



STATE OF NEW YORK INSURANCE DEPARTMENT  
REPORT ON MARKET CONDUCT EXAMINATION  
OF THE  
MONITOR LIFE INSURANCE COMPANY OF NEW YORK

CONDITION:

DECEMBER 31, 2006

DATE OF REPORT:

APRIL 11, 2008

STATE OF NEW YORK INSURANCE DEPARTMENT  
REPORT ON MARKET CONDUCT EXAMINATION  
OF THE  
MONITOR LIFE INSURANCE COMPANY OF NEW YORK  
AS OF  
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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

David A. Paterson  
Governor

James J. Wynn  
Superintendent

December 14, 2009

Honorable James J. Wynn  
Superintendent of Insurance  
Albany, New York 12257

Sir:

In accordance with instructions contained in Appointment No. 30206, dated September 24, 2008 and annexed hereto, a market conduct examination has been made into the affairs of Monitor Life Insurance Company of New York, hereinafter referred to as "the Company," at its home office located at 70 Genesee Street, Utica, New York 13502.

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

The material findings, violations and recommendations contained in this report are summarized below.

- The Company violated several sections of Department Regulation No. 64 and Section 2601 of the New York Insurance Law for failing to: effectuate prompt, fair and equitable settlements of claims submitted in which liability had become reasonably clear; provide notification to claimants in a timely manner; maintain claim files so that they can be reconstructed; and attempt in good faith to settle claims. (See Section 4C of this report)
- The Company violated Section 3211(b)(2) of the New York Insurance Law by failing to disclose to policyholders 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 of any cash surrender value or nonforfeiture benefit. The examiner recommends that the Company contact policyholders whose policy(ies) lapsed from January 1, 2003 to the present to determine if any benefits are payable since the policies were lapsed without proper notice. (See Section 4C of this report)
- The Company violated Section 3211(g) of the New York Insurance Law for failing to provide an annual notification to policyholders concerning cash surrender information. (See Section 4C of this report)
- The Company failed to file its commission schedules paid to agents and brokers for the sale of its large group life insurance policies. (See Section 6 of this report)

## 2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2004 through December 31, 2006. As necessary, the examiner reviewed transactions occurring subsequent to December 31, 2006 but prior to the date of this report (i.e., the completion date of the examination).

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

This report on examination is confined to comments on those matters which involve departure 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 October 15, 1971 under the name Monitor Insurance Company of New York. The Company was licensed to write accident and health business as specified by paragraph 3 of Section 1113(a) of the New York Insurance Law and commenced business on June 1, 1972.

On August 15, 1978, the Company amended its charter to include the writing of life insurance and annuities as specified in paragraphs 1 and 2 of Section 1113(a) of the New York Insurance Law.

On April 25, 1979, the Company's name was changed to Monitor Life Insurance Company of New York.

#### B. Territory and Plan of Operation

The Company is authorized to write life insurance, annuities and accident and health insurance as defined in paragraphs 1, 2 and 3 of Section 1113(a) of the New York Insurance Law.

The Company is licensed to transact business in 25 states and the District of Columbia. In 2006, 73.7% of life premiums were received from New York, 48.1% of annuity considerations were received from Pennsylvania, and 49.0% and 28.4% of accident and health premiums were received from Texas and Connecticut, respectively. Policies are written on a non-participating basis.

The Company's principal line of business during the examination period was group term life insurance targeted to small and mid size employers written in conjunction with group disability products offered by the parent, Commercial Travelers Mutual Insurance Company a New York accident and health insurance company. The marketing name of the combined effort is CT Group.

In 2003, the Company sold the vast majority of its individual life and annuity business by entering into a ceding agreement with Standard Security Life Insurance Company of New York ("SSLONY"). Effective October 31, 2003, the Company entered into a 100% coinsurance agreement with SSLONY that calls for SSLONY to reinsure the Company's inactive individual life and annuity business. The administration of the reinsured business was also turned over to

SSLONY as third party administrator (“TPA”). In 2005, SSLONY commenced the process of assuming the reinsured business, and the assumption is still underway. A closed block of individual senior life policies currently in run-off that were jointly marketed with Guarantee Reserve Life Insurance Company (“GRLIC”) are excluded from the assumption agreement, but are covered under a 100% coinsurance agreement with SSLONY and are administered by SSLONY.

