



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

CONDITION:

DECEMBER 31, 2004

DATE OF REPORT:

MAY 5, 2006

STATE OF NEW YORK INSURANCE DEPARTMENT

REPORT ON EXAMINATION

OF

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AS OF

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EXAMINER:

MARC A. TSE

REPORT ON ASSOCIATION EXAMINATION  
OF  
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA  
AS OF  
DECEMBER 31, 2004  
BY  
THE INSURANCE DEPARTMENTS  
OF THE  
STATE OF NEW YORK  
STATE OF MISSISSIPPI  
STATE OF NEVADA  
STATE OF OKLAHOMA

DATE OF REPORT:

MAY 5, 2006

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

George E. Pataki  
Governor

Howard Mills  
Superintendent

May 5, 2006

Honorable Howard Mills  
Superintendent of Insurance  
Albany, New York 12257

Sir:

In accordance with instructions contained in Appointment No. 22340, dated March 7, 2005 and annexed hereto, an examination has been made into the condition and affairs of The Guardian Life Insurance Company of America, hereinafter referred to as "the Company" or "Guardian" at its home office located at 7 Hanover Square, New York, New York 10004.

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.



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INSURANCE DEPARTMENT  
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May 5, 2006

Honorable Howard Mills  
Superintendent of Insurance  
State of New York

Honorable Jim Poolman  
Chair, Midwestern Zone  
Commissioner of Insurance  
State of North Dakota

Honorable Kevin McCarty  
Chair, Southeastern Zone  
Commissioner of Insurance Regulation  
State of Florida

Honorable Linda Hall  
Vice Chair, Western Zone  
Director of Insurance  
State of Alaska

Sirs:

An examination has been made into the condition and affairs of The Guardian Life Insurance Company of America, hereinafter referred to as "the Company" or "Guardian" at its home office located at 7 Hanover Square, New York, New York 10004.

The examination was conducted by the New York State Insurance Department, hereinafter referred to as the "the Department," with participation from the State of Oklahoma representing the Midwestern Zone, the State of Mississippi representing the Southeastern Zone and the State of Nevada representing the Western Zone.

The report on examination is respectfully submitted.

## 1. EXECUTIVE SUMMARY

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, 2004 filed annual statement. (See item 5 of this report)

The Company violated Section 308 of the New York Insurance Law and failed to comply with Department Circular Letter No. 17 (2001) by entering into three service agreements after September 1, 2001 without filing form CL 17 (2001) with the Department. (See item 3B of this report)

The Company violated Section 91.4(c) of Department Regulation No. 33 by not using an appropriate methodology to allocate net investment income generated from its BLIC products. The examiner recommends that the Company distribute net investment income for BLIC's individual annuities and supplementary contracts using either the reserve method or the fund method, or that another methodology be submitted to the Department for review. (See item 4 of this report)

The Company violated Section 51.6(b)(3) of Department Regulation No. 60 by failing to examine and ascertain that Disclosure Statements completed by its agents and submitted with applications during the examination period were accurate and complete with respect to the information on such Disclosure Statements pertaining to the existing coverage. The Company violated Section 243.2(b)(1) and (8) of Department Regulation No. 152 by failing to maintain the documentation obtained from the original insurer. The Company violated Section 51.6(b)(4) of Department Regulation No. 60 by failing to furnish, within ten days of receipt of the application, a copy of any proposal including the sales material used in the sale of the proposed life insurance policy and the completed Disclosure Statement to the insurer whose coverage was being replaced. The examiner recommends that the Company implement controls and procedures to comply with the above cited sections of Department Regulation No. 60.

The Company violated Section 3221(l)(11-a)(A) of the New York Insurance Law by failing to include the requisite policy language in its group health contracts providing for the availability of a prostate screening benefit. The Examiner recommends that the Company advise all policyholders and certificateholders of the availability of the prostate screening benefit and

provide the opportunity for certificateholders to submit previously unreported claims for prostate screening. (See item 6B of this report)

The Company violated Section 3201(b) of the New York Insurance Law by utilizing unapproved applications. (See item 6B of this report)

The Company violated Section 403(d) of the New York Insurance Law and Section 86.4(a) and (e) of Department Regulation No. 95 by utilizing policy forms that failed to contain the required fraud warning statement and by using policy forms with altered fraud warning statements without obtaining prior approval from the Department's Insurance Frauds Bureau. (See item 6B of this report)

The Company violated Section 4904(d) of the New York Insurance Law by allowing the same clinical peer reviewer to render both the initial adverse and subsequent appeals determinations. The examiner recommends that the Company re-open all appeals cases whereby the same clinical peer reviewer rendered both the initial adverse and subsequent appeals determinations and have such cases reviewed by a different clinical peer reviewer. (See item 6C of this report)

The Company violated Section 216.4(e) of Department Regulation No. 64 by failing to register all of its complaint activity in its central log. (See item 8 of this report)

The Company violated Section 3234(b)(3) of the New York Insurance Law by failing to provide on its Explanation of Benefits Forms ("EOBs"), an identification of the service for which a claim is made. The Company violated Section 3234(b)(7) of the New York Insurance Law by failing to provide information on its EOBs regarding the insured's or subscriber's right of appeal. The examiner recommends that the EOBs be modified to clearly indicate that the claims are processed pursuant to Guardian coverage under its Solutions product. (See item 8 of this report)

## 2. SCOPE OF EXAMINATION

The prior examination was conducted as of December 31, 1999. This examination covers the period from January 1, 2000 through December 31, 2004. As necessary, the examiner reviewed transactions occurring subsequent to December 31, 2004 but prior to the date of this report (i.e., the completion date of the examination).

The examination comprised a verification of assets and liabilities as of December 31, 2004 to determine whether the Company's 2004 filed annual statement fairly presents its financial condition. The examiner reviewed the Company's income and disbursements necessary to accomplish such verification and 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
- Officers' and employees' welfare and pension plans
- Territory and plan of operation
- Market conduct activities
- Growth of Company
- Business in force by states
- Mortality and loss experience
- Reinsurance
- Accounts and records
- Financial statements

The examiner reviewed the corrective actions taken by the Company with respect to violations, recommendations and/or comments contained in the prior report on examination. The results of the examiner's review are contained in item 9 of this report.

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

A special examination into the Company's cash surrender processing activities was conducted as of May 31, 2002. The purpose of the examination was to determine whether the Company adequately addressed violations of Section 3227 of the New York Insurance Law as contained in the report on examination as of December 31, 1999.

### 3. DESCRIPTION OF COMPANY

#### A. History

The Company was incorporated as a stock life insurance company under the laws of the State of New York on April 10, 1860 and commenced business on July 16, 1860 as The Germania Life Insurance Company. In 1918, the Company changed its name to its present name of The Guardian Life Insurance Company of America. In 1924, the Company adopted a plan to convert to a mutual company. In 1945, Guardian acquired all of the outstanding stock of the Company. Effective January 1, 1946, the Company adopted and amended its charter and by-laws and became a mutual company.

