MARKET CONDUCT REPORT ON EXAMINATION

OF THE

MONY LIFE INSURANCE COMPANY

AS OF DECEMBER 31, 2017

EXAMINER: **RORY CUMMINGS**

DATE OF REPORT: **MAY 9, 2019**

TABLE OF CONTENTS

ITEM		PAGE NO.
1.	Executive summary	2
2.	Scope of examination	3
3.	Description of Company	4
	A. History	4
	B. Territory and plan of operation	6
4.	Market conduct activities	7
	A. Treatment of policyholders	7
	B. Non-Facilitation of the examination	12
5.	Prior report summary and conclusions	14
6.	Summary and conclusions	15

KATHY HOCHUL
Governor

ADRIENNE A. HARRIS
Superintendent

November 1, 2022

Honorable Adrienne A. Harris
Superintendent of Financial Services
New York, New York 10004

Dear Adrienne A. Harris:

In accordance with instructions contained in Appointment No. 31771, dated May 31, 2018, and annexed hereto, an examination has been made into the condition and affairs of MONY Life Insurance Company ("MONY"), hereinafter referred to as "the Company" at its administrative office located at 2801 Highway 280 South, Birmingham, AL 35223. The Company's statutory home office is located at 5788 Widewaters Parkway, Syracuse, NY, 13214.

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

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

1. EXECUTIVE SUMMARY

The material violations contained in this report are summarized below.

- The Company violated Section 3211(b)(2) of the New York Insurance Law by failing to include the phrase, "…the policy shall terminate or lapse except as to the right to any cash surrender value or non-forfeiture benefit" on premium due or insufficiency notices. (See item 4A of this report.)
- The Company violated Section 310(a)(2)(3) of the New York Insurance Law by failing to make records and documents readily available and accessible; thereby, failing to facilitate the examination. (See item 4B of this report.)
- The Company violated Section 3214(c) of the New York Insurance Law by failing to pay interest or the correct amount of interest on proceeds of matured endowment contracts and supplementary contracts left under the interest settlement option. (See item 4A of this report.)
- The Company violated Section 3240(f)(1) of the New York Insurance Law by failing to establish procedures to reasonably confirm the death of an insured or accountholder and begin to locate beneficiaries within ninety days after the identification of a potential match. (See item 4A of this report.)

2. SCOPE OF EXAMINATION

This examination covers the period from January 1, 2011 to December 31, 2017. As necessary, the examiner reviewed matters occurring subsequent to December 31, 2017, 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 Regulations Handbook* or such other examination procedures, as deemed appropriate, in such review.

The examiner reviewed the corrective action taken by the Company with respect to the market conduct violation contained in the prior report on examination. The results of the examiner's review are contained in item 5 of this report.

This report on examination is confined to comments on 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 mutual life insurance company under the laws of New York on April 12, 1842, was licensed on April 12, 1842 and commenced business on February 1, 1843, under the name Mutual Life Insurance Company of New York ("MONY").

On April 1, 1952, the Company began to issue individual accident and health insurance. In 1953, the Company entered the group insurance business by offering a plan known as "module insurance," which provided for various combinations of life insurance, accident and health insurance and retirement income in a single package to small employer groups. In 1989, the Company exited the group employer life and accident and health insurance business. In 1990, the Company stopped writing group association life and accident and health insurance business. On December 31, 1993, the Company entered into an agreement with AEGON USA, Inc. under which the Company agreed to transfer substantially all of its group pension business and operations, including its full-service group pension contracts, to AEGON USA, Inc.'s wholly owned subsidiary, AUSA Life Insurance Company, Inc., now known as Transamerica Financial Life Insurance Company.

On November 16, 1998, pursuant to an order issued by the New York Superintendent of Insurance approving a Plan of Reorganization ("The Plan") under Section 7312 of the New York Insurance Law, as amended, the Company converted from a mutual life insurance company to a domestic stock life insurance company and became a wholly owned subsidiary of The MONY Group Inc. ("The MONY Group"), a Delaware corporation organized for the purpose of becoming the parent holding company of MONY. Also, on November 16, 1998, The MONY Group consummated an initial public offering of approximately 12.9 million shares of its common stock at $23.50 per share. Under The Plan, The MONY Group, in exchange for its policyholder membership interests in MONY, issued approximately 34.4 million shares of common stock, accrued or paid $20.6 million in cash, and credited $13.3 million in policy credits to its policyholders. Unassigned surplus of $610.7 million was transferred to paid in surplus in conjunction with the issuance of common stock to policyholders. Effective November 16, 1998, the Company changed its name to MONY Life Insurance Company.

