UPDATED

Agenda

CEFLI Compliance & Ethics Committee Meeting
Wednesday, February 13, 2019
2 PM EST/1 PM CST/12 Noon MST/11 AM PST
Dial In: (800) 239-9838
Passcode: 3646069

I. Welcome and Introduction. — Donald J. Walters

A. Antitrust Statement.

II. Approval of Minutes – January 23, 2019 Meeting. — The Committee

III. Issues for Review. — The Committee

A. New York Department of Financial Services Circular Letter No. 1 (2019) — The Committee

The NYDFS recently issued Circular Letter No. 1 regarding insurers use of external consumer data and information sources in underwriting for life insurance. (See copy attached.)

In 2017, the NYDFS issued a Section 308 letter seeking information on life insurers' use of "external consumer data or information sources" in connection with either an "accelerated or algorithmic underwriting programs."

Circular Letter No. 1 identifies two main areas of concern:

- The use of external data sources, algorithms and predictive models has a significant potential negative impact on the availability and affordability of life insurance for protected classes of consumers; and

- The use of external data sources is often accompanied by a lack of transparency for consumers.

The Committee will be asked to discuss the issues identified within NYDFS Circular Letter No. 1 which also have been identified by the NAIC Big Data Working Group as potential areas of concern for other state insurance regulators.

B. Discussion of Contestable Claims Practices. The Committee

The New York Department of Financial Services ("NYDFS") recently issued a consent order against an insurer with respect to its practices concerning contestable claims (i.e., a life insurance claim made within the two-year contestable period of a life insurance policy.) (See copy attached.)

The consent order indicates that the insurer would routinely request medical records from a deceased policyholder's beneficiary if the death occurred within the contestable period. In the event the beneficiary did not produce medical records, the insurer would deny the claim.

Moreover, the insurer would rescind claims when it received medical records and concluded that the deceased made a material representation without obtaining these rescissions to record action or by all beneficiaries agreeing to rescission after being made aware of their rights to contest the rescission claim in an action.

The Committee will be asked to discuss their company's practices with respect to the submission of claims within a life insurance policy's contestable period.

C. Disability Insurance Coverage - Massachusetts. The Committee

Within the past several weeks, Massachusetts Governor Charlie Baker signed into law Massachusetts House Bill 482 by adding a new Section 108N which reads (in pertinent part):

> *An insurer…authorized to issue policies against disability from injury or disease …shall not …discriminate…for reasons based solely upon an applicant's or insured's race, color, religious creed, national origin, sex, pregnancy, gender identity, sexual orientation or marital status.*

The new law becomes effective on January 1, 2020.

Some have read the new law to prohibit unisex rates as well as possibly prohibiting exclusions related to pregnancy.

The Committee will be asked to discuss what steps, if any, insurers may be taking to address the compliance requirements of this new Massachusetts law pertaining to disability income policies.

D. Retention and Destruction Practices — The Committee
Nonpublic Information – NAIC Insurance Data Security Model Law

The NAIC Insurance Data Security Model Law will be introduced for possible enactment in several states during 2019. (See related agenda item, *infra*.)

Section 4(B)(4) of the Model Law pertains to the retention and destruction of Nonpublic Information.

Section 3K of the Model Law defines Nonpublic Information to mean:

> *Information that is not Publicly Available Information and is:*
>
> *(1) Business related information of a Licensee the tampering with which, or unauthorized, disclosure access or use of which, would cause a material adverse impact to the business, operations or security of the Licensee;*
> *(2) Any information concerning a Consumer which because of name, number, personal Mark, or other identifier can be used to identify such Consumer, in combination with any or more the following data elements:*
> *(a) Social Security number,*
> *(b) Driver's license number or non-driver identification card number,*
> *(c) Account number, credit or debit card number, any security code, access code or password that would permit access to a Consumer's financial account, or*
> *(d) Biometric records;*
> *(3) Any information or data, except age or gender, in any form or medium created buyer derived from a healthcare provider or a Consumer and that relates to*
> *(a) The past, present or future physical, mental or behavioral health or condition of any Consumer or a member of the Consumer's family, the provision of healthcare to any Consumer, or*
> *(b) Payment for the provision of healthcare to any Consumer.*

Anticipating that the Model Law will be enacted in several states over the coming months, several questions have been presented to the Committee for discussion:

- *Do you have a Record Retention Schedule that accounts for Nonpublic Information that falls outside of a "Record" (i.e., unstructured data)?*

- *Do you have a mechanism for destruction of data in your applications when the Nonpublic Information is no longer needed? If not, how do you plan to comply given there is no carveout for situations where "disposal is not reasonably feasible due to the manner in which the information is maintained" (such as is contained within the NYDFS Cybersecurity Regulation)?*

- *Is the preservation of records potentially responsive to a legal request a concern for how you plan to destroy Nonpublic Information?*

The Committee will be asked to discuss their company's practices with respect to retention and destruction of Nonpublic Information as identified within the NAIC's Insurance Data Security Model Law.

E. New Hampshire Annuity Disclosures. The Committee

The New Hampshire Department of Insurance adopted an annuity disclosure rule that follows many of the elements of the NAIC Annuity Disclosure Model Regulation, but New Hampshire's annuity disclosure rule includes some unique elements. (See copy attached.)

Though New Hampshire's version of the Model Regulation adopts most of the provisions of the Model Regulation, New Hampshire added the following as required elements of the disclosure document:

- Name,
- Age, and
- Sex of the Proposed Annuitant.