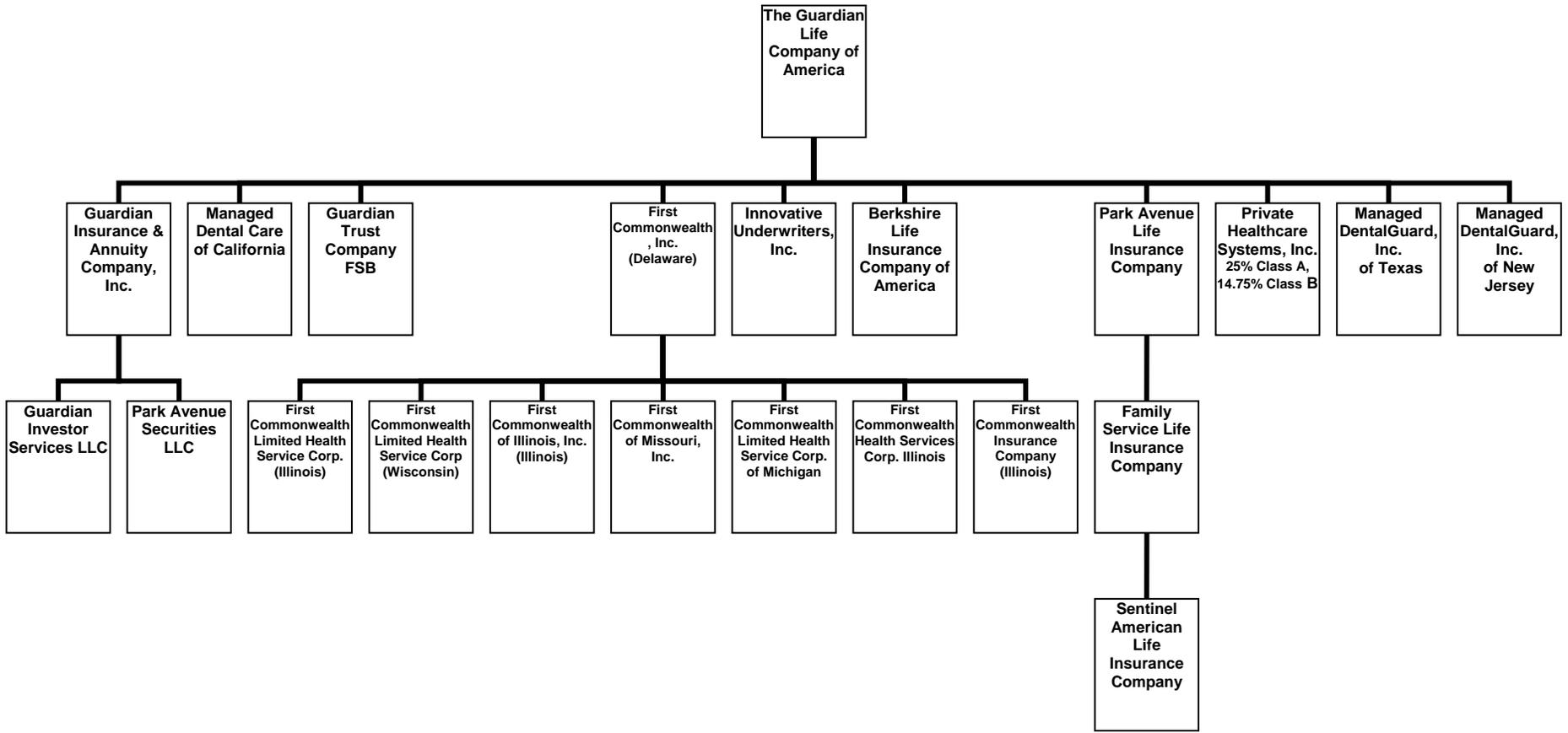
On September 24, 1999, the Company purchased Fiduciary Insurance Company of America (“FICA”), a New York domiciled accident and health insurer specializing in the writing of New York State disability insurance on a direct basis and assuming student accident and health business, for \$2,959,000. On or about January 2004, the Company sold all the issued and outstanding shares of common stock of FICA to Transportation Risk Group, a New York licensed risk purchasing group.

On July 1, 2001, the Company merged with Berkshire Life Insurance Company (“BLIC”) in a business combination accounted for as a statutory merger. As a statutory merger, approved by the New York and Massachusetts insurance departments and by policyowners of both companies, BLIC policyowners became the Company’s policyowners. The Company renamed Health Source Insurance Company, a then existing subsidiary, Berkshire Life Insurance Company of America (“BLICOA”). The Company paid \$267 million in capital to BLICOA and, pursuant to a reinsurance treaty effected between BLICOA and the Company, BLICOA reinsured 100% of BLIC’s and the Company’s existing disability income business. Effective July 1, 2001, BLICOA commenced writing its own disability income business. Going forward all new disability income business is written by BLICOA.

## B. Subsidiaries

The Company maintains a multi-tiered downstream holding company system through which its subsidiary operations are conducted. The Company has both insurance and non-insurance subsidiaries that market insurance and investment products in the United States and several foreign countries.

An organization chart reflecting the relationship between the Company and significant entities in its holding company system as of December 31, 2004 and a brief description of such subsidiaries follow:



The Guardian Insurance & Annuity Company, Inc. (“GIAC”) is a wholly-owned subsidiary of the Company. GIAC, domiciled in the state of Delaware, is licensed to conduct life and health insurance business in all fifty states and the District of Columbia. GIAC’s primary business is the sale of variable deferred annuity contracts and variable and term life insurance policies. Variable products, other than 401(k) products, are sold by GIAC licensed insurance agents who are either registered representatives of Park Avenue Securities LLC (“PAS”) or of other broker dealer firms that have entered into sales agreements with GIAC. GIAC’s general agency distribution system is used for the sale of other products and policies.

PAS, a wholly-owned subsidiary of GIAC, is a registered broker dealer under the Securities and Exchange Act of 1934. PAS was established as a broker dealer during 1999 and has acquired the registered representatives formerly affiliated with Guardian Investor Services LLC (“GIS”).

GIS, a wholly-owned subsidiary of GIAC, is a registered broker dealer under the Securities and Exchange Act of 1934 and is a registered investment advisor under the Investment Adviser’s Act of 1940. GIS is the distributor and underwriter for GIAC’s variable products, and the investment advisor to certain mutual funds sponsored by GIAC. Such funds are investment options for the variable products.

Managed DentalGuard, Inc. of Texas (“MDGT”), a wholly-owned subsidiary of the Company, was formed under the laws of the State of Texas on January 15, 1997, for the purpose of providing prepaid dental services for employer groups and unions in selected areas throughout the state. MDGT received its Certificate of Authority from the Texas Department of Insurance on March 24, 2000.

Managed DentalGuard, Inc. of New Jersey (“MDGNJ”), a wholly-owned subsidiary of the Company, was formed under the laws of the State of New Jersey on April 5, 2001, for the purpose of providing prepaid dental services for employer groups and unions in selected areas throughout the state. MDGNJ received its Certificate of Authority from the New Jersey Department of Banking and Insurance on December 5, 2001. MDGNJ commenced operations on March 4, 2002.

Managed Dental Care of California (“MDC”) was incorporated under the laws of the State of California on June 4, 1991, for the purposed of providing prepaid dental services for employer groups and unions in selected areas throughout the State. MDC was licensed by the

Department of Corporations on December 24, 1991 and has operated as a licensed health care service plan under the Knox-Keene Act since January 1, 1992. Effective in 2000, HMOs in the State of California are regulated by the Department of Managed Health Care. All of the outstanding shares of MDC were purchased by the Company on April 25, 1996.

Guardian Trust Company, FSB (“GTC”), a wholly-owned subsidiary of the Company, was established on April 27, 1999 and commenced operations on June 1, 1999. GTC is a federally chartered savings bank organized for the limited purpose of offering fiduciary services and is regulated primarily by the Office of Thrift Supervision . Although GTC is a member of the Federal Deposit Insurance Corporation (“FDIC”), GTC does not accept FDIC insured deposits from the public. GTC is registered with the Securities and Exchange Commission as an investment banker.

First Commonwealth, Inc. (“First Commonwealth”), a wholly-owned subsidiary of the Company, is a provider of managed dental care benefits in the upper Midwest region, including the metropolitan areas of Chicago, Milwaukee, St. Louis and Detroit. First Commonwealth also provides indemnity/preferred provider organization dental coverage and administrative claim services.

Innovative Underwriters, Inc. (“IUI”) was incorporated in the state of New Jersey on August 17, 1971. Effective July 27, 1999, IUI was acquired by and became a wholly-owned subsidiary of the Company. IUI operates as a full service brokerage agency that primarily markets and sells life and long term care insurance products.

Berkshire Life Insurance Company of America (“BLICOA”) is a wholly-owned stock subsidiary of the Company, domiciled in the Commonwealth of Massachusetts. BLICOA’s business is the sale and administration of disability income, long term care and life insurance products through independent agents. BLICOA is licensed and conducts business in the 50 states and the District of Columbia.

As discussed in section 3A, BLICOA was previously known as Healthsource Insurance Company (“Healthsource”), a dormant Tennessee domiciled insurer, owned by the Company. On July 1, 2001, Berkshire Life Insurance Company (“BLIC”), a mutual insurance company that wrote life, annuity and disability income business, consummated a statutory merger with the Company. In connection with this transaction, Healthsource was renamed Berkshire Life Insurance Company of America, was re-domesticated to Massachusetts, and received contributed

capital of \$267.5 million. All the previously written disability income business of BLIC and the Company was transferred to BLICOA by way of a 100% coinsurance transaction. Also, effective July 1, 2001, BLICOA commenced writing its own disability income business.

Park Avenue Life Insurance Company (“PALIC”) is a wholly-owned subsidiary of the Company. PALIC’s primary business is the administration of life insurance (principally term and universal life products). Although the Company is licensed in 48 states and the District of Columbia, it is not currently writing new business.

Family Service Life Insurance Company (“FSLIC”) and its wholly-owned subsidiary Sentinel American Life Insurance Company (“SALIC”), both Texas domiciled insurers, were purchased by PALIC, on June 1, 1998. FSLIC and SALIC’s primary business is the administration of life insurance and annuity policies. FSLIC is licensed in 43 states, the District of Columbia, and the U.S. Virgin Islands, whereas SALIC is licensed in 12 states. Neither FSLIC nor SALIC is currently writing new business.

Private Healthcare Systems, Inc. is a provider of comprehensive medical management systems that offer utilization review and quality assurance programs, preferred and exclusive provider organizations, and other healthcare cost containment and related services throughout the United States.

The Company had 8 service agreements in effect during the examination period.

