEMBER 31, 2003

#### Admitted Assets

Bonds	\$228,278,269
Stocks:	
Common stocks	430,721
Cash and short term investments	34,741,796
Contract loans	6,097,772
Investment income due and accrued	3,434,059
Premiums and considerations:	
Uncollected premiums and agents' balances	4,537,461
Deferred premiums, agents' balances and installments	3,850,449
Net deferred tax asset	3,983,801
Electronic data processing equipment and software	21,599
Receivable from parent, subsidiaries and affiliates	416,000
Funds due under reinsurance treaty	135,343
Premiums in course of collection	140,374
Amount withheld or retained by company	<u>14,421</u>
 Total admitted assets	 <u>\$286,082,065</u>

Liabilities, Capital, Surplus and Other Funds

Aggregate reserve for life policies and contracts	\$ 73,826,253
Aggregate reserve for accident and health policies	85,716,155
Policy and contract claims:	
Life	1,102,797
Accident and health	26,813,619
Premiums and annuity considerations for life and accident and health policies and contracts received in advance	786,197
Policy and contract liabilities:	
Interest maintenance reserve	9,178,048
General expenses due or accrued	3,822,705
Taxes, licenses and fees due or accrued	1,275,489
Federal and foreign income taxes	1,927,123
Amounts held for agents' account	935,454
Remittances and items not allocated	717,924
Miscellaneous liabilities:	
Asset valuation reserve	177,978
Reinsurance in unauthorized companies	91,023
Payable for securities	933,208
Other policyholder liabilities	30,800,000
Escheats	<u>181,525</u>
 Total liabilities	 <u>\$238,285,498</u>
 Common capital stock	 \$2,000,000
Gross paid in and contributed surplus	4,060,296
Unassigned funds (surplus)	<u>41,736,272</u>
 Total capital, surplus and other funds	 <u>\$ 47,796,568</u>
 Total liabilities, capital, surplus and other funds	 <u>\$286,082,066</u>

Other policyholder liabilities represent the potential deficiencies related to New York minimum loss ratio requirements. As of December 2003 the liabilities were established for two products, \$25.8 million for the HIP product and \$5 million for the HERO product.

B. CONDENSED SUMMARY OF OPERATIONS

	<u>2001</u>	<u>2002</u>	<u>2003</u>
Premiums and considerations	\$75,562,020	\$126,086,440	\$132,963,723
Investment income	19,315,152	14,659,802	10,911,124
Commissions and reserve adjustments on reinsurance ceded	247,972	1,748,587	3,249,447
Miscellaneous income	<u>26,172</u>	<u>0</u>	<u>0</u>
Total income	<u>\$95,151,316</u>	<u>\$142,494,829</u>	<u>\$147,124,294</u>
Benefit payments	\$45,252,471	\$ 65,258,147	\$ 60,581,093
Increase in reserves	(21,320,283)	9,450,177	13,067,151
Commissions	11,853,285	16,686,225	17,244,941
General expenses and taxes	28,259,484	28,889,967	25,649,695
Increase in loading on deferred and uncollected premium	248,887	(440,473)	(263,872)
Other policyholder liabilities	<u>2,800,000</u>	<u>6,000,000</u>	<u>4,300,000</u>
Total deductions	<u>\$67,093,844</u>	<u>\$125,844,043</u>	<u>\$120,579,008</u>
Net gain (loss)	\$28,057,472	\$ 16,650,786	\$ 26,545,286
Dividends	0	0	0
Federal and foreign income taxes incurred	<u>12,222,997</u>	<u>6,777,924</u>	<u>13,059,884</u>
Net gain (loss) from operations before net realized capital gains	\$15,834,475	\$ 9,872,862	\$ 13,485,402
Net realized capital gains (losses)	<u>(2,153,342)</u>	<u>(2,932,443)</u>	<u>20,766</u>
Net income	<u>\$13,681,133</u>	<u>\$ 6,940,419</u>	<u>\$ 13,506,168</u>