As a general practice, annuity disclosure documents are not personalized but are more general in nature. Therefore, there was interest expressed in determining the extent to which insurers were aware of this unique requirement in New Hampshire and, if so, there also was interest expressed in discussing what compliance strategies may have been explored to address its requirements.

The Committee will be asked to discuss their awareness of this variation in New Hampshire's annuity disclosure rule and will discuss possible strategies to comply with its requirements.

IV. Reporting Items. CEFLI Staff.

A. OR Senate Bill 769 - Redacting of Social Security Numbers in Consumer Correspondence and Document Destruction Policies.

Over the past several months, the Committee has been discussing issues associated with the enactment of Oregon Senate Bill 769 which would require insurers to redact Social Security numbers in consumer correspondence.

In consultation with John Mangan of the ACLI (ACLI's Oregon state representative), Mr. Mangan indicates that the ACLI intends to conduct a meeting with the Oregon Insurance Administration to discuss the operational challenges associated with Oregon Senate Bill 769.

CEFLI will continue to monitor activities associated with this issue.

B. California DOI Notice - Sales of Annuities and Other Products to Veterans.

The California Department of Insurance recently issued a Notice to inform all life insurers (and life agents) to of recent changes in Department of Veterans Affairs regulations designed to "… discourage those who are financially secure from transferring assets to qualify for VA pensions." (See copy attached.) (The Notice references concerns regarding transfers of covered assets to an annuity as a means to enhance a claimant's eligibility for VA pension benefits.)

The Notice provides several references to California Insurance Law requirements that may impact sales of annuity products to veterans including:

- Agents and brokers should have no financial incentive to refer seniors to veterans benefit programs;
- Limitations on advertisements directed at veterans; and
- Required disclosures for events, presentations, seminars, workshops or other public gatherings regarding veterans benefits or entitlements.

C. State-Fiduciary Laws - Maryland.

The Maryland State Senate recently introduced a bill which would apply a fiduciary standard to registered representatives of broker-dealers. Currently, Maryland law applies a fiduciary standard solely to investment advisers.

The bill is encountering resistance from industry groups that are requesting that the Maryland Legislature allow the SEC to develop its best interest standard rather than enacting a fiduciary standard.

Last year, Nevada enacted a fiduciary standard law and New Jersey is considering introducing similar legislation this year.

D. Banks Report a 12% Increase in Elder Financial Abuse.

A recent report indicated that US banks reported a record 24,454 suspected cases of elder financial abuse last year which represents a 12% increase from 2017 and a fivefold increase over the past five years.

As a result, banks are focusing on training programs for employees on how to detect, stop and report possible elder financial abuse without violating a customer's privacy.

E. FINRA to Examine for Compliance with Elder Financial Abuse Rules.

At a recent industry conference, James Wrona, Vice President and Associate General Counsel at FINRA, indicated that FINRA will be focusing on firms' compliance with its elder abuse rule as part of their next round of examination activities.

A focus of the review will be "to check on the systems and processes firms have in place, to check that issues are properly elevated and that there's an identified team to handle relevant decisions."

According to Mr. Wrona, FINRA does not plan to penalize firms but rather will use the examinations to learn more about current firm practices designed to detect and deter elder financial abuse.

F. NAIC Insurance Data Security Model Law.

Several states plan to introduce legislation to enact the NAIC's Insurance Data Security Model Law over the coming months.

The Model Law has been enacted in South Carolina and has been introduced recently in Ohio and Michigan.

G. Massachusetts Charges Scottrade, Inc. with Violating Impartial Conduct Standards of the DOL Fiduciary Rule.

Massachusetts Secretary of the Commonwealth, William Galvin, has charged Scottrade, Inc. with violating state law and internal policies and procedures by

conducting sales contests that do not comply with the impartial conduct standards under the DOL Fiduciary Rule.

Industry participants will be watching whether the case will be allowed to proceed given that Massachusetts is relying upon the DOL Fiduciary Rule as the basis for alleging violation of state securities laws.

H. Florida Commissioner David Altmeier Elected NAIC Vice President.

The NAIC recently announced the election of Florida Commissioner, David Altmeier, as NAIC Vice President.

Commissioner Altmeier replaces former Hawaii Commissioner Gordon Ito as NAIC Vice President.

V. CEFLI Activities.

A. Mark Your Calendar - CEFLI Webinar - Ethics - Tuesday, February 26.

CEFLI will be conducting a webinar on Promoting Ethics Awareness on Tuesday, February 26 at 1 PM EST/12 Noon CST/11 AM MST/10 AM PST in anticipation of National Ethics Awareness Month in March.

Andrew Bucknam, Chief Compliance and Privacy Officer with The Knights of Columbus will be joined by Maureen Mulville, Secretary & Vice President, Compliance & General Council of Illinois Mutual to share their insights concerning how they promote ethics within their respective organizations.

Please mark your calendar and plan to join us!

VI. Next Meeting.

The next meeting of the Committee is scheduled to take place:

March 20, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST

The Committee will hold its remaining 2018 meetings as follows:

April 17, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST
May 15, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST
June 11, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST
July 24, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST
August 14, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST
September 25, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST
October 16, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST

November 13, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST
December 18, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST

Please mark your calendar and plan to join us!

VII. Other Business.

The Committee will be asked to identify and discuss any other business to be brought before the Committee.

DRAFT

Minutes
Meeting of the
CEFLI Compliance & Ethics Committee
January 23, 2019
2 PM EDT/1 PM CDT/11 AM PDT

A meeting of the CEFLI Compliance & Ethics Committee (the "Committee") was held via conference call on Wednesday, January 23, 2019 at 2 PM EDT/1 PM CDT/11 AM PDT.