Type of Agreement	Effective Date	Provider(s) of Service(s)	Recipient(s) of Service(s)	Specific Service(s) Covered	Income/ (Expense)* For Each Year of the Examination	
					Year	Amount
Service Agreement	12/27/1971	The Company	Various subsidiaries	Provide office space, furniture, equipment, utilities and certain operational and support services	2000	\$183,843,935
					2001	\$190,392,138
					2002	\$177,327,423
					2003	\$166,810,514
					2004	\$153,328,113
Service Agreement	3/17/1997	The Company	MDC	Routine day to day functions including account establishment, billing, marketing, etc.	2000	\$408,678
					2001	\$969,831
					2002	\$510,699
					2003	\$425,943
					2004	\$169,853
Service Agreement	6/1/1999	The Company	GTC	General and administrative services including office services, IT, legal, etc.	2000	\$1,980,687
					2001	\$2,711,662
					2002	\$5,049,893
					2003	\$2,022,579
					2004	\$1,279,867
Service Agreement	3/24/2000	The Company	MDGT	Routine day to day functions including account establishment, billing, marketing, etc.	2000	\$ 0
					2001	\$ 6,620
					2002	\$ 62,299
					2003	\$239,396
					2004	\$348,789
Service Agreement	3/24/2000	Private Healthcare Systems, Inc.	The Company	Comprehensive utilization review and case management.	2000	(\$5,278,193)
					2001	(\$8,874,489)
					2002	(\$7,736,130)
					2003	(\$6,561,934)
					2004	(\$5,922,278)

Type of Agreement	Effective Date	Provider(s) of Service(s)	Recipient(s) of Service(s)	Specific Service(s) Covered	Income/ (Expense)* For Each Year of the Examination	
Service Agreement	2/27/2004	The Company	<ul style="list-style-type: none"> <li>• First Commonwealth Limited Health Service Corporation of Michigan</li> <li>• First Commonwealth</li> </ul>	Routine day to day functions including account establishment, billing, marketing, etc.	2000	N/A
					2001	N/A
					2002	N/A
					2003	N/A
					2004	\$ 0
Service Agreement	10/31/2001	The Company	MDGNJ	Routine day to day functions including account establishment, billing, marketing, etc.	2000	N/A
					2001	N/A
					2002	N/A
					2003	N/A
					2004	\$236,465
Service Agreement	11/1/2004	The Company	<ul style="list-style-type: none"> <li>• First Commonwealth</li> <li>• First Commonwealth of Illinois, Inc.</li> <li>• First Commonwealth Limited Health Service Corporation (Illinois)</li> <li>• First Commonwealth Limited Health Service Corporation (Wisconsin)</li> <li>• First Commonwealth of Missouri, Inc.</li> <li>• First Commonwealth Insurance Company</li> </ul>	Routine day to day functions including account establishment, billing, marketing, etc.	2000	N/A
					2001	N/A
					2002	N/A
					2003	N/A
					2004	\$6,217,291

\* Amount of income or (Expense) incurred by the Company.

The Company files a consolidated federal income tax return with its subsidiaries.

Section 308(a) of the New York Insurance Law states, in part:

“The superintendent may also address to any health maintenance organization or its officers or any authorized insurer or its officers any inquiry in relation to its transactions or condition or any matter connected therewith. Every corporation or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed by such individual, or by such officer or officers of a corporation, as he shall designate, and affirmed by them as true under the penalties of perjury. . . .”

Pursuant to Section 308(a) of the New York Insurance Law, the Superintendent issued Department Circular Letter No. 17 (2001) which states, in part:

“ . . . (4) Beginning September 1, 2001, every authorized domestic insurer that is exempt from the provisions of Article 15 of the New York Insurance Law is hereby directed, pursuant to Section 308 of the New York Insurance Law, to furnish this Department by e-mail with a report on the attached Form CL 17 (2001), at least 30 days in advance of entering into any of the following transactions: (An ‘affiliate’ means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with the insurer.) . . .

iv. Entering into any management agreements, service contracts, contracts of guarantee or surety and all cost-sharing arrangements. . . .”

During the examination period the Company entered into service agreements with various subsidiaries. On February 27, 2004 the Company entered into a service agreement with First Commonwealth and First Commonwealth Limited Health Services Corporation of Michigan. On October 31, 2001, the Company entered into a service agreement with MDGNJ. On November 1, 2004, the Company entered into another service agreement with First Commonwealth and its subsidiaries. The Company did not file the requisite reports on Form CL 17 for these three service agreements.

The Company violated Section 308 of the New York Insurance Law and failed to comply with Department Circular Letter No. 17 (2001) by entering into three service agreements after September 1, 2001 without filing form CL 17 (2001) with the Department.

### C. Management

The Company's by-laws provide that the board of directors shall be comprised of not less than 13 and not more than 20 directors. The directors are divided into three classes, as nearly equal as may be, to be elected annually in consecutive years for a term of three years. The charter provides for the election of directors to be held annually at the home office of the Company on the second Wednesday in December. As of December 31, 2004, the board of directors consisted of 16 members.

Section 3 of the Company's by-laws, as amended on March 13, 1996, states, in part:

“Regular meetings of the Board shall be held on the fourth Wednesday of February, May and August and on Wednesday of the week preceding Thanksgiving in November of each year except that any of the above dates may be changed provided the Board so approves at a prior regular meeting. . . .”

A review of the Company's minutes revealed that 11 out of 20 regular board meetings were held at times not conforming to the Company's by-laws. Further, board resolutions approving such alternate times are not documented in the minutes prior to the meeting.

The examiner recommends that the board of directors document in the board minutes the approval of meeting times which differ from those stated in its by-laws.

It is noted that the by-laws were further amended on July 28, 2004 to provide that regular meetings of the board of directors shall be held on the fourth Wednesday of February, April, July and October, and the second Wednesday of November in each year.

The 16 board members and their principal business affiliation, as of December 31, 2004, were as follows:

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>	<u>Year First Elected</u>
John B. Caswell* Tampa, FL	President and Chief Executive Officer The Omnia Group, Inc.	2001
Richard E. Cavanagh* Bronxville, NY	President and Chief Executive Officer The Conference Board	1998
Kay K. Clarke* East Haddam, CT	President Templeton, Ltd.	1989

<u>Name and Residence</u>	<u>Principal Business Affiliation</u>	<u>Year First Elected</u>
Martin J. Cleary* Sea Girt, NJ	Director The Lamson & Sessions Co.	1984
Albert C. Cornelio Pittsfield, MA	Director Berkshire Life Insurance Company of America	2001
James E. Daley* Plano, TX	Director Adobe Systems, Incorporated	1998
Arthur V. Ferrara* Orleans, MA	Director The Gabelli Capital Asset Fund	1981
Leo R. Futia Greenwich, CT	Director The Guardian Cash Fund, Inc.	1970
Paul B. Guenther* New York, NY	Chairman The New York Philharmonic	2003
Edward K. Kane New York, NY	Executive Vice President The Guardian Life Insurance Company of America	1989
James A. Kennedy* Bernardsville, NJ	Director Freedom House	1999
Dennis J. Manning Wilton, CT	President and Chief Executive Officer The Guardian Life Insurance Company of America	2002
Joseph D. Sargent Fairfield, CT	Director Berkshire Life Insurance Company of America	1993
John A. Somers* Leonardo, NJ	Executive Vice President Teachers Insurance and Annuity Association – College Retirement Equities Fund (TIAA-CREF)	1996
Barry F. Sullivan* Bronxville, NY	Vice Chairman and Chief Operating Officer KRoad Power	1995
Donald C. Waite III* Croton-on-Hudson, NY	Director of Office of Executives-in-Residence Adjunct Professor Columbia University Graduate School of Business	2002

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

In January 2005, Edward K. Kane retired from the board of directors and Joseph A. Caruso was appointed to the board. In December 2005, Albert C. Cornelio, Arthur V. Ferrara and Barry F. Sullivan retired from the board of directors. In January 2006, Deborah L. Duncan and Eric K. Shineski were appointed to the board.

The examiner's review of the minutes of the meetings of the board of directors and its committees indicated that meetings were well attended and that each director attended a majority of meetings.

The following is a listing of the principal officers of the Company as of December 31, 2004:

<u>Name</u>	<u>Title</u>
Dennis J. Manning	President and Chief Executive Officer
John H. Flannigan	Vice President, Corporate Controller
Joseph A. Caruso	Senior Vice President and Corporate Secretary
Armand Michael de Palo	Executive Vice President and Chief Actuary
Robert E. Broatch	Executive Vice President and Chief Financial Officer
Dennis S. Callahan	Executive Vice President and Chief Information Officer
Edward K. Kane	Executive Vice President
Gary B. Lenderink	Executive Vice President, Risk Management Products
Bruce C. Long	Executive Vice President, Equity Products
Thomas G. Sorell	Executive Vice President and Chief Investment Officer
David W. Allen	Senior Vice President, Individual Markets
Dennis P. Mosticchio	Senior Vice President, Group Pensions
James D. Ranton	Senior Vice President, Human Resources
Nancy Fulton Rogers-Golodetz	Senior Vice President, Corporate Marketing
Richard A. White	Senior Vice President Group Insurance
James P. Bodovitz*	Second Vice President, Chief Compliance Officer

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

In January 2005, Edward K. Kane retired from the Company.