C. CAPITAL AND SURPLUS ACCOUNT

	<u>2001</u>	<u>2002</u>	<u>2003</u>
Capital and surplus, December 31, prior year	\$ <u>50,362,227</u>	\$ <u>68,809,128</u>	\$ <u>40,218,579</u>
Net income	\$ 13,681,133	\$ 6,940,419	\$13,506,168
Change in net unrealized capital gains (losses)	1,880,453	234,706	(4,727)
Change in net deferred income tax	0	2,675,010	5,694,590
Change in non-admitted assets and related items	7,940	(3,041,830)	(5,011,224)
Change in liability for reinsurance in unauthorized companies	0	(1,034,157)	943,134
Change in reserve valuation basis	26,758,039	0	0
Change in asset valuation reserve	(280,664)	1,798,949	(49,952)
Cumulative effect of changes in accounting Principles	0	3,836,354	0
Dividends to stockholders	(23,600,000)	(40,000,000)	(7,500,000)
Net change in capital and surplus	\$ <u>18,446,901</u>	\$ <u>(28,590,549)</u>	\$ <u>7,577,989</u>
Capital and surplus, December 31, current year	\$ <u>68,809,128</u>	\$ <u>40,218,579</u>	\$ <u>47,796,568</u>

## 6. MARKET CONDUCT ACTIVITIES

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

### A. Advertising and Sales Activities

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

Section 41.3 of Department Regulation No. 143 states, in part:

“ . . . (a) all advertising material shall include a statement that receipt of the accelerated death benefits may affect eligibility for public assistance programs;  
(b) all advertising material shall include a statement that receipt of the accelerated death benefits may be taxable . . . ”

The Company presented advertising materials that did not provide the warnings specified in Sections 41.3(a) and (b) of Department Regulation No. 143.

The Company violated Section 41.3(a) and (b) of Department Regulation No. 143 by failing to disclose in its advertising materials that receipt of accelerated death benefits may affect the insured's eligibility for public assistance programs and may have certain tax consequences.

### B. Underwriting and Policy Forms

The examiner reviewed a sample of new underwriting files issued during the examination period and the applicable policy forms.

Section 3203(b)(1) of the New York Insurance Law states, in part:

“A life insurance policy delivered or issued for delivery in this state may exclude or restrict liability in the event of death occurring while the insured is resident in a specified foreign country or countries, but shall not

contain any provision excluding or restricting liability in the event of death caused in a certain specified manner, except as a result of . . .  
(B) suicide within two years from the date of issue of the policy . . .”

Department Circular Letter No. 4 (1963) advises that:

“Any suicide exclusion provision shall not include the words: ‘While sane or insane’. This prohibition does not apply to additional benefits in the event of death by accident.”

The Company acknowledged that the advertising brochure for policy form 46002 was not consistent with Section 3203(b)(1)(B) of the New York Insurance Law with respect to the suicide exclusion. The brochure states that the benefits will be limited if the insured commits suicide “while sane or insane”. Department Circular Letter No. 4 (1963), paragraph II.I.1 prohibits the use of that phrase in New York policies.

The Company violated Section 3203(b)(1)(B) of the New York Insurance Law by using language stating that benefits will be limited if the insured commits suicide “while sane or insane” in its advertising literature for policy form 46002.

The examiner recommends that the Company revise the brochure to exclude the words, “while sane or insane” in order to comply with Section 3203 of the New York Insurance Law.

Section 3207(b) of the New York Insurance Law states:

“An insurer may deliver or issue for delivery in this state a policy or policies of life insurance upon the life of a minor under the age of fourteen years and six months, provided that such policy or policies are effectuated by a person or persons having an insurable interest in the life of such minor or by a person or persons upon whom such minor is dependent for support and maintenance and provided further that an insurer shall not knowingly issue such a policy or policies for an amount which, together with the amount of life insurance under any other policy or policies then in force upon the life of such minor, is in excess of the limit of twenty-five thousand dollars or the limit of fifty per centum or the limit of twenty-five per centum in the case of a minor under the age of four years and six months of the amount of life insurance in force upon the life of the person effectuating the insurance at the date of issue of the policy on the life of such minor, whichever limit is the greater, and any amount of life insurance on the life of such minor not in excess of such limit when issued shall not be deemed to be in excess thereof by reason of any reduction

thereafter in the amount of life insurance in force upon the life of the person effectuating the insurance.”

A sample of policies issued on the lives of minors under the age of fourteen and one-half years was reviewed. Based upon evidence contained in the underwriting files, in 6 out of the 9 cases reviewed the Company knowingly issued policies on the lives of minors that were in excess of the limits allowed by Section 3207(b) of the New York Insurance Law.