The following CEFLI member company representatives participated in the meeting:

Molly Akin, Ohio National
Marcie Allen, Texas Life/Wilton Re
Renee Ambrosy, CNO Financial
Shannon Aussieker, Country Companies
Brendan Bakala, Catholic Order of Foresters
Kate Blalock, Western & Southern
Diane Boyette, Southern Farm Bureau
Vickie Bulger, Primerica
Andrea Christensen, Sagicor Life
Alayna Cook, MassMutual
Dana Cook, Assurity Life
Allison Corrado, Lincoln Heritage
Jacqueline Crader, CUNA Mutual
Nicholas Criscitelli, Voya Financial
Rebecca Criswell, Americo
John Cunningham, Fidelity Investments Life
William Dauksewicz, Protective Life
Bruce Eschbach, Texas Life/Wilton Re
Rita Fenani, Pacific Life
Paula Gentry, Cincinnati Life
Angela Gilsinn, SunLife
Rachel Gomez, State Farm Life
Ken Gould, Protective Life
Jody Harmon, Western & Southern
Dennis Herchel, SBLI MA
Lisa Holland, State Farm Life
Michelle Holmes, Voya Life

Donna Hough-Zukas, SunLife
Belinda Howard, Principal Life
Nathan Huss, Sammons
Marty Karp, Oxford Life
De Keimach, Delaware Life
William Keyes, John Hancock
Samantha Knackmuhs, State Farm Life
Megan Knapp, American Enterprise
Michele Kulish Danielson, American Enterprise
Marla Lacey, Homesteaders Life
Deanna Laidler, Standard Life
Daniel Leblanc, SBLI MA
Jennifer Lee, Pacific Life
Laurie Lewis, Amica Life
Margaret Mancarella, Vantis Life
Chris McAuliffe, SBLI MA
Ryan Meehan, RiverSource
Genevieve Messina, Global Atlantic Financial Group
Dave Milligan, American Equity Investment Life
Matt Missik, Pacific Life
Karoll Moran, Amica Life
Mark Neidinger, National Guardian Life
Sabrina Olender, Foresters
Monique Pascual, Pacific Guardian Life
Liza Perry, USAA Life
Megan Phillips, Principal Life
Irene Reid, Global Atlantic Financial Group
Daniel Reinecke, Gerber Life
Sally Roudebush, Lincoln Heritage
Heather Russo, Illinois Mutual
Rania Sarkis, Pacific Life
Scott Schabel, Jackson National
Angie Schneider, Cincinnati Life
Ryan Schwoebel, Protective Life
Devin Smith, Securian Life
Stephen Smith, Protective Life
Butch Spicka, American Enterprise
Lori Straight, Sammons
Carla Strauch, Thrivent
Nancy Sweet, CNO Financial
Bill Turner, American Fidelity Assurance
Laura Vanlaningham, Illinois Mutual
Rochelle Walk, Texas Life/Wilton Re
Larry Welch, Citizens, Inc.
Eric Westman, Athene USA
Stacey White, American National

Kathy Wiggins, Voya Financial
Emily Wilburn, Illinois Mutual
Tomiko Wright, Protective Life

Kelly Ireland and Donald J. Walters of CEFLI also participated in the meeting.

I. Welcome and Introduction.

The meeting began with a recitation of CEFLI's anti-trust statement.

II. Approval of Minutes – December 12, 2018 Meeting.

On motion, duly made and seconded and unanimously carried, the Committee: RESOLVED, that, the Minutes of the December 12, 2018 meeting are hereby approved.

III. Issues for Review.

A. Antifraud Practices and Monitoring Systems.

The Committee was asked to discuss company antifraud practices and monitoring systems designed to detect potential fraudulent activities by agents, customers and other external parties.

A Committee member reported that they have found the LIMRA CAP survey for new customers to be very helpful in ensuring the customer has received their policy, understands suitability, etc. It also allows customers to provide feedback or ask questions about the sales process – positive or negative – which is useful data to have.

Another Committee member indicated that they have developed their own Policyholder Questionnaire similar to the LIMRA CAP survey that they send to new customers.

Other Committee members reported using GIACT to help track payments back to the client's bank account by ensuring the name, address, account number, routing number matches the information on file with banks. This service has been helpful in detecting potential fraudulent activity.

Other antifraud resources that help verify a customer's legitimate address, bank account information, etc. that are used by Committee members include:

- Accurant by LEXIS-NEXIS.
- CLEAR by Thompson Reuters.
- TLOXP by Trans Union.

Pindrop, which is a call-center tool that matches telephone numbers and can detect voice patterns is also utilized by some Committee members.

Some Committee members have had success detecting fraud by relying on internal reports such as those detailing unusual amounts of producer volume or comparing customer bank account information with producer bank account information.

B. Financial Exploitation of the Elderly and Vulnerable Adults (New York Regulation 187).

The Committee was asked to discuss their practices designed to monitor and prevent possible financial exploitation of the elderly and vulnerable adults and, specifically, what types of reports may be generated to demonstrate compliance with regulatory requirements designed to "prevent financial exploitation and abuse."

A Committee member reported that they have conducted robust training for their field force on financial exploitation for vulnerable adults to help them identify potential abusive situations. They also have a head office team that works on vulnerable adult cases and coordinates with their field. If abuse is detected, the company will put a hold on client funds or limit account access. Clients must also be given the ability to name a trusted contact. In addition to complying with NY Reg 187, the program has been rolled out broadly across states they do business in.