#### 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 is licensed to transact business in all 50 states and the District of Columbia. In 2004, 32.5% of life premiums were received from New York (22.1%) and New Jersey (10.4%), and 28.0% of accident and health premiums were received from New York (16.8%) and California (11.2%). Policies are written on a participating basis.

The Company's principal lines of business sold during the examination period were group accident and health and individual life insurance. Group accident and health (55%) and individual life insurance (39.8%) represented 94.8% of premiums received in 2004.

The Company's strategy for selling its group accident and health products is aimed toward the small to medium sized employer market. The product portfolio is comprehensive, with available coverage for medical, dental, vision and disability benefits.

The primary individual life products are participating whole life and term insurance. The permanent whole life products consist of three main plans, L96, L100 and L1000. The L96 plan is the sales leader. The terms and features of each plan are very similar; the products generally differ only in face amount banding, premium and compensation structure, and availability of riders. There are other minor products such as EstateGuard (second to die whole life). All of these products are participating and thus are eligible for the annual policyholder dividend. The term products are YRT; "Lifespan" (indeterminate premium term), the biggest seller among individual term products; and a ten-year term product. Likewise, these products are participating.

The Company's agency operations are conducted on a general agency basis.

#### E. Reinsurance

As of December 31, 2004, the Company had reinsurance treaties in effect with 79 companies, of which 72 were authorized or accredited. The Company's life and accident and health businesses are reinsured on a coinsurance, modified-coinsurance, and yearly renewable term basis. Reinsurance is provided on an automatic and facultative basis.

The maximum retention limit for individual life contracts is \$5,000,000. The total face amount of life insurance ceded as of December 31, 2004, was \$64,801,018,414, which represents 23% of the total face amount of life insurance in force. Reserve credit taken for reinsurance ceded to unauthorized companies, totaling \$10,231,037, was fully supported by letters of credit, trust agreements, and funds withheld.

The total face amount of life insurance assumed as of December 31, 2004, was \$12,655,876,380.

As of December 31, 2004, the Company ceded accident and health insurance to 32 insurers. The Company ceded \$353,034,420 of premiums under these reinsurance contracts in 2004. Of this amount, 96.7% was ceded to BLICOA (79.4%) and Health Net (Bermuda), LTD (17.3%). The underlying business ceded under these reinsurance contracts are group policies.

As of December 31, 2004, the Company assumed accident and health insurance from 48 insurers. The Company received \$534,752,867 in premiums under these reinsurance contracts in 2004. Of this amount, 95.8% was received from Health Net of New Jersey (45.6%), Health Net of New York (35.4%) and Health Net of Connecticut (14.8%). The underlying business assumed under these reinsurance contracts are group policies.

#### 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. 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 during the period under review:

	December 31, <u>2000</u>	December 31, <u>2004</u>	Increase (Decrease)
Admitted assets	<u>\$17,989,337,147</u>	<u>\$23,336,264,101</u>	<u>\$5,346,926,954</u>
Liabilities	<u>\$16,335,407,706</u>	<u>\$20,430,977,679</u>	<u>\$4,095,569,973</u>
Aggregate write-ins for special surplus funds:			
Contingency reserve for group life	\$ 66,413,020	\$ 82,567,564	\$ 16,154,544
Contingency reserve for aviation reinsurance	3,000,000	3,000,000	0
Permanent reserve (Arkansas requirement)	1,000,000	1,000,000	0
Contingency reserve for deposit administration	2,807	2,344	(463)
Unassigned funds (surplus)	<u>1,583,513,614</u>	<u>2,818,716,514</u>	<u>1,235,202,900</u>
Total surplus	<u>\$ 1,653,929,441</u>	<u>\$ 2,905,286,422</u>	<u>\$1,251,356,981</u>
Total liabilities and surplus	<u>\$17,989,337,147</u>	<u>\$23,336,264,101</u>	<u>\$5,346,926,954</u>

The Company's invested assets as of December 31, 2004, were mainly comprised of bonds (68.8%), stocks (12.3%), mortgage loans (9.6%) and contract loans (7.4%).

The majority (93%) of the Company's bond portfolio, as of December 31, 2004, was comprised of investment grade obligations.

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

“(a) General instructions. (1) It is the responsibility of each life insurer to use only such methods of allocation as will produce a suitable and equitable distribution of income and expenses by lines of business. Unless impractical or unfeasible, an insurer may use only such methods of allocation in its distribution of income and expenses within annual statement lines of business as are compatible with the methods it uses for distribution between annual statement lines of business . . .

(c) Net investment income (receipts). (1) The cost of granting and servicing premium notes and policy loans and liens shall be allocated to investment expenses. The resulting net income on premium notes and policy loans and liens may be distributed to those lines of business which produced such income. In making such distribution, due consideration shall be given to the variation in the interest rate and incidence of expense on such notes, loans and liens. Any miscellaneous interest income arising from policy or annuity transactions may be allocated directly to the line of business producing such income.

(2) Net investment income, after adjustment, if any, as permitted by the preceding paragraph shall be distributed to major annual statement lines of business either:

(i) in proportion to the total mean policy reserves and liabilities of each of such major annual statement lines of business or

(ii) in proportion to the total mean funds of each of such major annual statement lines of business.

If the reserve method pursuant to subparagraph (i), above, is so used, it shall also be used in distributing net investment income to each secondary annual statement line of business. If the fund method pursuant to subparagraph (ii) above, is so used, either the reserve method or the fund method shall be used in distributing net investment income to each secondary annual statement line of business.”

Prior to 2001, the Company used the fund method to allocate net investment income to major annual statement lines of business, in accordance with Section 91.4(c)(2)(ii) of Department Regulation No. 33. In 2001, the Company acquired BLIC. During the review of net investment income it was revealed that the assets from BLIC’s ordinary life, individual annuity and supplementary contracts, deemed secondary lines of business, were transferred to the Company’s ordinary life funds for allocation purposes. The BLIC assets were placed in one line and were therefore not allocated by any method. As a result, the income and expenses resulting from the BLIC annuities and supplementary contracts were not adequately matched.

The Company violated Section 91.4(c) of Department Regulation No. 33 by not using an appropriate methodology to allocate net investment income generated from its BLIC products.

The examiner recommends that the Company distribute net investment income for BLIC’s individual annuities and supplementary contracts using either the reserve method or the fund method, or that another methodology be submitted to the Department for review.

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>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
Ordinary:					
Life insurance	\$ 12,222,079	\$(87,864,202)	\$(103,706,865)	\$ 56,216,512	\$ 52,663,427
Individual					
Annuities	1,929,522	(3,988,837)	(6,035,180)	(1,394,409)	(4,972,861)
Supplementary					
Contracts	<u>1,276,081</u>	<u>16,632,941</u>	<u>21,353,344</u>	<u>15,460,314</u>	<u>17,795,480</u>
Total ordinary	\$ <u>15,427,682</u>	\$ <u>(75,220,098)</u>	\$ <u>(88,388,701)</u>	\$ <u>70,282,417</u>	\$ <u>65,486,046</u>
Credit life	\$ <u>(3,959,314)</u>	\$ <u>5,938,697</u>	\$ <u>(15,533,964)</u>	\$ <u>5,305,197</u>	\$ <u>2,684,221</u>
Group:					
Life	\$ 38,637,425	\$ 47,049,507	\$ 28,763,293	\$ 50,617,957	\$ 76,633,380
Annuities	<u>20,474,891</u>	<u>10,948,939</u>	<u>14,951,044</u>	<u>158,972</u>	<u>7,132,176</u>
Total group	\$ <u>59,112,316</u>	\$ <u>57,998,446</u>	\$ <u>43,714,337</u>	\$ <u>50,776,929</u>	\$ <u>83,765,556</u>
Accident and health:					
Group	\$117,278,624	\$ 31,395,451	\$ 84,926,431	\$186,677,876	\$120,553,346
Credit	(3,860,121)	(2,650,775)	24,519,162	1,571,132	(323,606)
Other	<u>(26,020,192)</u>	<u>(21,162,309)</u>	<u>3,839,925</u>	<u>2,180,503</u>	<u>(5,536)</u>
Total accident and health	\$ <u>87,398,311</u>	\$ <u>7,582,367</u>	\$ <u>113,285,518</u>	\$ <u>190,429,511</u>	\$ <u>120,224,204</u>
All other lines	\$ <u>(810,147)</u>	\$ <u>(15,442,381)</u>	\$ <u>(1,011,986)</u>	\$ <u>(2,198,507)</u>	\$ <u>191,299</u>
Total	\$ <u>157,168,848</u>	\$ <u>(19,142,969)</u>	\$ <u>52,065,204</u>	\$ <u>314,595,547</u>	\$ <u>272,351,326</u>

The Company experienced losses of \$87,864,202 and \$103,706,865 in 2001 and 2002 for ordinary life insurance. The loss in 2001 is primarily attributable to an increase in dividends to policyholders of \$94 million. The loss became greater in 2002 primarily due to a decrease in federal income tax benefit as compared to the previous year.