The Company violated Section 3207(b) of the New York Insurance Law by knowingly issuing life insurance on the lives of minors in excess of the limits permitted.

Section 3203(a) of the New York Insurance Law states, in part:

“All life insurance policies, except as otherwise stated herein, delivered or issued for delivery in this state, shall contain in substance the following provisions, or provisions which the superintendent deems to be more favorable to policyholders . . .

(8)(H) any policy which provides for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter may also provide that if any indebtedness is owed to the insurer on any part of the loan value which would otherwise be credited with additional amounts, such additional amounts may be reduced so that the total amounts credited on such part are so credited at a rate that is up to two percent per annum less than the applicable loan interest rate charged or at such other rate as the superintendent, upon the insurer's demonstrating justification therefor, may allow . . .”

The interest rate to be charged on loans is 6% in advance. Cash values impaired by loans are credited at 4%. A 6% rate charged in advance is equivalent to an effective rate of 6.383%, resulting in a spread of 2.383%.

The Company violated Section 3203(a)(8)(H) of the New York Insurance Law by reducing the credit of additional amounts on certain policies that had policy loans by 2.383%, which exceeds the 2% limit allowed under Section 3203(a)(8)(H) of the New York Insurance Law.

Section 4235(h) of the New York Insurance Law states, in part:

“(1) Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of such fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer, other than as agent or broker to any individuals, firms or corporations pertaining to such class of business, whether transacted within or without the state. . .

(3) No insurer shall issue any policy of group accident, group health or group accident and health insurance the premium rate under which for the first policy year is less than that determined by the schedules of such insurer as then on file with the superintendent; nor shall it pay to the agent or agents or to a broker or brokers for the solicitation or sale of such policy or for any other purpose related to such policy any commission, compensation or other fees or allowances in excess of that determined on the basis of the schedules of such insurer as then on file with the superintendent; nor shall such insurer pay for services pertaining to the service or administration thereof to any individual, firm or corporation any fees, commissions or allowances in excess of that determined on the basis of the schedules of such insurer as then on file with the superintendent or for such services not rendered in behalf of such insurer; provided, however, that nothing contained herein shall apply to or affect the computation of dividends or experience rating credits. . . .”

The examiner’s review of a sample of group underwriting files, detailed claim, premium, and reinsurance bordereaux and statement of account detail records related to group EMSL cases that were produced by BP (“program manager”) during the examination period revealed that in a number of instances, the Company paid brokers a commission rate between 14.75% and 15%. This rate exceeded the 12.5% commission rate on file with the Department.

The Company violated Section 4235(h)(3) of the New York Insurance Law by paying rates of commission to brokers that exceeded the limits on file with the Department in connection with a number of group EMSL cases produced by BP during the examination period.

### C. Treatment of Policyholders

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

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

“(a)(1) No policy of life insurance or non-cancellable disability insurance delivered or issued for delivery in this state, and no life insurance certificate delivered or issued for delivery in this state by a fraternal benefit society, shall terminate or lapse by reason of default in payment of any premium, installment, or interest on any policy loan in less than one year after such default, unless a notice shall have been duly mailed at least fifteen and not more than forty-five days prior to the day when such payment becomes due. A separate notice shall not be required for insurance that is supplemental to a policy of life insurance. . .

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

Section 243.2(b) of Department Regulation No. 152 states, in part:

“Except as otherwise required by law or regulation, an insurer shall maintain:

(1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this part. A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to subdivision (a) of Section 243.3 of this Part. A policy record shall include . . .

(iii) The contract or policy forms issued including the declaration pages, endorsements, riders, and termination notices of the contract or policy. Binders shall be retained if a contract or policy was not issued . . .

(8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review . . . .”

The examiner reviewed specimen premium notices mailed to in-force life and disability income policyholders in 2003. The examiner's review of the premium notices generated from the Life 70 and LGL policy administration systems revealed that these notices failed to contain a statement indicating that unless such payment is made on or before the date when due or within the specified grace period thereafter, the policy shall terminate or lapse except as to the right to any cash surrender value or nonforfeiture benefit.