On February 27, 2002, pursuant to the Articles of Incorporation approved by the Delaware Secretary of State, MONY Holdings, LLC became a wholly-owned subsidiary of The MONY Group. All issued and outstanding shares of the Company were transferred to MONY Holdings, LLC.

On July 8, 2004, AXA Financial, Inc. completed its acquisition of The MONY Group. On November 30, 2007, MONY Holdings, LLC merged into AXA Equitable Financial Services, LLC ("AEFS"), a wholly-owned subsidiary of AXA Financial Inc.

On October 1, 2013, Protective Life Insurance Company ("PLICO"), purchased the Company for $685.6 million. The acquisition of the Company by PLICO was contemplated by the master agreement (the "Master Agreement") dated April 10, 2013. Pursuant to the Master Agreement with AXA and AEFS, PLICO acquired the stock of the Company from AEFS. Prior to the PLICO transaction, the Company transferred as dividends its ownership interest in several wholly-owned subsidiaries to AEFS with a total value of $611.2 million. At that time, the Company also transferred to AEFS as a dividend, its ownership interest in other investments at fair value totaling $189.6 million. Also, immediately prior to the PLIC transaction, the Company effectively received capital contributions totaling $238.1 million from AEFS that resulted from AEFS assuming certain liabilities of the Company.

As a result of the purchase, the Company's business is comprised of run-off books of life insurance, including whole life, term life, variable, universal life and a small amount of fixed and variable annuities.

The Company is a wholly-owned subsidiary of PLICO an insurance company domiciled in Tennessee. PLICO is a wholly-owned subsidiary of Protective Life Corporation ("PLC"), an insurance holding Company.

On February 1, 2015, PLC, immediate parent of PLICO and ultimate parent of the Company, was acquired by The Dai-ichi Life Insurance Company, Limited, a kabushiki kaisha (publicly traded company) organized under the laws of Japan.

Effective October 1, 2016, The Dai-ichi Life Insurance Company, Limited reorganized into a holding company structure and changed its name to Dai-ichi Life Holdings, Inc. ("Dai-ichi"), and Dai-ichi contributed substantially all of the assets and liabilities relating to the domestic life insurance business of The Dai-ichi Life Insurance Company, Limited (excluding The Dai-ichi Frontier Life Insurance Co., Ltd. and The Neo First Life Insurance Company, Limited, each being

a wholly-owned subsidiary of Dai-ichi), to a new wholly-owned direct subsidiary of Dai-ichi, which was renamed The Dai-ichi Life Insurance Company, Limited.

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 all 50 states, the District of Columbia, Guam, Puerto Rico, U.S. Virgin Islands, and Canada. In 2017, 20.2% of life premiums, 73.9% of annuity considerations and 9.9% of accident and health premiums were received from New York. Policies are written on a participating and non-participating basis.

The following tables show the percentage of direct premiums received, by state, and by major lines of business for the year 2017:

Life Insurance Premiums		Annuity Considerations	
New York	20. 2%	New York	73.9%
Texas	6.7	New Jersey	6.4
California	5.9	Georgia	5.0
Illinois	5.5	Texas	3.8
Pennsylvania	5.3	State	2.9
Subtotal	43.6%	Subtotal	92.0%
All others	56.4	All others	8.0
Total	100.0%	Total	100.0%

Accident and Health Insurance Premiums	
New York	9.9%
Illinois	8.3
California	8.2
Pennsylvania	6.7
Florida	6.6
Subtotal	39.7%
All others	60.3
Total	100.0%

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

> "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.' ". . .

The examiner reviewed a sample of 19 disability claims. In 19 out of 19 (100%) disability claims reviewed, the Company did not include the required fraud warning statement on the claim form.

The examiner reviewed a sample of 17 supplementary contract death claims. In 1 out 17 (6%) supplementary contract death claims reviewed, the Company did not include the fraud warning statement on the clam form.