Another Committee member indicated they have begun additional monitoring for cases involving individuals 65 and older.

C. California Assembly Bill 2634 - Notification of Adverse Changes in the Current Scale of Non-Guaranteed Elements.

The Committee was asked to discuss whether they interpret the requirements of new California Insurance Code Section 10113.70 to provide a notification and illustration of an adverse change in the current scale of nonguaranteed elements as applying to each adverse change in the current scale of nonguaranteed elements (regardless of whether it may impact the policy owned by a consumer) or whether the notification and illustration requirement pertains solely to a change in the company's current scale of nonguaranteed elements (that relates specifically to the policy owned by a consumer).

A Committee member stated that the California requirements are not that dissimilar from the requirements in New York. Both require notification if there is a potential negative impact on the consumer.

Some Committee members feel that it is operationally easier to send notification to all policyholders of a product for which an adverse change to a non-guaranteed element is made, even if an individual's policy in particular is not impacted.

Other Committee members are sending only to those policyholders who are impacted by the change.

D. Filing of Life Insurance Policy Illustration Certifications.

The Committee was asked to discuss whether their company files both life insurance policy illustration certifications (i.e., an annual illustration certification listing all policy forms as well as a separate certification before a new policy is illustrated) through the Compact in those states that have adopted the NAIC Life Illustration Model Regulation.

A Committee member indicated that they file directly through the state and only in those states that have adopted the Model Regulation.

Another Committee member reported filing their products through the Compact. For those products marketed with an illustration, a certification is also filed to satisfy the Model's requirements.

A Committee member mentioned that Washington state had expected the annual filing of certifications to be directly to the state, but the company is filing through the compact and will only file separately in non-Compact states.

E. OR Senate Bill 769 - Redacting of Social Security Numbers in Consumer Correspondence and Document Destruction Policies.

The Committee has previously discussed a new Oregon law that pertains to the use of Social Security numbers in consumer correspondence disallowing the printing of a consumer's SSN on mail to a consumer and requiring the SSN to be redacted on documents the consumer.

The Committee was asked to discuss whether anyone has received any updates from the Oregon Insurance Administration regarding the impact of Oregon Senate Bill 769 on life insurer practices.

CEFLI staff reported that the ACLI was scheduled to discuss this issue with Oregon today. CEFLI will reach out for details of that discussion and report back to the Committee.

IV. Reporting Items.

A. New State Insurance Commissioners.

CEFLI staff reported that there are several new state insurance commissioners in selected states due to prior year elections and/or new appointments.

In 2019, there will be 11 new state insurance commissioners. These changes are as follows:

State	New Commissioner	Former Commissioner
California	Ricardo Lara	Dave Jones
Connecticut	Paul Lombardo	Katherine Wade
Georgia	Jim Beck	Ralph Hudgens
Hawaii	Colin Hayashida	Gordon Ito
Kansas	Vicki Schmidt	Ken Selzer
Illinois	Karin Zosel	Jennifer Hammer
Michigan	Anita Fox	Patrick McPharlin
Minnesota	Steve Kelley	Fred Andersen (Acting)
New York	Linda Lacewell	Maria Vullo
Oklahoma	Glen Mulready	John Doak
Wisconsin	Tony Evers	Ted Nickel (NAIC Fall National Meeting)

B. NAIC Committee Assignments.

CEFLI staff reported that the NAIC recently announced its 2019 Committee Chairs and Vice Chairs.

Two Committee assignments of interest to CEFLI member companies include:

<u>Life Insurance and Annuities (A) Committee</u>
Chair: Doug Ommen, Commissioner, Iowa Insurance Division
Vice-Chair: Stephen C. Taylor, Commissioner, District of Columbia Department of Insurance, Securities and Banking

<u>Market Regulation and Consumer Affairs (D) Committee</u>
Chair: Chlora Lindley-Myers, Director, Missouri Department of Insurance, Financial Institutions and Professional Registration ("DIFP")
Vice-Chair: Allen W. Kerr, Commissioner, Arkansas Insurance Department

C. FINRA 2019 Risk Monitoring and Examination Priorities Letter.

CEFLI staff reported that FINRA recently released its 2019 Risk Monitoring and Examination Priorities Letter which identifies those subject matters that FINRA examination activities will focus on in the upcoming year.

The Letter is divided into distinct areas of concern including sales practice risks, operational risks, market risks and financial risks.

Subject areas noted as areas for in the Sales Practice Risks section of the Letter include:

- Suitability including Variable Annuities;
- Senior Investors;
- Anti-Money Laundering;
- Outside Business Activities and Private Securities Transactions; and
- Supervision

D. SEC 2019 Examination Priorities.

CEFLI staff reported that the SEC's Office of Compliance Inspections and Examinations recently issued their 2019 examination priorities.

Areas for heightened focus during examinations in 2019 may include:

- Conflicts of Interest
- Senior Investors and Retirement Accounts and Products
- Cybersecurity
- Anti-Money Laundering Programs

E. SEC Risk Alert - Advisor Texting and Social Media Use.

CEFLI staff reported that the SEC's Office of Compliance Inspections and Examinations recently issued a Risk Alert to outline observations from recent investment adviser examinations conducted by the SEC with a focus on electronic messaging.

For purposes of this exam activity, "electronic messaging" included text/SMS messaging, instant messaging, personal email and personal or private messaging.

The Risk Alert offers examples of practices concerning the use of electronic messaging that the SEC believes may help advisers in meeting compliance obligations. The Risk Alert offers recommendations concerning policies and procedures, employee training and attestations, supervisory review and control over devices.