Additionally, the examiner selected a number of life policies that lapsed during the examination period for nonpayment of premium. The Company was asked to provide evidence that the Company generated and mailed the premium due notice, past due notice, and lapse notice to the policyowner in accordance with the Company's written procedures. For the sample of life lapse transactions selected, the Company was unable to provide evidence that: 1) the Company sent the policyholder the premium notice in accordance with Section 3211(a)(1) of the New York Insurance Law; 2) the Company sent the policyholder a reminder notice in accordance with its own written procedures; and 3) the Company sent the policyholder a lapse (or termination) notice stating that coverage under their policy or contract was no longer in effect due to non-payment of premium in accordance with their own written procedures.

The Company violated Section 3211(b)(2) of the New York Insurance Law by disseminating premium notices that failed to contain required language pertaining to policy termination or lapse when the premium is not paid on or before the due date shown or within the specified grace period of the policy.

The Company violated Section 243.2(b) of Department Regulation No. 152 by failing to maintain billing cycle registers or similar documentation for the Life 70 policy administration system in order to demonstrate that the Company complies with Section 3211(a) of the New York Insurance Law, as well as its own written procedures, with regard to the time frames that reminder notices and lapse or termination notices are generated from the policy administration system and mailed to policyholders.

Section 4221(n-1)(3) of the New York Insurance Law states, in part:

“A policy that meets the requirements of this subsection must provide for cash surrender values that meet the requirements of either subparagraph (A) or subparagraph (B) and comply with the provisions of subparagraphs (C) and (D) of this paragraph . . .

(B) Cash surrender values shall be deemed to meet the requirements of this subparagraph, if the following conditions are met . . .

(iii) The policy shall provide that at least once each policy year the policyholder has the option to apply the portion of the cash surrender value necessary to provide an amount of guaranteed paid-up life insurance at least as great as the lesser of (I) and (II), where (I) is the amount of paid-up life insurance provided by applying the cash surrender value to provide such paid-up insurance, computed on the basis of an interest rate (not less than four percent) guaranteed in the policy for this purpose, and a mortality basis (not less favorable to the policyholder than the mortality basis specified for an insured not medically underwritten in item (iv) of subparagraph (A) of this paragraph) guaranteed in the policy for this purpose, and (II) is the amount of paid-up life insurance such that the amount at risk on the paid-up insurance is the same as the amount at risk under the policy. If the option is elected, the portion of the cash surrender value not applied to provide the paid-up life insurance shall be paid to the policyholder. The guaranteed paid-up life insurance benefit may be provided under the policy or by means of a separate single premium life insurance policy issued by the company or an affiliate or subsidiary thereof. For purposes of this item, the term "cash surrender value" is after reduction for outstanding loans or other amounts due under the policy. . . .”

As a result of the Company electing Section 4221(n-1)(3)(B) of the New York Insurance Law for the provision of cash surrender values on universal life policies, the policy must provide an option to purchase paid up insurance that fully complies with Section 4221(n-1)(3)(B)(iii) of the New York Insurance Law. The Company failed to provide an option to purchase paid up insurance that fully complies with Section 4221(n-1)(3)(B)(iii) of the New York Insurance Law.

The Company violated Section 4221(n-1)(3)(B)(iii) of the New York Insurance Law by failing to provide an option to purchase paid up insurance for its universal life policy form 46002.

## 7. INTERNAL AUDIT

The Company does not have an independent internal audit function of its own; it relies on the internal audit department of AC. During the examination period, AC's internal audit department's resources were dedicated to Sarbanes Oxley reviews and audits of other entities within the AON holding company system. There were no audits performed on the Company other than the CPA annual audit. During the examination period, the Company's board of director meeting minutes indicated that the internal audit function was outsourced to the Company's CPA firm. However, there was no evidence to suggest that the CPA audit plan, which was reviewed and approved by the board of directors, was updated or revised as compared to prior years' audits for the added responsibility of the internal audit function.

Internal audit is an integral part of effective corporate governance that also includes the audit committee, the board of directors, senior management and the external auditors. In particular, internal auditors and audit committees are mutually supportive. Consideration of the work of internal auditors is essential for the audit committee to gain a complete understanding of the Company's operations. Internal audit identifies strategic, operational and financial risks facing the organization and assesses controls put in place by management to mitigate those risks.

The examiner recommends that the Company establish and maintain an independent, adequately resourced, and competently staffed internal audit function to provide management and the audit committee with ongoing assessments of the Company's risk management processes and the accompanying system of internal control.