The Company violated Section 403(d) of the New York Insurance law by failing to include the fraud warning statement on the claim form.

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

> "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 non-forfeiture benefit."

The examiner reviewed a sample of 35 lapsed policy files. The lapse files were comprised of 12 term life, 7 universal life, 7 group universal life, 4 group life, 3 variable universal life and 2 whole life policy files.

In 14 out of 14 (100%) term and whole life lapses files reviewed, the Company's premium due notices sent to policyholders did not contain the phrase, "…the policy shall terminate or lapse except as to the right to any cash surrender value or non-forfeiture benefit." Instead, the term and whole life premium due notices sent to policyholders contained the phrase, "…the policy and all payments on it will become forfeited and void, except as to the right to surrender value…."

In 7 out 7 (100%) universal life lapse files reviewed, the Company's insufficiency notices sent to policyholders did not contain the phrase, "…the policy shall terminate or lapse except as to the right to any cash surrender value or non-forfeiture benefit."

The Company violated Section 3211(b)(2) of the New York Insurance Law by failing to include the phrase, "…the policy shall terminate or lapse except as to the right to any cash surrender value or non-forfeiture benefit" on premium due or insufficiency notices.

Upon notification, the Company completed a lapse remediation of their universal life files and determined that 5 insureds died within one year of the non-compliant insufficiency notice. The Company has paid 4 of the claims and will escheat the benefits to the State for the remaining claim if it cannot locate the beneficiaries.

The examiner recommends that the Company upgrade their term and whole premium due notices to be in compliance with the statutory language, "…the policy shall terminate or lapse except as to the right to any cash surrender value or non-forfeiture benefit."

3. 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."

A. The examiner reviewed a sample of 20 matured policies. In 5 out of 20 (25%) matured policies reviewed, the Company failed to pay interest or the correct amount of interest on proceeds of endowment contracts left under the interest settlement option.

B. The examiner reviewed a sample of 17 supplemental contract death claims. In 1 out of 17 (6%) supplementary contracts reviewed, the Company failed to pay the correct amount of interest.

The Company violated Section 3214(c) of the New York Insurance Law by failing to pay interest or the correct amount of interest on proceeds of matured endowment contracts and supplementary contracts left under the interest settlement option.

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

> "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 expenses 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) . . . 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…"

A. The examiner reviewed a sample of 9 other accident and health paid claims. In 9 out of 9 (100%) paid claims reviewed, the explanation of benefits ("EOB") form did not include the identification of the service for which the claim was made and did not contain 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.

B. The examiner reviewed a sample of 4 group health paid claims. In 4 out of 4 (100%) group claims reviewed, the explanation of benefits ("EOB") form did not include the identification of the service for which the claim was made and did not contain a description of the time limit 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 Company violated Section 3234(b)(3) of the New York Insurance Law by failing to identify the service for which the claim is made on the EOB form.

The Company also violated Section 3234(b)(7) of the New York Insurance Law by failing to include on the EOB form the description of the time limit 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.

5. Section 3240 of the New York Insurance Law states, in part:

> "(b)(2)(A) with respect to a policy delivered or issued for delivery outside this state, a domestic insurer may, in lieu of the requirements of this section, implement procedures that meet the minimum requirements of the state in which the insurer delivered or issued the policy, provided that the superintendent determines that such other requirements are no less favorable to the policy owner and beneficiary than those required by this section; and…
> (f) Standards for locating claimants. (1) An insurer shall establish procedures to reasonably confirm the death of an insured or accountholder and begin to locate beneficiaries within ninety days after the identification of a potential match made by a death index cross-check or by a search conducted by the insurer pursuant to subsection (e) of this section. If the insurer cannot locate beneficiaries within ninety days after the identification of a potential match, then the insurer shall continue to search for beneficiaries until the benefits escheat in accordance with applicable state law…"

The examiner reviewed a sample of 264 policies from the Company's 2017 in-force data file where the insured' attained age was 80 years and above. The examiner also reviewed a population of 169 policies from the Company's expiry inventory where the insured's attained age was 90 years and over. The examiner used the insured's social security number, the insured's name and date of birth to perform searches on the online death databases. The examiner's search of the samples revealed that a few individuals were deceased before the date the policy expired.