While the Risk Alert pertains solely to registered investment advisers, it may be helpful to inform those companies that may be considering strategies to permit use of texting/SMS messaging and other communication methods for their insurance producers.

F. FINRA Report on Selected Cybersecurity Practices.

CEFLI staff reported that late last year, FINRA released its Report on Selected Cybersecurity Practices for broker-dealer firms.

The report outlines FINRA's observations regarding effective practices that firms have implemented to address certain cybersecurity risks.

Given the ongoing challenge that cybersecurity risks pose for the life insurance industry, it is hoped that this report may help life insurance companies in the assessment of their own cybersecurity practices.

G. Illinois Biometric Information Privacy Act Litigation – Rivera/Weiss v. Google.

CEFLI staff reported that the US District Court for the Northern District of Illinois (Eastern Division) recently issued an opinion in favor of Google and dismissed plaintiffs' claims that Google's practice of automatically creating a faced template when android users upload photos taken on their smart phone to Google's cloud-based service violates the Illinois Biometric Information Privacy Act.

Illinois was the first state in the country to regulate the collection of biometric information, which includes facial recognition data. Biometric information is being explored by life insurers as a means to make the life insurance underwriting process more efficient.

This may be an important case as social media companies (and life insurance companies) increasingly explore the use of biometric information for targeted advertising and filtered content.

H. Wells Fargo Agrees to Pay $575 Million Regarding Sales Practices.

CEFLI staff reported that Wells Fargo recently announced that it has agreed to pay $575 million to resolve claims from 50 state attorneys general and the District of Columbia related to opening millions of fake accounts for consumers in several states.

This settlement between the bank and state attorneys general is separate from actions taken by federal regulators.

Wells Fargo serves as a continuing reminder of the importance (and cost) of establishing a sound culture of compliance and ethics within financial services organizations.

V. CEFLI Activities.

A. Mark Your Calendar - CEFLI Webinar - Cost of Insurance - Tuesday, January 29.

CEFLI will be conducting a webinar with representatives from CEFLI's Affiliate Member law firm, Drinker Biddle, on the Cost of Insurance Litigation and Regulatory Developments on Tuesday, January 29 at 1 PM EST/12 Noon CST/11 AM MST/10 AM PST.

Please mark your calendar and plan to join us!

B. Open Invitation - Faculty Members for CEFLI Webinars.

As we embark on a new year, CEFLI would like to invite members of the Committee to consider possibly serving as faculty members for future CEFLI webinars.

Please bear in mind that CEFLI webinars also serve as an excellent professional development opportunity for members of your staff that may not have regular access to public speaking venues.

Please contact Kelly Ireland on CEFLI's staff if you (or a member of your staff) may have an interest in serving as a faculty member at an upcoming CEFLI webinar.

VI. Next Meeting.

The Committee will hold its next meeting on February 13, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST.

The Committee will hold further 2019 meetings as follows:

March 20, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST
April 17, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST
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December 18, 2019 - 2 PM EST/1 PM CST/12 Noon MST/11 AM PST

Please mark your calendar and plan to join us!

VII. Other Business.

There being no further business to discuss, the meeting was adjourned.

Insurance Circular Letter No. 1 (2019)

January 18, 2019

TO: **All Insurers Authorized to Write Life Insurance in New York State**

RE: **Use of External Consumer Data and Information Sources in Underwriting for Life Insurance**

STATUTORY REFERENCES: Insurance Law § 4224; Insurance Law Articles 24 and 26; General Business Law Article 25 (Fair Credit Reporting Act); Executive Law Article 15 (Human Rights Law); and the Federal Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (codified as amended in scattered sections of 2 U.S.C., 28 U.S.C., and 42 U.S.C.).

I. Summary

The purpose of this circular letter is to advise insurers authorized to write life insurance in New York of their statutory obligations regarding the use of external consumer data and information sources in underwriting for life insurance.

II. Discussion

Following reports of the emergence of unconventional sources or types of external data available to insurers, including within algorithms and predictive models, the New York State Department of Financial Services ("Department") commenced an investigation of insurers' underwriting guidelines and practices in New York related to the use of external data in underwriting for life insurance.

For purposes of this Circular Letter, external data includes any data or information sources not directly related to the medical condition of the applicant that is used – in whole or in part – to supplement traditional medical underwriting, as a proxy for traditional medical underwriting, or to establish "lifestyle indicators" that may contribute to an underwriting assessment of an applicant for life insurance coverage. For the purposes of this Circular Letter, external data sources do not include an MIB Group, Inc. member information exchange service, a motor vehicle report, or a criminal history search[1].

The Department fully supports innovation and the use of technology to improve access to financial services. Indeed, insurers' use of external data sources has the potential to benefit

insurers and consumers alike by simplifying and expediting life insurance sales and underwriting processes. External data sources also have the potential to result in more accurate underwriting and pricing of life insurance. At the same time, however, the accuracy and reliability of external data sources can vary greatly, and many external data sources are companies that are not subject to regulatory oversight and consumer protections, which raises significant concerns about the potential negative impact on consumers, insurers and the life insurance marketplace in New York.