## 8. DISASTER RECOVERY AND BUSINESS CONTINUITY PLANS

The objective of a disaster recovery plan is to provide reasonable assurance that data, systems and operations can be successfully recovered and be available to users in the event of a disaster. The objective of a business continuity plan is to reasonably ensure that the recovery of critical business processes could take place in the event of a disaster.

Upon the examiner's request for the Company's Disaster Recovery Plan and the Business Continuity Plan, the Company stated that these plans are currently in progress and that final plans will not be available until September 30, 2004. The Company's Disaster Recovery Plan and Business Continuity Plan are being developed at the holding company level (on a corporate wide basis). A number of business processes, including electronic data processing operations and services, are provided under a service agreement by its parent, CICA. While the Company did provide a copy of the Business Impact Analysis (business risk assessments) for each department or business process that is conducted at the Company's home office in Latham, New York, it did not provide this information for business processes that are provided outside of New York. Further, although the Company did provide a Disaster Recovery Plan for each department or business process that is conducted at the Company's home office in Latham, New York, the Company did not provide information that encompassed EDP processes provided outside of New York by CICA.

The examiner recommends that the Company continue to develop a disaster recovery plan. Such a plan should address hardware and system recovery, data retrieval procedures, emergency contact information, hardware/software vendor information, telecommunications recovery procedures, disaster declaration approval procedures, and physical recovery location. The plan should contain provisions to ensure periodical testing. The disaster recovery plan should be aligned with the business continuity plans, approved, and periodically reviewed by management to ensure that it meets the needs of the business. Documentation of the disaster recovery test plan and results (indicating problems found or successful completions) and documentation of management approval of the plan should be maintained.

The examiner also recommends that the Company continue to develop a business continuity plan. Such a plan should identify the recovery of critical business processes. The plan should also identify supporting systems applications, vendors that would assist with locating alternate processing and office site locations, forms and documentation arrangements, network and application restoration procedures, and procedures to be followed by Company personnel during the disaster and recovery period. The plan should contain provisions to ensure periodical testing. The business continuity plan should be approved and periodically reviewed by management to ensure that it meets the needs of the business. Documentation of the business continuity test plan and results and documentation of management approval of the plan should be maintained.

9. ACCURATE AND COMPLETE REPORTING OF THE COMPANY'S FINANCIAL  
CONDITION AND RESULTS OF OPERATIONS

Section 243.2(b) of Department Regulation No. 152 states, in part:

“Except as otherwise required by law or regulation, an insurer shall maintain . . .

(7) A financial record necessary to verify the financial condition of an insurer, including ledgers, journals, trial balances, annual and quarterly statement workpapers, evidence of asset, ownership, and source documents, for six calendar years from its creation or until after the filing of the report on examination in which the record was subject to review, whichever is longer. . . .”

Section 243.2(d) of Department Regulation No. 152 states:

“An insurer shall require, by contract or other means, that a person authorized to act on its behalf in connection with the doing of an insurance business, including a managing general agent, an administrator, or other person or entity, shall comply with the provisions of this Part in maintaining records that the insurer would otherwise be required to maintain. Notwithstanding the above, the insurer shall be responsible if the person or entity fails to maintain the records in the required manner.”

The Company did not report complete information in the Exhibit of Number of Policies for accident and health insurance in its filed annual statements for the examination period. The Company stated the following:

“The Group count is a result of business handled through Third Party Administrators (“TPAs”). These TPAs maintain the information. The number of individuals covered and the in force premium are not available to the company. The counts are the TPAs with business dealing with the company at the beginning and end of the year. The in force premium is not completed.”

The Company's response, as well as the documentation submitted and reviewed by the examiners with regard to the Company's group accident and health operations, revealed that the Company does not maintain adequate control and monitoring procedures over its TPAs and that it does not require periodic reporting by the TPAs of integral financial and administrative information related to the blocks of group accident and health business that are written by the Company. The Company is responsible for

obtaining, maintaining, and fairly and accurately presenting in all material respects the financial condition and results of operations of the Company.

The Company violated Sections 243.2(b)(7) and 243.2(d) of Department Regulation No. 152 by failing to obtain and maintain workpapers and supporting detail records required to support the Company's filed annual statement with regard to the Company's group accident and health operations.