A. In 7 out of 264 (3%) in-force life policies searched, the insureds were deceased.

B. In 2 out of 169 (1%) expired policies searched, the insureds were deceased prior to the expiry date of the policies.

The Company violated Section 3240(f)(1) of the New York Insurance Law by failing to establish procedures to reasonably confirm the death of an insured or accountholder and begin to locate beneficiaries within ninety days after the identification of a potential match.

6. Section 216.5(a)(1) of 11 NYCRR 216 (Insurance Regulation 64) states:

> "Every insurer shall commence an investigation of any claim filed by a claimant, or by a claimant's authorized representative, within 15 business days of receiving notice of claim. An insurer shall furnish to every claimant, or claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving notice of the claim. A claim filed with an agent of an insurer shall be deemed to have been filed with the insurer unless, consistent with law or contract, such agent notifies the person filing the claim that the agent is not authorized to receive notices of claim."

The examiner reviewed a sample of 17 supplementary contract death claims. In 1 out of 17 (6%) death claims reviewed, the Company failed to provide the claimants with notification of all items, statements and forms, which the insurer reasonably believes will be required of the claimants, within 15 business days of receipt of the claim notices.

The Company violated Section 216.5(a)(1) of 11 NYCRR 216 (Insurance Regulation 64) by failing to furnish to the claimants, or claimants' authorized representatives, notifications of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving the claim notices.

7. Section 243.2(b) of 11 NYCRR 243 (Insurance Regulation 152) states, in part:

> "Except as otherwise required by law or regulation, an insurer shall maintain:
> (1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this Part A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to Section 243.3(a) of this Part. A policy record shall include: . . .
>
> (8) Any other record for six calendar years from its creation or until after the filing of a report on examination or the conclusion of an investigation in which the record was subject to review."

The examiner reviewed a sample of 35 lapsed policy files. In 2 out of 35 (6%) policy files reviewed, the Company failed to maintain the lapse or termination notices. In 9 out of 35 (26%) policy files reviewed, the Company failed to maintain a copy of the insufficiency notices. In 1 out of 35 (3%) policy files reviewed, the Company failed to maintain a copy of the annual report.

The Company violated Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain copies of lapse notices or termination notices, insufficiency notice and an annual report 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. The examiner reviewed a sample of 35 lapsed policy files. In 2 out of 35 (6%) policy files reviewed, the Company failed to maintain the lapse or termination notices.

The Company violated Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain copies of lapse notices or termination notices 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.

B. The examiner reviewed a sample of 35 lapsed policy files. In 9 out of 35 (26%) policy files reviewed, the Company failed to maintain a copy of the insufficiency notices. In 1 out of 35 (3%) policy files reviewed, the Company failed to maintain a copy of the annual report.

The Company violated Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain a copy of the insufficiency notice and the annual report 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.

B. Non-Facilitation of the Examination

Section 310(a) of the New York Insurance Law ("NYIL") states, in part:

> "(2) Any examiner authorized by the superintendent shall be given convenient access at all reasonable hours to the books, records, files, securities and other documents of such insurer or other person, including those of any affiliated or subsidiary companies thereof, which are relevant to the examination, and shall have power to administer oaths and to examine under oath any officer or agent of such insurer or other person, and any other person having custody or control of such documents, regarding any matter relevant to the examination.

> (3) The officers and agents of such insurer or other person shall facilitate such examination and aid such examiners in conducting the same so far as it is in their power to do so.
> (4) The refusal of any insurer to submit to examination shall be ground for revocation or refusal of a license or renewal license."

The Market Conduct examinations of MONY and Protective Life and Annuity Insurance Company ("PLAIC") were delayed periodically due to the Companies' refusal or inability to provide responses to both pre-examination and examination requests timely which impeded the completion of the examination. The market conduct examination was conducted concurrently with PLAIC, an affiliate Company. The Company was cited in two instances for not facilitating the examination.

The first instance was the result of not providing pre-examination data timely. In advance of both examinations, the Department requested that the Company prepare certain data files, covering the period of January 1, 2011, through December 31, 2017. The data requested was to be used to verify the validity of the underlying data supporting the annual statement exhibits. The Department also requested that some of the data files, such as those for claims and surrender benefits, be reconciled to the annual statement exhibits in advance of the examiner's selection of samples to review for the market conduct examination.