The Company experienced losses in the individual annuities lines for years 2001 through 2004. The loss incurred in 2001 is mainly due to an increase in surrender benefits and withdrawal for life contracts as compared to the previous year. The loss incurred in 2002 is

primarily due to an increase in reserves which is mainly attributable to significant increase in sales during 2002 as compared to 2001. The increase of approximately \$5 million in 2003 is primarily attributable to increase in federal income tax benefit due to a reinsurance treaty transaction of approximately \$4 million. In 2004, disability benefits of \$9 million were erroneously included in individual annuity but should have been included in ordinary life.

The increase in supplementary contracts in 2001 is primarily attributed to new reporting requirements associated with Codification. Under Codification, deposit type accounting is used for these products as opposed to recording premium income and expenses through the summary of operations.

The Company reported losses for credit life in 2000 and 2002. The losses are primarily due to reinsurance business assumed by the Company in 2000 and subsequently retroceded in 2002. In 2000, the loss is mainly attributable to an increase in commissions and expense allowance on the reinsurance assumed. In 2002, the loss is mainly attributable to federal income tax on the gains from the retrocession transaction.

The decrease in group life in 2002 is primarily attributable to a decrease in net investment income of approximately \$10 million and an increase in group conversions of approximately \$6 million.

Net gains from operations for group annuities exhibited large declines in 2001 and 2003. These decreases are largely attributable to the significant decrease in the financial markets which resulted in the Company crediting more to benefit plans to cover the losses in these plans. Included in this line of business are mostly defined benefit plans credited at a rate of 5% per year. Due to the decline in actual rates of return of the assets, the Company would credit to these plans the difference between the actual rates of return and credited rate.

The decrease in group accident and health in 2001 is mainly attributable to approximately \$132 million in health reinsurance pool reserve strengthening, most of which was related to September 11, 2001 funding, offset by a \$43 million decrease in federal income tax expense as compared to the previous year. In 2003, the increase is mainly attributable to a favorable change in the incurred claim loss ratio as compared to the previous year.

The Company experienced losses in credit accident and health and other accident and health lines of business in years 2000, 2001 and 2004. Similar to the credit life line of business previously mentioned, the results of the credit accident and health are primarily related to

reinsurance business assumed by the Company in 2000 and subsequently retroceded in 2002. The losses in 2000 and 2001 for other accident and health are primarily due to higher than expected morbidity as compared to previous years. The loss in 2004 for other Accident and Health is related to a closed block of individual medical policies.

The loss for all other lines in 2000 was due primarily to losses from two closed aviation pools. The increase in the loss in 2001 was due primarily to increased reserves recorded in space and aviation pools, including a reserve directly attributable to the events of September 11, 2001. The Company did not write any new aviation business during 2002 and 2003. The sustained losses therefore result from the continual run-off of various space and aviation pools.

## 5. FINANCIAL STATEMENTS

The following statements show the assets, liabilities, surplus and other funds as of December 31, 2004, as contained in the Company's 2004 filed annual statement, a condensed summary of operations and a reconciliation of the surplus account for each of the years under review. 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, 2004 filed annual statement.

### A. ASSETS, LIABILITIES, SURPLUS AND OTHER FUNDS AS OF DECEMBER 31, 2004

#### Admitted Assets

Bonds	\$14,794,961,523
Stocks:	
Preferred stocks	253,642,921
Common stocks	2,389,179,052
Mortgage loans on real estate	
First liens	2,071,623,565
Real estate:	
Properties occupied by the company	31,900,059
Properties held for the production of income	103,895,454
Properties held for sale	5,800,000
Cash, cash equivalents and short term investments	232,808,918
Contract loans	1,594,176,713
Other invested assets	32,887,562
Receivable for securities	3,252,536
Currency forward – puts	984,100
Investment income due and accrued	227,948,058
Premiums and considerations:	
Uncollected premiums and agents' balances in the course of collection	230,994,723
Deferred premiums, agents' balances and installments booked but deferred and not yet due	672,754,019
Reinsurance:	
Amounts recoverable from reinsurers	35,564,329
Funds held by or deposited with reinsured companies	31,347,270
Other amounts receivable under reinsurance contracts	19,976,213
Amounts receivable relating to uninsured plans	49,281,305
Net deferred tax asset	488,634,989
Guaranty funds receivable or on deposit	602,920
Electronic data processing equipment and software	10,587,539
Receivables from parent, subsidiaries and affiliates	16,008,809

Health care and other amounts receivable	3,535,475
Franchise and MTA taxes recoverable	19,894,146
Prepaid asset – pension plan	6,750,000
Suspense accounts	4,923,161
Other	1,824,106
Premium tax receivable	<u>524,637</u>
Total admitted assets	<u>\$23,336,264,102</u>

Liabilities, Surplus and Other Funds

Aggregate reserve for life policies and contracts	\$16,109,122,613
Aggregate reserve for accident and health contracts	671,867,099
Liability for deposit-type contracts	443,093,113
Contract claims:	
Life	104,458,258
Accident and health	719,696,710
Policyholders' dividends and coupons due and unpaid	(19,635,318)
Provision for policyholders' dividends and coupons payable in following calendar year – estimated amounts	
Dividends apportioned for payment	550,450,601
Premiums and annuity considerations for life and accident and health contracts received in advance	71,342,318
Contract liabilities not included elsewhere	
Interest maintenance reserve	376,259,336
Commissions to agents due or accrued	65,351,793
Commissions and expense allowances payable on reinsurance assumed	11,294,197
General expenses due or accrued	227,331,886
Taxes, licenses and fees due or accrued, excluding federal income taxes	18,485,812
Current federal and foreign income taxes	70,824,188
Unearned investment income	44,783,342
Amounts withheld or retained by company as agent or trustee	64,135,099
Amounts held for agents' account	1,050,210
Remittances and items not allocated	80,344,185
Liability for benefits for employees and agents if not included above	166,059,996
Miscellaneous liabilities:	
Asset valuation reserve	426,891,387
Reinsurance in unauthorized companies	72,084
Funds held under reinsurance treaties with unauthorized reinsurers	64,232
Payable to parent, subsidiaries and affiliates	18,819,050
Liability for amounts held under uninsured accident and health plans	1,056,907
Funds held under coinsurance	79,655,751
Payable for securities	52,870,439
Currency forwards	20,297,122
Contingent reserve for group life premiums and retired lives	17,411,031
Claims liabilities for all other lines of business – pools	13,538,824
Miscellaneous reinsurance liabilities	9,026,536
Miscellaneous liabilities	7,900,937
Minimum loss liability, New York Insurance Law – Section 4308(h)	4,000,000
Put option	1,533,104
Reserve for special litigation expense	<u>1,524,838</u>
Total liabilities	<u>\$20,430,977,680</u>

Contingency reserve for group life	82,567,564
Contingency reserve for aviation reinsurance	3,000,000
Permanent surplus (Arkansas requirements)	1,000,000
Contingency reserve for deposit administration	2,344
Unassigned funds (surplus)	<u>2,818,716,514</u>
Total surplus	\$ <u>2,905,286,422</u>
Total liabilities and surplus	<u>\$23,336,264,102</u>

In its 2004 filed annual statement, the Company reported \$16,008,809 for receivables from parent, subsidiaries and affiliates on page 2, line 20, and \$18,819,050 for payable to parent, subsidiaries and affiliates on Page 3, line 24.4. The review of accounts revealed that five of the 21 accounts that comprise the \$16,008,809 intercompany receivable reported by the Company at December 31, 2004 include amounts due from affiliated entities for federal income tax and reinsurance transactions. Further, \$8,494,353 of the \$18,819,050 intercompany payable resulted from a reinsurance transaction with BLICOA. The annual statement instructions provide that amounts due from intercompany tax sharing agreements and reinsurance transactions be excluded from the intercompany settlement accounts and instead, be reported on the appropriate line items for income tax and reinsurance, respectively.

The examiner recommends that the Company comply with the annual statement instructions by excluding amounts related to intercompany tax sharing agreements and reinsurance transactions from the intercompany accounts and instead, report them separately in the appropriate income tax and reinsurance line items in the annual statement.