This circular letter addresses two particular areas of immediate concern with the use of external data sources, algorithms or predictive models that were identified during the Department's investigation. First, the use of external data sources, algorithms, and predictive models has a significant potential negative impact on the availability and affordability of life insurance for protected classes of consumers. An insurer should not use an external data source, algorithm or predictive model for underwriting or rating purposes unless the insurer can establish that the data source does not use and is not based in any way on race, color, creed, national origin, status as a victim of domestic violence, past lawful travel, or sexual orientation in any manner, or any other protected class. Moreover, an insurer should also not use an external data source for underwriting or rating purposes unless the use of the external data source is not unfairly discriminatory and complies with all other requirements in the Insurance Law and Insurance Regulations. Second, the use of external data sources is often accompanied by a lack of transparency for consumers. Where an insurer is using external data sources or predictive models, the reason or reasons for any declination, limitation, rate differential or other adverse underwriting decision provided to the insured or potential insured should include details about all information upon which the insurer based such decision, including the specific source of the information upon which the insurer based its adverse underwriting decision.

It is important to note that this circular letter is not intended to provide an all-inclusive list of potential issues that could arise from the use of external data sources (including for both life and other kinds of insurance), nor is it intended to suggest that an insurer's due diligence in assessing an external data source should be limited to the above two concerns.

A. Unlawful Discrimination

The N.Y. Insurance Law, Executive Law, General Business Law, and federal Civil Rights Act, protect against discrimination for certain classes of individuals. These laws govern the activities of insurers, including the ability of insurers to underwrite based on certain criteria. For example, Insurance Law Article 26 prohibits the use of race, color, creed, national origin, status as a victim of domestic violence, or past lawful travel in any manner, among other things, in underwriting. In addition, Insurance Law §§ 4224(a)(2) and (b)(2) prohibit insurers from refusing to insure or continuing to insure, limiting the amount, extent or kind of coverage, or charging a different rate for the same coverage solely because of the physical or mental disability, impairment or disease, or prior history of the disability or disease of an insured or potential insured except where the refusal, limitation or rate differential is permitted by law or regulation and is based on sound actuarial principles or is related to actual or reasonably anticipated experience. Insurers are responsible for complying with these anti-discrimination laws irrespective of whether they themselves are collecting data and directly underwriting consumers, or relying on external data

sources, algorithms of external vendors or predictive models that are intended to be partial or full substitutes for direct underwriting. In short, an insurer may not use an external data source to collect or use information that the insurer would otherwise be prohibited from collecting or using directly.

Based on its investigation, the Department has determined that insurers' use of external data sources in underwriting has the strong potential to mask the forms of discrimination prohibited by these laws. Many of these external data sources use geographical data (including community-level mortality, addiction or smoking data), homeownership data, credit information, educational attainment, licensures, civil judgments and court records, which all have the potential to reflect disguised and illegal race-based underwriting that violates Articles 26 and 42.

Other models and algorithms purport to make predictions about a consumer's health status based on the consumer's retail purchase history; social media, internet or mobile activity; geographic location tracking; the condition or type of an applicant's electronic devices (and any systems or applications operating thereon); or based on how the consumer appears in a photograph. At the very least, the use of these models may either lack a sufficient rationale or actuarial basis and may also have a strong potential to have a disparate impact on the protected classes identified in New York and federal law.

In light of the Department's investigation and findings, the Department is providing the following principles that insurers should use as guidance in using external data sources in underwriting.

First, an insurer should not use an external data source, algorithm or predictive model in underwriting or rating unless the insurer has determined that the external tools or data sources do not collect or utilize prohibited criteria. An insurer may not simply rely on a vendor's claim of non-discrimination or the proprietary nature of a third-party process as a justification for a failure to independently determine compliance with anti-discrimination laws. The burden remains with the insurer at all times.

Second, an insurer should not use an external data source, algorithm or predictive model in underwriting or rating unless the insurer can establish that the underwriting or rating guidelines are not unfairly discriminatory in violation of Articles 26 and 42. In evaluating whether an underwriting or rating guideline derived from external data sources or information is unfairly discriminatory, an insurer should consider the following questions:

(1) Is the underwriting or rating guideline that is derived, in whole or in part, from external data sources or information supported by generally accepted actuarial principles or actual or reasonably anticipated experience that justifies different results for similarly situated applicants?

(2) Is there a valid explanation or rationale for the differential treatment of similarly situated applicants reflected by the underwriting or rating guideline that is derived, in whole or in part, from external data sources or information?

Importantly, even if statistical data is interpreted to support an underwriting or rating guideline, there must still be a valid rationale or explanation supporting the differential treatment of otherwise like risks. The second part of this inquiry is particularly important where there is no

demonstrable causal link between the classification and increased mortality and also where an underwriting or rating guideline has a disparate impact on protected classes.

Data, algorithms, and models that purport to predict health status based on a single or limited number of unconventional criteria also raise significant concerns about the validity of such models.

An insurer may establish guidelines and practices to assess an applicant's health status and identify individuals at higher mortality risk if based on sound actuarial principles or if related to actual or reasonably anticipated experience. However, the data, algorithms, and predictive modeling used by the insurer must comport with the principles set forth above and all other relevant requirements in federal and New York law. An insurer may not rely on external data or external predictive algorithms or models unless the insurer has determined that the external data or predictive model is otherwise permitted by law or regulation and is based on both sound actuarial principles or experience and a valid explanation or rationale.