The Company’s agency operations were conducted on a general agency basis.

#### 4. MARKET CONDUCT ACTIVITIES

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

##### A. Advertising and Sales Activities

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

Based upon the sample reviewed, no significant findings were noted.

##### B. Underwriting and Policy Forms

The examiner reviewed a sample of new underwriting files, both issued and declined, and the applicable policy forms.

Based upon the sample reviewed, no significant findings were noted.

##### C. Treatment of Policyholders

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

###### 1. Pending, Contestable and Denied Claims

During the examination period, the majority of the Company's individual life and annuity claims were processed by the TPA. A review of claims was conducted as part of the examination to ensure that the Company's policyholders were being treated fairly and equitably in accordance with the New York Insurance Law and Department Regulation.

Section 2 of the TPA's written claim processing procedures state, in part, the following with respect to contestable claims:

"c. Contestable claims . . .

- i. If a policy includes Evidence of Insurability (EOI) and the insured dies either within 2 years of the policy issue date or 2 years of a reinstatement for which an EOI application was taken, we . . .
- 3. Requested HIPAA documentation and (usually) NY Letters Testamentary indicating that the claimant has authority to act on behalf of the deceased in requesting medical records . . .
- 8. If we fail to receive requested information and are unable to conduct medical investigation, we rescind policy, refund premium, and invite beneficiary to provide the missing information allowing us to reopen the claim.”

Section 4 of the TPA’s written claim processing procedures states:

“4. Receive claim materials

- a. Check for accuracy and completeness of documents against materials requested in item #3 above.
- b. If claim is missing required information, telephone claimant asking for information over phone.
- c. If claim is missing required documents, call and/or write to claimant asking that missing documents be provided and explaining again what is needed.”

The examiner reviewed a number of pending, contestable, and denied life claims processed by the TPA. The TPA’s handling and disposition of pending, denied and contestable claims revealed that in general, the internal control process in place to ensure equitable, fair and timely processing of claims during the examination period was inadequate and ineffective.

During the examination period through the last date of field work, the Company did not conduct any compliance, quality control, or internal audits on the outsourced functions being provided by the TPA. In addition, internal or compliance audits were not performed by the TPA on its own processes and internal controls and no independent SAS 70 reviews were performed during this period.

The examiner recommends that the Company perform internal audits of the functions provided by the TPA.

- a) Section 2601(a) of the New York Insurance Law states, in part:

“No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices:

- (1) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue . . .
- (4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear . . .”

Shortly after the TPA took over administration of the business it adopted the practice of, when a claim was received within the contestable period, requiring the beneficiary(ies) to obtain a Letter of Testamentary or Letter of Administration in addition to completing a HIPAA authorization to facilitate the receipt of medical records on the insured. The TPA did not provide the beneficiary with the forms required to obtain such affidavits from the New York State Unified Court System. In many instances, there was no evidence in the claim record to demonstrate that the TPA fully explained the need for such documentation or that it offered to assist the beneficiary with the required applications. It is not clear that the Letter of Testamentary or Letter of Administration documentation was necessary to pay the claim or that the TPA acted fairly in its demand of the claimant to provide such documentation. The policy provisions do not condition payment of proceeds upon the receipt of a Letter of Testamentary or Letter of Administration. In addition, in some instances the TPA requested that the claimant obtain medical records and paid the claimant for the expenses incurred only if the claimant requested to be reimbursed.

In 9 out of 23 denied and rescinded claims reviewed, the claim was denied and all premiums paid on the policy since issue were refunded in accordance with the TPA’s written procedures because it was either unable to obtain medical records from the medical providers or the claimant did not provide a Letter of Testamentary or Letter of Administration. In these instances there was no medical evidence to support that the insured materially misrepresented themselves on the application for insurance or reinstatement or that there was a breach of policy provisions. In one of these claims, the TPA escheated the refund to the State.