## 10. ELECTRONIC RECORDS

The examiner utilized an audit software package during the examination to analyze a number of data files provided by the Company. The examiner's objective with regard to the master in force data file analysis was to reconcile the data files to the year-end in force policy counts, year-end in force face amounts and year-end in force premium amounts that were reported in various exhibits of the filed annual statements for the period under review as well as all activity, increases and deductions, since the last examination period, December 31, 2000. The examiner encountered problems obtaining a data file that contained a seriatim inventory of contract or policy loans, including but not limited to the following fields: principal balance; interest paid to date; interest income due and accrued; and unearned interest as of December 31, 2003. When data files were provided to the examiners, the data was frequently inaccurate and new data files were required in order to meet the examiner's objective. In addition, the Company did not provide data dictionaries defining the various codes that were contained in the fields comprising the master in force data file. This information had to be requested on a field by field basis, and in many cases, this information was not immediately available. Overall, the examiner's progress on the analysis of data files was delayed by the lack of integrity of the data provided and the poor coordination between the various departments involved in the financial reporting process and the individuals responsible for creating the data files.

The examiner recommends that the Company maintain proper documentation, including but not limited to electronic data extracts to support the amounts reported in its filed Annual Statement, and that such documentation be readily available and accessible for future examinations. A similar recommendation appeared in the prior report on examination.

## 11. RECORD RETENTION PLAN

Section 243.3 of Department Regulation No. 152 states, in part:

“(a)(1) Records and indices of records required to be maintained under this Part may be maintained in any durable medium . . .

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

The Department requested a copy of the Company’s record retention plan required under Section 243.3(c) of Department Regulation No. 152 on November 7, 2003. By May 5, 2004, a copy of the records retention plan had yet to be provided. The Company responded in writing to the examiner as follows:

“The Company's Records Retention Plan cannot be located and therefore, the Company has submitted a new Records Retention Plan to the Company's Board of Directors for their review and approval. The Company's Board of Directors approved the new Records Retention Plan on May 13, 2004. The new Plan is attached for your information. The new plan will be submitted to the New York Department of Insurance for their review and approval.”

The examiner’s review of the document provided as the Company’s Record Retention Plan revealed that the plan failed to include an index of the records that are required to be maintained under the Regulation, as well as a description of the types of records being maintained, the method of retention (i.e. media - microfiche, imaging software, hard copy, etc.) and the safeguards established to prevent alteration of the records.

The examiner recommends that the Company revise its record retention plan to include an index of the records being retained, a description of the types of records being maintained, the method of retention, and the safeguards established to prevent alteration of the records.

## 12. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in the prior report on examination and the subsequent actions taken by the Company in response to each citation:

<u>Item</u>	<u>Description</u>
A	<p>The examiner recommends that the Company file a revised and updated service agreement with the Department, incorporating all changes and revisions since the current agreement came into effect.</p> <p>On December 30, 2003, the Company filed a revised service agreement with the Department. However, a similar violation appears in this report on examination.</p>
B	<p>The examiner recommends that the Company revise its tax agreement to reflect the changes which have occurred in the structure of the holding company system since the effective date of the current tax agreement, and that the Department be notified within 30 days of such revision.</p> <p>On January 15, 2004, the Company filed a revised Tax Allocation Agreement between the Company, Aon corporation, and Aon subsidiary companies.</p>
C	<p>The Company violated Section 1202(b)(2) of the New York Insurance Law by not having an independent committee of its board of directors recommend the compensation of its principal officers to the board of directors.</p> <p>The examiners review of the Company's corporate governance committee minutes revealed that it recommended the compensation of its principal officers to the board of directors.</p>
D	<p>The Company violated Section 4230(a) of the New York Insurance Law by not having the salaries of employees whose compensation exceeded that of certain principal officers of the Company, authorized by a vote of the Company's board of directors.</p> <p>The examiner's review of the minutes of the board of directors and the New York supplement to the filed annual statement indicated that the board of directors approved employee's salaries whose compensation exceeded that of certain principal officers.</p>