## B. CONDENSED SUMMARY OF OPERATIONS

	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
Premiums and considerations	\$5,142,055,636	\$4,338,468,127	\$5,251,208,525	\$5,439,029,601	\$5,610,735,703
Investment income	1,084,473,474	1,087,315,281	1,000,904,256	1,137,346,902	1,262,168,469
Commissions and reserve adjustments on reinsurance ceded	700,177,340	190,485,593	264,324,849	146,396,232	131,300,000
Miscellaneous income	<u>41,798,349</u>	<u>(3,055,864)</u>	<u>22,035,469</u>	<u>8,892,706</u>	<u>17,112,565</u>
Total income	<u>\$6,968,504,799</u>	<u>\$5,613,213,137</u>	<u>\$6,538,473,099</u>	<u>\$6,731,665,441</u>	<u>\$7,021,316,737</u>
Benefit payments	\$3,362,887,816	\$3,471,749,107	\$3,325,602,118	\$3,285,106,067	\$3,666,028,739
Increase in reserves	962,862,699	74,377,477	1,100,049,043	1,160,093,007	1,037,816,365
Commissions	430,601,413	441,519,412	391,902,812	399,802,677	402,412,465
General expenses and taxes	970,050,713	1,021,242,751	1,028,356,140	956,968,870	1,023,762,946
Increase in loading on deferred and uncollected premiums	4,770,521	(1,928,512)	(444,886)	(14,224,664)	(27,418,367)
Miscellaneous deductions	<u>706,374,036</u>	<u>132,433,053</u>	<u>56,595,121</u>	<u>62,400,709</u>	<u>38,867,135</u>
Total deductions	<u>\$6,437,547,198</u>	<u>\$5,139,393,288</u>	<u>\$5,902,060,348</u>	<u>\$5,850,146,666</u>	<u>\$6,141,469,283</u>
Net gain	\$ 530,957,601	\$ 473,819,849	\$ 636,412,751	\$ 881,518,775	\$ 879,847,454
Dividends	432,422,673	537,858,543	513,979,631	518,777,344	538,041,491
Federal and foreign income taxes incurred	<u>(58,633,917)</u>	<u>(44,895,725)</u>	<u>70,367,918</u>	<u>48,145,882</u>	<u>69,454,634</u>
Net gain (loss) from operations before net realized capital gains	\$ 157,168,845	\$ (19,142,969)	\$52,065,202	\$ 314,595,549	\$ 272,351,329
Net realized capital gains (losses)	<u>229,620,515</u>	<u>(182,837,911)</u>	<u>(452,253,199)</u>	<u>(96,936,601)</u>	<u>13,173,980</u>
Net income	<u>\$ 386,789,360</u>	<u>\$ (201,980,880)</u>	<u>\$ (400,187,997)</u>	<u>\$ 217,658,948</u>	<u>\$ 285,525,309</u>

C. SURPLUS ACCOUNT

	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
Capital and surplus, December 31, prior year	\$ <u>1,525,070,938</u>	\$ <u>1,775,787,781*</u>	\$ <u>1,527,470,030</u>	\$ <u>1,913,261,996</u>	\$ <u>2,595,742,128</u>
Net income	\$ 386,789,360	\$ (201,980,880)	\$ (400,187,997)	\$ 217,658,948	\$ 285,525,309
Change in net unrealized capital gains (losses)	(741,415,621)	(248,125,716)	77,079,198	112,644,651	54,081,122
Change in net unrealized foreign exchange capital gain	0	0	61,479,429	54,272,520	8,659,586
Change in net deferred income tax	0	0	(6,323,613)	107,726,086	(67,879,587)
Change in non-admitted assets and related items	6,059,335	(38,155,695)	13,960,779	206,126,451	140,105,368
Change in liability for reinsurance in unauthorized companies	(1,125,145)	(3,104,279)	5,420,313	204,334	(62,876)
Change in reserve valuation basis	16,579,498	2,099,092	129,432,216	0	0
Change in asset valuation reserve	493,938,782	120,164,679	236,797,774	3,922,197	(69,569,389)
Cumulative effect of changes in accounting principles	0	70,414,549	204,008,808	0	0
Surplus adjustments:					
Change in surplus as a result of reinsurance	17,634,938	(9,605,175)	72,894,371	(20,435,055)	(21,669,815)
Miscellaneous gains	0	(268,505)	(666,265)	360,000	4,467,540
Change in surplus: additional pension liability	(69,654,145)	62,744,176	(8,103,047)	0	0
Contribution to charitable trust	0	(2,500,000)	0	0	0
Transfer of IMR – Mortgage	3,540,140	0	0	0	0
Surplus adjustment: merger expenses	(1,358,699)	0	0	0	0
Change in provision for guarantee association investments	5,199,715	0	0	0	0
Change in provision for investments	4,771,020	0	0	0	0

	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
Adjustment of liability for federal income taxes, prior years	7,899,322	0	0	0	0
Adjustment of prior year reinsurance recoverable	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>(24,112,960)</u>
Net change in capital and surplus for the year	<u>\$ 128,858,500</u>	<u>\$ (248,317,754)</u>	<u>\$ 385,791,966</u>	<u>\$ 682,480,132</u>	<u>\$ 309,544,298</u>
Capital and surplus, December 31, current year	<u>\$1,653,929,438</u>	<u>\$1,527,470,030</u>	<u>\$1,913,261,996</u>	<u>\$2,595,742,128</u>	<u>\$2,905,286,426</u>

\* Starting with January 1, 2001, surplus amounts shown above include the impact of the Company's merger with Berkshire Life Insurance Company ("BLIC") on July 1, 2001.

## 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.

The examiner selected a sample of 50 life insurance replacement files out of a total population of 2,814. The sample was randomly selected from a data file which the Company represented as being comprised exclusively of life insurance replacements issued by the Company in New York. However, upon review of the files, it was noted that the sample consisted of the following:

- 37 New York files issued by Guardian (10 internal and 27 external)
- 8 New York files issued by BLICOA (1 internal and 7 external)
- 2 files which did not contain any documentation and, therefore, neither the replacement company nor the issue state could be verified
- 1 out-of-state replacement file
- 2 files furnished subsequent to the examination completion that were not reviewed

Based on the examiner's review of 45 replacement files, various violations of Department Regulation No. 60 were found.

Section 51.6(b) of Department Regulation No. 60 states, in part:

“Where a replacement has occurred or is likely to occur, the insurer replacing the life insurance policy or annuity contract shall . . .

(3) Examine any proposal used, including the sales material used in the sale of the proposed life insurance policy or annuity contract, and the ‘Disclosure Statement,’ and ascertain that they are accurate and meet the requirements of the Insurance Law and this Part . . .

(4) Within ten days of receipt of the application furnish to the insurer whose coverage is being replaced a copy of any proposal, including the sales material

used in the sale of the proposed life insurance policy or annuity contract, and the completed 'Disclosure Statement' . . . ”

Section 51.6(e) of Department Regulation No. 60 states:

“Both the insurer whose life insurance policy or annuity contract is being replaced and the insurer replacing the life insurance policy or annuity contract shall establish and implement procedures to ensure compliance with the requirements of this Part. These procedures shall include a requirement that all material be dated upon receipt. . . .”

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 . . .  
 (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 review revealed that 21 (17 Guardian and 4 BLICOA) of 34 (62%) external replacement files did not contain a letter or any disclosure information obtained from the company whose policy was being replaced. In response to this finding the Company advised that it does not require the agents to submit the information obtained from the original insurer. Without a copy of the information provided by the existing insurer, it is impossible for the Company to determine the accuracy and completeness of the information reported on the Disclosure Statement for the existing policy(s) or contract(s).

The Company violated Section 51.6(b)(3) of Department Regulation No. 60 by failing to examine and ascertain that Disclosure Statements completed by its agents and submitted with applications during the examination period were accurate and complete with respect to the information on such Disclosure Statements pertaining to the existing coverage.

The Company violated Sections 243.2(b)(1) and (8) of Department Regulation No. 152 by failing to maintain the documentation obtained from the original insurer.

In three of the 34 (9%) external replacement files the Company sent the notification letter to the original insurer more than ten days after receiving the application. In two (6%) other files, the notification letter failed to indicate that the required disclosure information was attached.

The Company violated Section 51.6(b)(4) of Department Regulation No. 60 by failing to furnish, within ten days of receipt of the application, a copy of any proposal including the sales material used in the sale of the proposed life insurance policy and the completed Disclosure Statement to the insurer whose coverage was being replaced.

As noted above, 17 Guardian external replacement files failed to contain disclosure information obtained from the original insurer. In 13 of these 17 files, the examiner was unable to determine the number of days that elapsed between giving notification to the company whose policy was being replaced (authorization letter) and when such company furnished the required information to Guardian (20 day limit). The examiner was unable to make this determination due to the Company's failure both to record the date the authorization letter was mailed and to date stamp the information upon receipt.

In 35 instances (25 applications and 10 Disclosure Statements) documentation contained in the replacement files did not contain a date stamp indicating when the information was received by the Company. The Company advised that its procedure is to date stamp the agents' certification upon receipt. The agent's certification, however, is not part of the application or a recognized Department Regulation No. 60 form. Furthermore, the agent's certification may be received at a different time than the application and the required Department Regulation No.60 forms.

The Examiner recommends that the Company date stamp the application and all Department Regulation No. 60 forms.

The examiner recommends that the Company implement controls and procedures to comply with the above cited sections of Department Regulation No. 60.

#### B. Underwriting and Policy Forms

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

Section 3221(l)(11-a)(A) of the New York Insurance Law states:

“Every policy delivered or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall provide, upon the prescription of a health care provider legally

authorized to prescribe under title eight of the education law, the following coverage for diagnostic screening for prostatic cancer:

- (i) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and
- (ii) an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risk factors.”