In a number of claims where simplified issue underwriting was used at the time of application, the applicant clearly responded yes to one of the limited medical questions, but the Company performed little to no medical investigation at the time the application was taken. In several instances, medical records were requested after the insured had died to prove that the insured materially misrepresented themselves at the time of application.

The Company violated Sections 2601(a)(1) and (4) of the New York Insurance Law by misrepresenting facts and policy provisions relating to coverage and failing to attempt in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability had become reasonably clear.

The examiner recommends that the Company conduct a review of all claims that were denied or resisted during the examination period and through the last date of field work (April 11, 2008), complete the claims investigation and pay any claims where the Company has no evidence of material misrepresentation by the insured.

The examiner also recommends that the Company review paid claims and reimburse beneficiaries for expenses incurred in obtaining medical records on behalf of the Company.

During the examination period, the TPA experienced significant turnover in its Claims Department. The TPA also admitted that during the examination period it did not have documented control procedures. In an effort to improve the internal controls over claims processing, the TPA changed the reporting structure of its Claims Department. During 2007, the TPA analyzed, assessed and documented its claims processing procedures. Implementation of new control procedures commenced in August 2007 and effectiveness and relevance of the newly implemented controls are still in the process of being evaluated.

b) Section 216.4 of Department Regulation No. 64 states, in part:

“(a) Every insurer, upon notification of a claim, shall, within 15 business days, acknowledge the receipt of such notice. Such acknowledgment may be in writing. If an acknowledgment is made by other means, an appropriate notation shall be made in the claim file of the insurer . . .

(b) An appropriate reply shall be made within 15 business days on all other pertinent communications.”

Section 216.6(c) of Department Regulation No. 64 states, in part:

“Within 15 business days after receipt by the insurer of a properly executed proof of loss and/or receipt of all items, statements and forms which the insurer requested from the claimant, the claimant, or the claimant’s authorized representative, shall be advised in writing of the acceptance or rejection of the claim by the insurer . . . If the insurer needs more time to determine whether the claim should be accepted or rejected, it shall so notify the claimant, or the claimant’s authorized representative, within 15 business days after receipt of such

proof of loss, or requested information. Such notification shall include the reasons additional time is needed for investigation. If the claim remains unsettled, unless the matter is in litigation or arbitration, the insurer shall, 90 days from the date of the initial letter setting forth the need for further time to investigate, and every 90 days thereafter, send to the claimant, or the claimant's authorized representative, a letter setting forth the reasons additional time is needed for investigation. If the claim is accepted, in whole or in part, the claimant, or the claimant's authorized representative, shall be advised in writing of the amount offered. In any case where the claim is rejected, the insurer shall notify the claimant, or the claimant's authorized representative, in writing, of any applicable policy provision limiting the claimant's right to sue the insurer.

The examiner reviewed 35 pending and rescinded life claim files. In 23 out of the 35 claim files reviewed, there was little to no pertinent communications with claimants and/or beneficiaries. Not all of the claims reviewed were contestable. In these instances, the claim files failed to indicate that the TPA made a clear effort to assist the claimant in resolving the claim.

In 10 out of 60 pending, rescinded, and paid claims reviewed by the examiner, the TPA took 15 business days or longer to process the claim once all of the required information was received.

The TPA admitted that during the examination period, it did not typically advise the claimant in writing whether or not additional time was needed to determine if the claim should be accepted or rejected. The TPA also admitted that it was unaware of statutory requirements regarding correspondence with claimants regarding the status of outstanding claims.

The Company violated Section 216.4(b) of Department Regulation No. 64 by failing to follow up on pertinent communications with the claimant.

The Company violated Section 216.6(c) of Department Regulation No. 64 by failing to:

- 1) notify claimants or the claimant's authorized representative within 15 business days after receipt of proof of loss and other requested information of its decision to accept or deny the claim; and
- 2) notify claimants that the insurer would need additional time to investigate the claim in order to determine whether or not the claim should be accepted or rejected.

c) Section 216.11 of Department Regulation No. 64 states:

“To verify compliance with this Part and related statutes, Insurance Department examiners will investigate the market performance of insurers. To enable department personnel to reconstruct an insurer’s activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.”