B. Consumer Disclosure/Transparency

Transparency is an important consideration in the use of external data sources to underwrite life insurance. Pursuant to Insurance Law § 4224(a)(2), insurers must notify the insured or potential insured of the right to receive the specific reason or reasons for a declination, limitation, rate differential or other adverse underwriting decision. An adverse underwriting decision would include the inability of an applicant to utilize an expedited, accelerated or algorithmic underwriting process in lieu of a traditional medical underwriting. Where an insurer is using external data sources or predictive models, the reason or reasons provided to the insured or potential insured must include details about all information upon which the insurer based any declination, limitation, rate differential or other adverse underwriting decision, including the specific source of the information upon which the insurer based its adverse underwriting decision. An insurer may not rely on the proprietary nature of a third-party vendor's algorithmic processes to justify the lack of specificity related to an adverse underwriting action. Insurers must also provide notice to and obtain consent from consumers to access external data, where required by law or regulation. The failure to adequately disclose the material elements of an accelerated or algorithmic underwriting process, and the external data sources upon which it relies, to a consumer may constitute an unfair trade practice under Insurance Law Article 24.

III. Conclusion

The Department supports efforts to improve the effectiveness and timeliness of insurance underwriting decisions in order to provide consumers with increased access to financial services consistently with law. Accordingly, an insurer should not use external data sources, algorithms or predictive models in underwriting or rating unless the insurer has determined that the processes do not collect or utilize prohibited criteria and that the use of the external data sources, algorithms or predictive models are not unfairly discriminatory. The insurer must establish that the external data sources, algorithms or predictive models are based on sound actuarial principles with a valid explanation or rationale for any claimed correlation or causal connection.

An insurer must also disclose to consumers the content and source of any external data upon which the insurer has based an adverse underwriting decision.

The Department reserves the right to audit and examine an insurer's underwriting criteria, programs, algorithms, and models, including within the scope of regular market conduct examinations, and to take disciplinary action, including fines, revocation and suspension of license, and the withdrawal of product forms.

Please direct any questions regarding this circular letter to: Peter Dumar, Chief Insurance Attorney, Life Bureau, New York State Department of Financial Services, One Commerce Plaza, Albany, New York 12257 or by email at **peter.dumar@dfs.ny.gov**.

Sincerely,

James Regalbuto
Deputy Superintendent - Life Insurance

[1] Criminal history only includes past convictions or pending criminal matters. It does not include prior arrests, pleas or imprisonment for which an individual was not convicted of any crime; or civil dispute history such as appearances in housing court, civil litigation, liens, bankruptcy, etc. See Executive Law § 296(16). Criminal history does include being sanctioned by the U.S. Government (or any agency thereof), or by any international organization in which the U.S. Government (or any agency thereof) is a member, for money laundering, terrorism, trafficking, etc.

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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In the Matter of

GLOBE LIFE INSURANCE COMPANY OF NEW YORK, No. 2018-0085-S

Respondent.

----------X

CONSENT ORDER

WHEREAS, the New York State Department of Financial Services ("DFS" or "Department") commenced an examination (the "Examination") pursuant to the New York State Insurance Law of Globe Life Insurance Company of New York (hereinafter "Respondent");

WHEREAS, the Department commenced an investigation ("Investigation") subsequent to the Examination pursuant to Insurance Law Section 308 concerning the Respondent's contestable claim practices for the period of January 1, 2006 through December 31, 2016 (the "Relevant period").

WHEREAS, from 2006 through 2016, the Respondent marketed on a direct response basis and sold small face value simplified issue life insurance policies to low- and middle-income consumers in New York.

WHEREAS, the Department concluded that the Respondent improperly closed claims when policyholders died within the two-year contestable period without proving in an action a misrepresentation by the policyholder on the application for insurance as required by the Insurance Law;

WHEREAS, the Department further concluded that the Respondent engaged in unfair claims settlement practices in violation of the New York Insurance Law by improperly misrepresenting facts and policy provisions relating to coverage and not attempting in good faith to

effectuate prompt, fair, and equitable settlements of submitted claims in which liability had become reasonably clear;

WHEREAS, the Department further concluded that the Respondent violated Insurance Department Regulations by failing to refer in writing to a specific policy provision, condition, or exclusion in a policy that was the basis for denying a claim, or by not providing a specific reason for disclaiming coverage;

WHEREAS, this Consent Order contains the Department's findings and the relief agreed to by the Department and Respondent.

NOW, THEREFORE, the Department and Respondent are willing to resolve the matters cited herein in lieu of proceeding by notice and hearing.

TERMS

1. For purposes of this Consent Order, the following terms shall have the meanings as set forth herein:
    a. "Contestable period" means the period of two years dating from a policy's date of issue or from the effective date of certain increases or changes to the policy, after which time a life insurance policy in force during the life of the policyholder becomes incontestable.
    b. "Contestable claim" is a life insurance claim made during the two-year contestable period.

FINDINGS

2. Respondent is a domestic insurance company authorized to transact life, annuities and accident and health insurance business in this State pursuant to Section 1113(a) of the New York Insurance Law.
3. During the Relevant Period, the Respondent routinely requested medical records from a deceased policyholder's beneficiary or beneficiaries if the death occurred within the contestable period.
4. If medical records were not produced, the Respondent refused to pay the face amount of the policy. Instead, the Respondent unilaterally closed the claim and notified the beneficiary or

beneficiaries that the policy would not be paid because of the failure to provide medical records as requested.

5. During the Relevant Period, the Respondent also unilaterally rescinded claims when it received medical records and concluded that the deceased made a material misrepresentation. The Respondent did not obtain these rescissions through a court action. Upon rescission, the Respondent returned the policyholder's premiums to his or her beneficiary or beneficiaries.

6. As part of its review, the Department evaluated a sample of various types of claims.

7. For claims in which the policyholder's death was reported by someone other than a beneficiary, the Department's review of records found no evidence that the Respondent's personnel made a good faith attempt to locate the beneficiary or beneficiaries.