<u>Item</u>	<u>Description</u>
E	<p>The Company violated Section 4233(b) of the New York Insurance Law by not providing the salary, compensation, or emoluments of all three of its senior officers in its filed annual statement.</p> <p>The Company provided information regarding the salary, compensation, or emoluments of all of its senior officers in its filed annual statement.</p>
F	<p>The examiner recommends that the Company take the necessary steps to ensure that all directors, officers, and responsible employees complete forms, providing for the disclosure to its board of directors of any material interest or affiliation likely to conflict with their official duties, on an annual basis.</p> <p>The examiner verified that all directors, officers, and key employees completed conflict of interest questionnaires for the period under examination.</p>
G	<p>The examiner recommends that the Company continue to monitor its experience data and review its expected loss ratios.</p> <p>The Company is required to submit a filing to the Department in July of each year with respect to those policy forms where the paid loss ratio falls below the required minimums mandated by Section 52.45(a) of Department Regulation No. 62.</p>
H	<p>The examiner recommends that the Company write off the difference of \$1,767,898 of the reported policy loan asset.</p> <p>A general ledger adjusting entry was made in September of 2001 to write down the general ledger policy loan asset so that it reconciled with the policy administration system loan data. The net effect to surplus was approximately \$532,503.</p>
I	<p>The Company violated Section 53-2.3 of Department Regulation No. 74 by not providing prospective policyholders, either on the application or with the application, the required disclosure notice.</p> <p>On November 16, 2001, the Company filed a revised application for use with its limited benefits whole life policy issued to applicants between the ages of 55 and 70. The revised application, policy form 433069R, includes the disclosure notice required by Section 53-2.3 of Department Regulation No. 74.</p>

<u>Item</u>	<u>Description</u>
J	<p>The Company violated Section 4228(f)(1)(A) of the New York Insurance Law by not filing agent compensation plans in use prior to January 1998 and its revised override schedules with the Department.</p> <p>The Company has satisfied the Department's requirements in this regard.</p>
K	<p>The Company violated Section 4228(d) of the New York Insurance Law by paying general agents commissions in excess of 63% of any qualifying first year premium.</p> <p>The Department provided the Company with a resolution letter for this matter stating that management compensation that is not due to personal production is not subject to the 4228(d) inside limits and therefore, is not subject to the agent compensation filing requirements under Section 4228(f) of the New York Insurance Law.</p>
L	<p>The examiner recommends that for future examinations, the Company take the necessary steps to maintain updated data dictionaries and file layouts, coordinate and centralize examiner data file requests, provide accurate data and respond in a timely manner.</p> <p>The examiner encountered similar problems with data integrity during the course of the current examination. See item 10 of this report.</p>

### 13. SUMMARY AND CONCLUSIONS

Following are the violations and recommendations contained in this report:

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
A	The Company violated Section 1505(d)(3) of the New York Insurance Law by failing to notify the superintendent in writing of its intention to enter into an agreement whereby an affiliate renders services to the Company on a regular and systematic basis.	8
B	The Company violated Section 1505(a) of the New York Insurance Law by failing to: 1) reimburse CICA a reasonable amount for certain services provided on a regular and systematic basis and 2) bill or charge CICA a reasonable amount for certain services that were provided on a regular and systematic basis.	9
C	The Company violated Section 1505(d)(3) of the New York Insurance Law by: 1) receiving certain services from CICA on a regular and systematic basis that were not provided for in the filed service agreement between the Company and CICA where CICA is the provider of services and 2) providing certain services to CICA on a regular and systematic basis that were not provided for in the filed service agreement between the Company CICA where the Company is the provider of services.	9
D	The examiner recommends that the Company enter into a separate reinsurance agreement with CVS that does include any affiliates.	10
E	The examiner recommends that the Company enter into a separate claims servicing agreement with Administrative Concepts, Inc. that does not include any affiliates.	10
F	The examiner recommends that the Company review its service agreements and revise them to accurately reflect the manner in which services are billed, how settlements are made and which affiliate is actually providing services.	12
G	The examiner recommends that the Company settle amounts due under holding company service agreements in a timely manner	12
H	The examiner recommends that the Company replace those directors who fail to attend a majority of the meetings.	14