In 8 out of 50 pending and paid claims reviewed, the examiner was unable to reconstruct the events relating to the inception, handling and disposition of the claim based upon the claim or policy record provided for review. Additionally, the TPA admitted that during the examination period, it did not have a procedural requirement that a conversation sheet be completed for each telephone call received with respect to an open claim.

The Company violated Section 216.11 of Department Regulation No. 64 by failing to maintain claim files so that all events relating to a claim can be reconstructed by the examiner.

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

“(a)(1) No policy of life insurance . . . delivered or issued for delivery in this state . . . 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 . . .

(b) The notice required by paragraph one of subsection (a) hereof shall . . .

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

The examiner reviewed the specimen notice of payment due provided by the Company for the small block of ordinary life policies retained by the Company.

The examiner also reviewed the front and back sides of specimen notices of payment due provided to whole life and term policyholders on direct bill by the TPA.

Both notices of premium due failed to include required language 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.

In addition, 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 TPA generated and mailed the notice of payment due, grace period expiration notice, and lapse notice to the policyowner in accordance with the Company's written procedures.

In response, the TPA stated the following:

"Initially, when we began administering the Monitor policies, we had trouble identifying some of the plans. Lapse letters did not generate on some of Monitor's plans due to this problem. Effective 1/1/2006, our Model Office was created. Model office is now able to identify the plans and make sure that the proper correspondence is set up on each plan. All Monitor's policies now are able to generate lapse letters."

The Company violated Section 3211(b)(2) of the New York Insurance Law by failing to fully disclose to whole life and term policyholders 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 policyholder's right to any cash surrender value or nonforfeiture benefit thereunder.

The examiner recommends that the Company contact policyholders whose policy(ies) lapsed from October 31, 2003 to January 31, 2008 to determine if any benefits are payable since the policies were lapsed without proper notice.

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

"In the case of life insurance policies to which this section is applicable and which contain a cash surrender value, the insurer must provide an annual notification that the policy contains a cash surrender value and that further information, including the amount thereof, is available from the insurer upon written request from the policyowner . . . Any notice or statement which informs a policyowner of the policy's cash surrender value at least annually shall be deemed to comply with the requirements of this subsection."

In connection with life insurance policies that contain a cash surrender value and are administered by the TPA, the TPA stated the following with regard to its compliance with Section 3211(g) of the New York Insurance Law during the examination period:

“In regard to request #9, I regret to inform you that we have not been issuing the annual cash value notices thus far. Based on my review, it appears that approximately one half of the policies we administer in NY should be receiving such notices. We are taking immediate action to institute the required process and expect to have our systems updated and able to issue the notices by mid-December (2007).”

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

4. Section 86.4 of Department Regulation No. 95 states, in part:

“(a) Except with respect to automobile insurance, all claim forms for insurance . . . provided to any person residing or located in this State in connection with insurance policies for issuance or issuance for delivery in this State, shall contain the following statement:

‘Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.’ . . .

(d) Location of warning statements and type size. The warning statements required by subdivisions (a), (b) and (e) of this section shall be placed immediately above the space provided for the signature of the person executing the application or claim form and shall be printed in type which will produce a warning statement of conspicuous size . . .

(e) Notwithstanding the provisions of subdivisions (a) and (b) of this section, insurers may use substantially similar warning statements provided such warning statements are submitted to the Insurance Frauds Bureau for prior approval.”

The examiner reviewed a number of life and annuity claims processed during the examination period by the TPA. The examiner’s review indicated that the claim form (claimant’s statement Form C1000 (SSL-MON)) used during the examination period contained

language that differed from the language required by Section 86.4(a) of Department Regulation No. 95. Additionally, the Company provided no evidence that the fraud warning on Form C1000 (SSL-MON) was approved by the Insurance Frauds Bureau prior to its use.