Since January 1, 2001, the effective date of the above stated mandate, the Company issued 702 group health contracts that did not include language notifying the contractholder of the availability of a prostate screening benefit. Although the examination review did not uncover any instances where the Company denied a prostate screening claim on the basis that the benefit was not covered under the contract, the examiner was unable to determine the number of instances where either a claim for the screening was not submitted or the benefit was not utilized at all due to the Company’s failure to identify this coverage in the group contract.

The Company violated Section 3221(l)(11-a)(A) of the New York Insurance Law by failing to include the requisite policy language in its group health contracts providing for the availability of a prostate screening benefit.

The examiner recommends that the Company notify all policyholders and certificateholders of the availability of the prostate screening benefit and provide the opportunity for certificateholders to submit previously unreported claims for prostate screening.

Section 3201 of the New York Insurance Law states, in part:

- “(a) . . . policy form means any policy, contract, certificate, or evidence of insurance and any application therefor, or rider or endorsement thereto . . .
- (b)(1) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law. . . .”

A review of policy forms revealed that the Group Insurance Enrollment and Record Form (form #GG-011364S) was not filed with and approved by the Superintendent. The form is an application for insurance.

A review of 55 group underwriting files revealed nine instances where the Company used application form #GG-012638 for plans issued in New York. Form #GG-012638, however, is filed with the Department exclusively for use in the sale of plans outside New York.

The Company violated Section 3201(b) of the New York Insurance Law by utilizing unapproved applications.

Section 403(d) of the New York Insurance Law states, in part:

(d) All applications for commercial insurance, individual, group or blanket accident and health insurance and all claim forms...shall contain a notice in a form approved by the superintendent that clearly states in substance the following:

"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."

Pursuant to Section 403(d) of the New York Insurance Law, the Superintendent promulgated Section 86.4 of Department Regulation No. 95, which states in part:

“(a) . . . all claim forms for insurance, and all applications for commercial insurance and accident and health 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.’ . . .

(e) . . . insurers may use substantially similar warning statements provided such warning statements are submitted to the Insurance Frauds Bureau for prior approval.”

A review of 55 group underwriting files revealed the following.

- In nine instances, the Company used policy forms #GG-010702 and #GG-010703 that were filed with and approved by the Superintendent in 1989. However, these forms were not updated as

required by Department Regulation No. 95 and, as a result, do not contain any fraud language.

- In two instances, the Company used policy forms #GG-012637 and #GG-013874, that were filed with and approved by the Superintendent. However, the fraud warning statement that was originally filed and approved was subsequently altered. Such altered language neither conforms to Section 86.4 of Department Regulation No. 95 nor was it submitted for prior approval.

The Company violated Section 403(d) of the New York Insurance Law and Section 86.4(a) and (e) of Department Regulation No. 95 by utilizing policy forms that failed to contain the required fraud warning statement and by using policy forms with altered fraud warning statements without obtaining prior approval from the Department's Insurance Frauds Bureau.

### 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.

Regarding the review of health care services, Section 4904(d) of New York Insurance Law states:

“Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.”

A review of the Company's appeals procedures as it relates to the processing of dental claims was performed. Based on a sample of 20 files, it was revealed that in 2 instances the same clinical peer reviewer rendered both the initial adverse and subsequent appeals determinations.

The Company violated Section 4904(d) of the New York Insurance Law by allowing the same clinical peer reviewer to render both the initial adverse and subsequent appeals determinations.

The examiner recommends that the Company re-open all appeals cases whereby the same clinical peer reviewer rendered both the initial adverse and subsequent appeals determinations and have such cases reviewed by a different clinical peer reviewer.

The review of life insurance claims revealed that the Company's standard method for paying claims is through a retained asset account. The Company calls its retained asset arrangement the Guardian Asset Account ("GAA"). The GAA is a draft account administered and payable through State Street Bank. Upon receipt of a death claim, the beneficiary is provided with a checkbook which is drawn on State Street Bank. The Company will open a GAA for the beneficiary if: a method of payment was not selected by the policyowner; the amount of the proceeds is greater than \$10,000; and the beneficiary has not selected another option on the claim form.

The claim form lists seven options from which the beneficiary may choose, provided that a particular option had not previously been selected by the policyowner. The seven options are as follows:

- Place proceeds under a Supplement Contract
- Place proceeds into a Guardian Asset Account, GAA
- Option I – Interest Option — Hold proceeds making: (1) periodic interest payments; or (2) interest to accumulate
- Option II, Specified Amount — Make monthly payments of a specified amount until proceeds and interest are fully paid
- Option III, Specified Period — Make monthly payments of a specified number of years
- Option IV, Life Income — 10 years certain and Life — Making monthly payments for 10 years and for the remaining lifetime of the person on whose life the option is based.
- Other manner of payment \_\_\_\_\_

To make a selection, the claimant/beneficiary would check the box in front of the desired option. If no selection is made, the default option is the GAA. If the beneficiary wishes to receive a single check for the proceeds, the "Other manner of payment" option is to be checked and the words "Lump Sum" are then written on the blank line. The instructions provided by the Company clearly identify this procedure.

A review of 47 individual life insurance claims revealed that while 30 claims were eligible for GAA, 25 claimants elected to receive a single check and 5 received the GAA. Based on the sample, it appears that the single check is the favored method of payment selected by beneficiaries. Accordingly, it seems that the form would be more manageable if the lump sum option was clearly identified as one of the specific options listed.

The examiner recommends that the Company add a lump sum option on the claim form for the convenience of its claimants.

## 7. RECORD RETENTION

During the course of the examination, there were numerous instances where the Company was unable to produce requested applications and claim files and/or the underlying support. The following record retention deficiencies were also noted.

- In 23 of the 34 declined individual life insurance policy files provided, the Company failed to maintain the letter advising the applicant that a denial determination had been made.
- During the examination the Company stated that two of the 50 replacement files requested could not be provided. Subsequent to the examination completion the files were provided, but were not reviewed.
- The Company was unable to provide three Explanation of Benefit Forms and 18 claim forms supporting its group medical claims determinations.
- During the examination the Company stated that seven dental claims files could not be produced due to age. Subsequent to the examination completion the files were provided, but have not been reviewed.

The examiner recommends that the Company improve its record retention policies and procedures such that requested files and the underlying documentation supporting such files can be furnished in a timely manner.

## 8. HEALTH NET

The Company has a joint venture arrangement with Health Net Insurance Company of NY, Inc. (“Health Net”). Such joint venture provides the Company with the exclusive right to market and sell Health Net’s out-of-network products (Health Maintenance Organizations, Preferred Provider Organizations and Point of Service Plans) to small employer groups. Under the contractual arrangement the Company performs the premium billing and collection services, while Health Net provides all claims administration functions. The Company and Health Net share the profits and losses through a 50% reinsurance agreement. The underlying group policies are written on the Company’s policy form, and marketed under the name Guardian Health Care Solutions (“Solutions”).

Section 216.4(e) of Department Regulation No. 64 states:

“As part of its complaint handling function, an insurer's consumer services department shall maintain an ongoing central log to register and monitor all complaint activity.”

The examiner’s comparison of the complaint log obtained from the Department’s Consumer Services Bureau with the Company’s central complaint log revealed complaint cases which the Company failed to maintain in the central log. It was determined that the Company failed to maintain in its central log certain complaints involving its policies, which were filed with Health Net and handled by Health Net.

The Company violated Section 216.4(e) of Department Regulation No. 64 by failing to register all of its complaint activity in its central log.

The review included an analysis of the Explanation of Benefits forms (“EOBs”) sent to subscribers and/or providers for services provided under its Solutions product. An EOB is an important link between the subscriber, provider and insurance company. It should clearly communicate to the subscriber and/or provider that the Company has processed a claim and how that claim was processed. It should correctly describe the charges submitted, the date the claim was received, the amount allowed for the specific services rendered and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other insurance carriers.

Section 3234 of the New York Insurance Law states, in part:

“(a) Every insurer . . . is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expense or home care expense benefits.

(b) The explanation of benefits form must include at least the following . . .

(3) an identification of the service for which the claim is made . . .

(7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made.”

The examiner's review of a sample of EOBs revealed the following deficiencies.

- EOBs do not provide an identification of the service for which the claim is made. Rather than identifying the specific service(s) for which the claim was submitted, it identifies the general category of care, i.e. “Office,” “In-Patient,” “Out-Patient” and “Other.” This type of disclosure is inadequate as it denies the insured or subscriber information needed in order to establish whether an appeal or complaint is warranted or whether a fraudulent bill was submitted.
- Prior to March 2003, EOBs did not contain adequate appeals language as required under Section 3234(b)(7) of the New York Insurance Law. Instead, the EOBs directed subscribers to their member ID cards in order to obtain the necessary information.
- EOBs do not indicate the name of the Company or that the processed claim was for services rendered under the Solutions contract. Further, the only insurer identified on the letterhead is Health Net. Health Net, however, is deemed a third party administrator in the processing of the Solutions' claims, as the ultimate responsibility for paying the claims rests with the Company. As the EOB fails to identify the Company or the specific contract for which the claim is processed, the subscriber or insured is likely to believe that Health Net bears the ultimate claims paying responsibility. This confusion was

highlighted during the review of complaints, where it was noted that some of the Company's complaints were initially made against Health Net.