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
I	The Company violated Section 1308(f)(1)(A) of the New York Insurance Law by ceding substantially all or 100% of the net amount at risk under certain blocks of the Company's group accident and health business, referred to as Program Business, during the examination period without obtaining prior written approval of the Superintendent.	20
J	The Company violated Section 2117(a) of the New York Insurance Law when, under the guise of reinsurance, it effectively aided unauthorized reinsurers to engage in activities that would otherwise require a license under New York Insurance Law. The examiner recommends that the Company develop a cure for the violation of Section 2117(a) of the New York Insurance Law.	20 – 21
K	The Company violated Section 91.4(a)(2) of Department Regulation No. 33 by failing to maintain records with sufficient detail to show fully: (i) the system actually used for allocation of expenses; (ii) the actual basis of allocation; and (iii) the actual monetary distribution of the respective items of expense and salaries to annual statement lines of business and companies.	24
L	The Company violated Section 41.3(a) and (b) of Department Regulation No. 143 by failing to disclose in its advertising materials that receipt of accelerated death benefits may affect the insured's eligibility for public assistance programs and the possibility of certain tax consequences.	29
M	The Company violated Section 3203(b)(1)(B) of the New York Insurance Law by using language stating that benefits will be limited if the insured commits suicide "while sane or insane" in its advertising literature for policy form 46002.	29 – 30
N	The examiner recommends that the Company revise the advertising brochure for policy form 46002 to exclude the words "while sane or insane" in order to comply with Section 3203 of the New York Insurance Law.	30
O	The Company violated Section 3207(b) of the New York Insurance Law by knowingly issuing life insurance on the lives of minors in excess of the limits allowed by that section.	30 – 31

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
P	The Company violated Section 3203(a)(8)(H) of the New York Insurance Law by reducing the credit of additional amounts on certain policies that had policy loans by 2.383%, which exceeds the 2% limit allowed under Section 3203(a)(8)(H) of the New York Insurance Law.	31
Q	The Company violated Section 4235(h)(3) of the New York Insurance Law by paying rates of commission to brokers that exceeded the limits on file with the Department in connection with a number of group EMSL cases produced by BP during the examination period.	32
R	The Company violated Section 3211(b)(2) of the New York Insurance Law by disseminating premium notices that failed to contain required language pertaining to policy termination or lapse when the premium is not paid on or before the due date shown or within the specified grace period of the policy.	33 – 34
S	The Company violated Section 243.2(b) of Department Regulation No. 152 by failing to maintain billing cycle registers for the Life 70 policy administration system in order to demonstrate that the Company complies with Section 3211(a) of the New York Insurance Law, as well as its own written procedures, with regard to the time frames that reminder notices and lapse or termination notices are generated from the policy administration system and mailed to policyholders.	33 – 34
T	The Company violated Section 4221(n-1)(3)(B)(iii) of the New York Insurance Law by failing to provide an option to purchase paid up insurance for its universal life policy form 46002.	35
U	The examiner recommends that the Company establish and maintain an independent, adequately resourced, and competently staffed internal audit function to provide management and the audit committee with ongoing assessments of the Company's risk management processes and the accompanying system of internal control.	36
V	The examiner recommends that the Company continue to develop a disaster recovery plan.	37
W	The examiner recommends that the Company continue to develop a business continuity plan.	38

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
X	The Company violated Section 243.2(b)(7) and 243.2(d) of Department Regulation No. 152 by failing to obtain and maintain workpapers and supporting detail records required to support the Company's filed annual statement with regard to the Company's group accident and health operations.	39 – 40
Y	The examiner recommends that the Company maintain proper documentation, including but not limited to electronic data extracts to support the amounts reported in its filed Annual Statement, and that such documentation be readily available and accessible for future examinations. A similar recommendation appeared in the prior report on examination.	41
Z	The examiner recommends that the Company revise its record retention plan to include an index of the records being retained, a description of the types of records being maintained, the method of retention, and the safeguards established to prevent alteration of the records.	42



STATE OF NEW YORK  
**INSURANCE DEPARTMENT**

I, GREGORY V. SERIO, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**EDEN SUNDERMAN**

as a proper person to examine into the affairs of the

**COMBINED LIFE INSURANCE COMPANY OF NEW YORK**

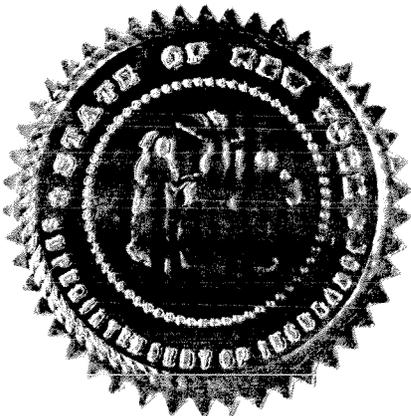
and to make a report to me in writing of the condition of the said

**COMPANY**

with such other information as she shall deem requisite.

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

this 15th day of January, 2004



**GREGORY V. SERIO**

Superintendent of Insurance

  
Superintendent