Further, the fraud warning statement is not placed immediately above the space provided for the signature of the person executing the claim form.

The Company violated Section 86.4(a) of Department Regulation No. 95 by using claim forms that failed to contain the required fraud warning language.

The Company violated Section 86.4(d) of Department Regulation No. 95 by failing to position the fraud warning statement on its claim form immediately above the space provided for the signature of the person executing the claim statement.

5. Section 3214(c) of the New York Insurance Law states:

“If no action has been commenced, interest upon the principal sum paid to the beneficiary or policyholder shall be computed daily at the rate of interest currently paid by the insurer on proceeds left under the interest settlement option, from the date of the death of an insured or annuitant in connection with a death claim on such a policy of life insurance or contract of annuity and from the date of maturity of an endowment contract to the date of payment and shall be added to and be a part of the total sum paid.”

The Company was asked to provide a listing of the interest rates paid on proceeds left under the interest settlement option and death claims during the examination period as part of the First Day Letter request (August 6, 2007). The Company provided a list of interest rates in response to this request on December 10, 2007. However, the rates provided were not the rates used to process group and individual life and annuity claims paid during the examination period.

The examiner was unable to verify the accuracy of interest on benefit payments for group and individual life insurance claims processed by the Company for the period January 1, 2004 through April 27, 2006 due to the fact that records were not maintained (see Section 5a of this report).

The Company violated Section 3214(c) of the New York Insurance Law by failing to pay the correct interest rate on death claims.

5. DEPARTMENT REGULATION NO. 152

- a) 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 . . . 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 . . .
- (d) 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.”

For the sample of life lapse transactions selected, the Company was unable to provide evidence that its TPA: 1) sent the policyholder the notice of payment due in accordance with Section 3211(a)(1) of the New York Insurance Law; 2) sent the policyholder a reminder notice in accordance with its own written procedures; and 3) 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 also stated that its TPA did not maintain billing reports for periods longer than 120 days during the examination period.

In January 1998, by resolution of the board of directors, a procedure was adopted whereby a monthly settlement option interest rate was generated by the Treasury Department. The board approved the formula and method used to derive the interest rate crediting strategy for the Company’s interest sensitive products (i.e. the interest settlement option rate). However, the Company failed to maintain documentation related to the derived rates produced by such formula for the period between January 1, 2004 and April 27, 2006.

The Company violated Section 243.2(b)(8) of Department Regulation No. 152 by failing to maintain: 1) documentation regarding lapsed life insurance policies; and 2) documentation related to the rates of interest paid on death claims incurred between January 1, 2004 and April 27, 2006.

b) 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 August 6, 2007. The Company provided a response on December 7, 2007, but it was not comprehensive with regard to the types of records required to be maintained for examination purposes (for instance, claims, rating, underwriting, marketing, complaint, producer licensing records, and any other record subject to examination by the Superintendent). The documentation provided described the Company’s back-up procedures for mission critical systems as well as the location of back up tapes with respect to the Company’s disaster recovery plan only. The documentation 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 Company violated Section 243.3(c) of Department Regulation No. 152 by failing to establish and maintain a record retention plan that includes a description of the types of records being retained, the method of retention, and the safeguards established to prevent alteration of such records.

## 6. AGENT COMPENSATION

Section 4216(e) of the New York Insurance Law states, in part:

“Each domestic insurer . . . doing business in this state shall file with the superintendent its schedule of rates of commissions, compensation and other fees or allowances to agents and brokers pertaining to the solicitation or sale of group life insurance . . . .”

The examiner requested copies of all commission filings made with the Department for its group life insurance business pursuant to Section 4216(e) of the New York Insurance Law. The Company was not able to locate evidence that it filed its large group commission rates with the Department.

The Company violated Section 4216(e) of the New York Insurance Law by failing to file its commission schedules paid to agents and brokers for the sale of its large group life insurance policies.