- EOBs provided for mental and behavioral health and therapeutic (chiropractic and physical medicine) claims were not available for examination review as Health Net does not obtain copies of them from its third party administrators, MHN, Inc. and Landmark HealthCare, Inc. ("Landmark"), respectively. However, during the review of Department complaints, the examiner discovered an EOB provided by Landmark that did not contain the proper appeals language. It was also noted that the only insurer referenced in the correspondence was Health Net.

The Company violated Section 3234(b)(3) of the New York Insurance Law by failing to provide on its EOBs an identification of the service for which a claim is made.

The Company violated Section 3234(b)(7) of the New York Insurance Law by failing to provide information on its EOBs regarding the insured's or subscriber's right of appeal.

The examiner recommends that the EOBs be modified to clearly indicate that the claims are processed pursuant to the Company's coverage under its Solutions product.

## 9. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following are the violations, recommendations and comment 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 Company violated Section 51.6(a) of Department Regulation No. 60 by not having a completed "Definition of Replacement" form signed by the applicant and agent in all cases.</p> <p>A review of replacement files did not reveal any instances whereby the Company failed to obtain a completed Definition of Replacement form.</p>
B	<p>The Company violated Section 51.6(e) of Department Regulation No. 60 by not dating "Definition of Replacement" forms.</p> <p>A review of replacement files did not reveal any instances where a Definition of Replacement form was not dated.</p>
C	<p>The Company did not comply with its filed replacement procedures.</p> <p>A similar violation appears in this report. (See item 6A of this report)</p>
D	<p>The Company violated Section 52.54(c)(2)(iv) of Department Regulation No. 62 by not having the required language in its Disclosure Statement.</p> <p>A review of policy forms did not reveal any instances whereby the Company violated 52.54(c)(iv) of Department Regulation No. 62.</p>
E	<p>The examiner recommends that the Company review its forms, acceptance letters and renewal letters used in connection with limited benefits and major medical insurance issued under the joint venture and change those documents as necessary.</p> <p>A review of policy forms did not reveal forms that were inappropriately worded.</p>
F	<p>The Company violated the stipulation agreement from the previous report on examination.</p> <p>A review of surrender files did not reveal any instances whereby the Company violated the terms of the stipulation agreement from the examination as of December 31, 1995.</p>

<u>Item</u>	<u>Description</u>
G	<p>The Company violated Section 3227 of the New York Insurance Law.</p> <p>A review of surrenders did not reveal any instances whereby the Company violated Section 3227 of the New York Insurance Law.</p>
H	<p>The Company violated Section 216.11 of Department Regulation No. 64 by not maintaining its surrender files so as to enable the examiner to determine the Company's compliance with Section 3227 of the New York Insurance Law.</p> <p>The Company was able to produce the necessary records to support the surrenders for the sample selected by the examiner.</p>
I	<p>Comment that the Company did not pay the correct interest on surrenders as required by the stipulation.</p> <p>A review of surrenders did not reveal any instances whereby interest was paid incorrectly.</p>
J	<p>The Company violated Section 243.2(b) of Department Regulation No. 152 by not maintaining application and claim files.</p> <p>The Company again violated Section 243.2(b) of Department Regulation No. 152 by not maintaining application and claim files. (See item 7 of this report)</p>
K	<p>The Company violated Section 243.2(b) of Department Regulation No. 152 by failing to maintain policies and applications files from 1991, until the filing of the report on examination in which the record was subject to review.</p> <p>The Company again violated Section 243.2(b) of Department Regulation No. 152 by not maintaining all of its policy and claim files.</p>
L	<p>The examiner recommends that the Company maintain all signed copies of their "Destruction Notification" forms.</p> <p>According to the Company, no records were destroyed during the period under examination. Therefore no "Destruction Notification" forms were applicable to the examination period.</p>

<u>Item</u>	<u>Description</u>
M	<p>The examiner recommends that the Company conduct a thorough review of its file maintenance and disaster recovery procedures and take the steps necessary to clearly demonstrate that it has complied with Department Regulation No. 152.</p> <p>Although the Company asserts that it has taken steps to address its record keeping deficiencies, the Company continues to violate Department Regulation No. 152 by not maintaining all of its records such as policy and claim files. (See Section 7 of this report)</p>

## 10. 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 308 of the New York Insurance Law and failed to comply with Department Circular Letter No. 17 (2001) by entering into three service agreements after September 1, 2001 without filing form CL 17 (2001) with the Department.	13
B	The examiner recommends that the board of directors document in the board minutes the approval of meeting times which differ from those stated in its by-laws.	14
C	The Company violated Section 91.4(c) of Department Regulation No. 33 by not using an appropriate methodology to allocate net investment income generated from its BLIC products.	20
D	The examiner recommends that the Company distribute net investment income for BLIC's individual annuities and supplementary contracts using either the reserve method or the fund method, or that another methodology be submitted to the Department for review.	20
E	The examiner recommends that the Company comply with the annual statement instructions by excluding amounts related to intercompany tax sharing agreements and reinsurance transactions from the intercompany accounts and, instead, report them separately in the appropriate income tax and reinsurance line items in the annual statement.	27
F	The Company violated Section 51.6(b)(3) of Department Regulation No. 60 by failing to examine and ascertain that Disclosure Statements completed by its agents and submitted with applications during the examination period were accurate and complete with respect to the information on such Disclosure Statements pertaining to the existing coverage..	32
G	The Company violated Section 243.2(b)(1) and (8) of Department Regulation No. 152 by failing to maintain the documentation obtained from the original insurer.	32

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
H	The Company violated Section 51.6(b)(4) of Department Regulation No. 60 by failing to furnish, within ten days of receipt of the application, a copy of any proposal including the sales material used in the sale of the proposed life insurance policy and the completed "Disclosure Statement" to the insurer whose coverage was being replaced.	32-33
I	The Examiner recommends that the Company date stamp the application and all Department Regulation No. 60 forms.	33
J	The Examiner recommends that the Company implement controls and procedures to comply with the above cited sections of Department Regulation No. 60.	33
K	The Company violated Section 3221(l)(11-a)(A) of the New York Insurance Law by failing to include the requisite policy language in its group health contracts providing for the availability of a prostate screening benefit.	34
L	The Examiner recommends that the Company advise all policyholders and certificateholders of the availability of the prostate screening benefit and provide the opportunity for certificateholders to submit previously unreported claims for prostate screening.	34
M	The Company violated Section 3201(b) of the New York Insurance Law by utilizing unapproved applications.	34 - 35
N	The Company violated Section 403(d) of the New York Insurance Law and Section 86.4(a) and (e) of Department Regulation No. 95 by utilizing policy forms that failed to contain the required fraud warning statement and by using policy forms with altered fraud warning statements without obtaining prior approval from the Department's Insurance Frauds Bureau.	35 - 36
O	The Company violated Section 4904(d) of the New York Insurance Law by allowing the same clinical peer reviewer to render both the initial adverse and subsequent appeals determinations.	36
P	The examiner recommends that the Company re-open all appeals cases whereby the same clinical peer reviewer rendered both the initial adverse and subsequent appeals determinations and have such cases reviewed by a different clinical peer reviewer.	37

<u>Item</u>	<u>Description</u>	<u>Page No(s).</u>
Q	The examiner recommends that the Company add a lump sum option on the claim form for the convenience of its claimants.	38
R	The examiner recommends that the Company improve its record retention policies and procedures such that requested files and the underlying documentation supporting such files can be furnished in a timely manner.	38
S	The Company violated Section 216.4(e) of Department Regulation No. 64 by failing to register all of its complaint activity in its central log.	39
T	The Company violated Section 3234(b)(3) of the New York Insurance Law by failing to provide on the EOBs an identification of the service for which a claim is made.	40 - 41
U	The Company violated Section 3234(b)(7) of the New York Insurance Law by failing to provide on the EOBs the information regarding the insured's or subscriber's right of appeal.	40 - 41
V	The examiner recommends that the EOBs be modified to clearly indicate that the claims are processed pursuant to the Company's coverage under its Solutions product.	41



**APPOINTMENT NO. 22340**

**STATE OF NEW YORK**  
**INSURANCE DEPARTMENT**

I, HOWARD MILLS, Acting Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**MARC TSE**

*as a proper person to examine into the affairs of the*

**GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**

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

**COMPANY**

*with such other information as he 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 7th day of March, 2005*



**HOWARD MILLS**

*Acting Superintendent of Insurance*

A handwritten signature in cursive script, appearing to read "Howard Mills", written over a horizontal line.

*Acting Superintendent*