The second instance was the result of not responding to examination requests timely. Throughout the examination the Company was granted extensions to provide responses to examination requests and were additionally warned that not providing responses timely to examination request constitutes non-facilitation of examination.

The Company violated Section 310(a)(2)(3) of the New York Insurance Law by failing to make records and documents readily available and accessible; thereby, failing to facilitate the examination.

5. PRIOR REPORT SUMMARY AND CONCLUSIONS

Following is the violation contained in the prior report on examination and the subsequent action taken by the Company in response to the citation:

Item	Description
A	The Company violated Section 3227 of the New York State Insurance Law by failing to pay the required interest on surrendered policies. The Company took corrective actions when this error was brought to its attention. The examiner’s review of surrender policy files revealed that the Company paid the required interest on surrendered policies.

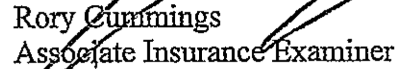
6. SUMMARY AND CONCLUSIONS

Following are the violations contained in this report:

Item	Description	Page No(s).
A	The Company violated Section 403(d) of the New York Insurance Law by failing to include the fraud warning statement on the claim form.	7
B	The Company violated Section 3211(b)(2) of the New York Insurance Law by failing to include the phrase, "…the policy shall terminate or lapse except as to the right to any cash surrender value or non-forfeiture benefit" on premium due or insufficiency notices.	8
C	The examiner recommends that the Company upgrade their term and whole premium due notices to be in compliance with the statutory language, "…the policy shall terminate or lapse except as to the right to any cash surrender value or non-forfeiture benefit."	8
D	The Company violated Section 3214(c) of the New York Insurance law by failing to pay interest or the correct amount of interest on proceeds of matured endowment contracts and supplementary contracts left under the interest settlement option.	9
E	The Company violated Section 3234(b)(3) of the New York Insurance Law by failing to identify the service for which the claim is made on the EOB form.	10
F	The Company violated Section 3234(b)(7) of the New York Insurance Law by failing to include on the EOB form the description of the time limit 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.	10
G	The Company violated Section 3240(f)(1) of the New York Insurance Law by failing to establish procedures to reasonably confirm the death of an insured or accountholder and begin to locate beneficiaries within ninety days after the identification of a potential match.	11
H	The Company violated Section 216.5(a)(1) of 11 NYCRR 216 (Insurance Regulation 64) by failing to furnish to the claimants, or claimants' authorized representatives, notifications of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant, within 15 business days of receiving the claim notices.	11

Item	Description	Page No(s).
I	The Company violated Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) by failing to maintain copies of the lapse notices or termination notices, insufficiency notices and an annual report 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.	12
J	The Company violated Section 310(a)(2)(3) of the New York Insurance Law by failing to make records and documents readily available and accessible; thereby, failing to facilitate the examination.	13

Respectfully submitted,



Rory Cummings
Associate Insurance Examiner

STATE OF NEW YORK)
)SS:
COUNTY OF NEW YORK)

Rory Cummings, being duly sworn, deposes and says that the foregoing report, subscribed by him, is true to the best of his knowledge and belief.

Rory Cummings

Subscribed and sworn to before me
this 1st day of November 2022
Audrey Hall

AUDREY HALL
Notary Public, State of New York
No. 01HA6274900
Qualified in Kings County
Commission Expires January 28, 2025

Respectfully submitted,

/s/
Mostafa Mahmoud
Principal Insurance Examiner

STATE OF NEW YORK)
)SS:
COUNTY OF NEW YORK)

Mostafa Mahmoud, being duly sworn, deposes and says that the foregoing report, subscribed by him, is true to the best of his knowledge and belief.

/s/
Mostafa Mahmoud

Subscribed and sworn to before me

this__________ day of ____________________

APPOINTMENT NO. 31771

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, MARIA T. VULLO, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:

RORY CUMMINGS

as a proper person to examine the affairs of the

MONY LIFE INSURANCE COMPANY

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

COMPANY

with such other information as he shall deem requisite.

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

this 31st day of May, 2018

MARIA T. VULLO
Superintendent of Financial Services

By: Mark McLeod

MARK MCLEOD
DEPUTY CHIEF - LIFE BUREAU