## 7. 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 examiner recommends that the Company perform internal audits of the functions provided by the TPA.	7
B	The Company violated Sections 2601(a)(1) and (4) of the New York Insurance Law by misrepresenting facts and policy provisions relating to coverage and failing to attempt in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability had become reasonably clear.	9
C	The examiner recommends that the Company conduct a review of all claims that were denied or resisted during the examination period and through the last date of field work (April 11, 2008) and pay any claims where the Company has no evidence of material misrepresentation by the insured.	9
D	The examiner recommends that the Company review paid claims and reimburse beneficiaries for expenses incurred in obtaining medical records on behalf of the Company.	9
E	The Company violated Section 216.4(b) of Department Regulation No. 64 by failing to follow up on pertinent communications with the claimant.	10
F	The Company violated Section 216.6(c) of Department Regulation No. 64 by failing to: 1) notify claimants or the claimant's authorized representative within 15 business days after receipt of proof of loss and other requested information of its decision to accept or deny the claim; and 2) notify claimants that the insurer would need additional time to investigate the claim in order to determine whether or not the claim should be accepted or rejected.	10
G	The Company violated Section 216.11 of Department Regulation No. 64 by failing to maintain claim files so that all events relating to a claim can be reconstructed by the examiner.	11
H	The Company violated Section 3211(b)(2) of the New York Insurance Law by failing to fully disclose to whole life and term policyholders 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 policyholder's right to any cash surrender value or nonforfeiture benefit thereunder.	12

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
I	The examiner recommends that the Company contact policyholders whose policy(ies) lapsed from January 1, 2003 to January 31, 2008 to determine if any benefits are payable since the policies were lapsed without proper notice.	12
J	The Company violated Section 3211(g) of the New York Insurance Law by failing to provide an annual notification to policyholders, whose policies are applicable to this section and contain a cash surrender value, that the policy contains a cash surrender value and that further information, including the amount thereof, is available from the insurer upon written request from the policyowner.	13
K	The Company violated Section 86.4(a) of Department Regulation No. 95 by using claim forms that failed to contain the required fraud warning language.	14
L	The Company violated Section 86.4(d) of Department Regulation No. 95 by failing to position the fraud warning statement on its claim form immediately above the space provided for the signature of the person executing the claim statement.	14
M	The Company violated Section 3214(c) of the New York Insurance Law by failing to pay the correct interest rate on death claims.	14
N	The Company violated Section 243.2(b)(8) of Department Regulation No. 152 by failing to maintain: 1) documentation regarding lapsed life insurance policies; and 2) documentation related to the rates of interest paid on death claims incurred between January 1, 2004 and April 27, 2006.	16
O	The Company violated Section 243.3(c) of Department Regulation No. 152 by failing to establish and maintain a record retention plan that includes a description of the types of records being retained, the method of retention, and the safeguards established to prevent alteration of such records.	16
P	The Company violated Section 4216(e) of the New York Insurance Law by failing to file its commission schedules paid to agents and brokers for the sale of its large group life insurance policies.	17



APPOINTMENT NO. 30206

STATE OF NEW YORK  
**INSURANCE DEPARTMENT**

I, ERIC R. DINALLO, 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

**MONITOR LIFE INSURANCE COMPANY OF NEW YORK**

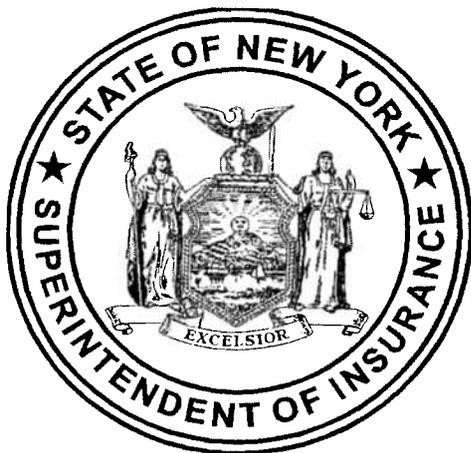
and to make a report to me in writing of the condition of the said

**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 24th day of September, 2008



ERIC R. DINALLO

Superintendent of Insurance

A handwritten signature in black ink that reads "Eric Dinallo".

Superintendent