8. When policyholders died during the contestable period, the Respondent requested medical records or other records related to the policyholder's death. The Respondent closed these contestable claims without payment if it did not receive the policyholder's medical records upon demand to the beneficiary. Respondent did not obtain rescission through a court action or by all beneficiaries agreeing to rescission after being made aware of their rights to contest the rescission claim in an action.

9. In a sample of 17 contestable claims that were closed without payment of the benefit, the beneficiaries provided the required proofs of death, including a certified death certificate.

10. During the period covered by the Investigation, the Respondent did not inform beneficiaries of any specific policy provision, condition, or exclusion in the policy that were the grounds of the denial, or cite any specific reason for disclaiming coverage.

NEW YORK CONTESTABLE CLAIMS

11. During the Relevant Period, the Respondent had 439 contestable claims with a face amount totaling approximately $7,330,000 in New York State in which the claims were closed without payment or remained pending because the Respondent did not receive medical records and Respondent did not obtain rescission through a court action or by all beneficiaries agreeing to rescission after being made aware of their rights to contest the rescission claim in an action.

RELEVANT STATUTES, REGULATIONS, AND NEW YORK CASE LAW

12. Pursuant to Insurance Law Section 3203(a)(3), life insurance policies are incontestable after being in force during the life of the insured for a period of two years from its date of issue or, as to certain increases in the death benefit or changes in other policy provisions, from the effective date of those increases or changes. Pursuant to Insurance Law Sections 3203(a)(3), 3105(a), and 3105(b)(1), within the two-year contestable period, an insurer may only contest a covered claim on the basis of a misrepresentation if the insurer proves a material misrepresentation by the insured on the application for insurance.

13. Insurance Law Section 3105(a) provides that a misrepresentation is a false statement by an applicant concerning past or present fact made to the insurer at or before the making of the insurance contract as an inducement to make the contract, such as a false statement that the applicant has not had a particular disease, ailment, or medical impairment.

14. Under Insurance Law Section 3105(b), a misrepresentation will not avoid or defeat recovery under any insurance policy unless the misrepresentation was material. A misrepresentation is material if knowledge by the insurer of the facts misrepresented would have led to the insurer's refusal to make the contract.

15. Insurance Law Section 3105(d) provides: "If in any action to rescind any such [insurance] contract or to recover thereon, any such misrepresentation is proved by the insurer, and the insured or any other person having or claiming a right under such contract shall prevent full disclosure and proof of the nature of such medical impairment, such misrepresentation shall be presumed to have been material."

16. Under relevant New York jurisprudence, if there is a change in the status quo, such as the death of the insured, then an insurer must obtain rescission through a judicial determination or by all beneficiaries agreeing to rescission after being made aware of their rights to contest the rescission claim in an action.

17. Pursuant to Insurance Law Section 2601(a)(1), (2), and (4), it is an unfair claim settlement practice for an insurer to commit the following acts without just cause and with such frequency to indicate a general business practice:

a. Knowingly misrepresenting to claimants pertinent facts and policy provisions relating to coverages at issue;
b. Failing to acknowledge with reasonable promptness pertinent communications regarding claims arising under its policies; and
c. Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

18. Pursuant to Insurance Regulation No. 64, 11 N.Y.C.R.R. Section 216.3(b), no insurer shall deny any element of a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is made in writing to the insured, beneficiary, or claimant.

19. Also, pursuant to Insurance Regulation No. 64, 11 N.Y.C.R.R. Section 216.6(d), an insurer shall inform the claimant in writing as soon as it is determined that there was no policy in force or that the insurer is disclaiming liability because of a breach of policy provisions by the policyholder. The insurer must also explain its specific reasons for disclaiming coverage.

20. Respondent for the time period 2006 to 2016:
a. misrepresented facts and policy provisions relating to coverage;
b. failed to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies;
c. failed to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability had become reasonably clear; and
d. failed to refer in writing to a specific policy provision, condition, or exclusion in the policy that was the ground for denial of a claim, or by failing to provide a specific reason for disclaiming coverage.

21. Respondent's violations during the aforementioned time period contravened New York Insurance Law.

VIOLATIONS

22. By reason of the foregoing,
Respondent violated:
Insurance Regulation No. 64, 11 NYCRR Section 216.3(b) and 216.6(d); and

New York Insurance Law Sections 2601(a)(1), (2), and (4).

AGREEMENT

IT IS HEREBY UNDERSTOOD AND AGREED by Respondent, its successors and assigns (on behalf of its agents, representatives, employees, parent company, holding company, and any corporation, subsidiary or division through which Respondent operates) that:

CEASE AND DESIST

23. Respondent shall cease and desist the practices found by the Department to have violated the Insurance Law and Regulations.

OTHER INJUNCTIVE TERMS

24. In order to comply with the requirements of Insurance Law Sections 2601, 3105, and 3203, Respondent shall adopt the following practices with respect to payment and investigation of contestable claims:

    a. Respondent, not beneficiaries or a policyholder's estate, bears the burden of investigating claims submitted within the contestable period;
    b. Respondent may only contest a contestable claim on evidence of a material misrepresentation by the insured on the application for insurance, as provided in Insurance Law Sections 3105(a) and 3105(b)(1);
    c. The materiality of a misrepresentation shall be whether, had the Respondent known the facts misrepresented, it would have refused to make such contract, as provided in Insurance Law Section 3105(b)(1);
    d. A presumption of materiality of a misrepresentation shall arise in an action to rescind or defeat recovery, as provided in Insurance Law Section 3105(d);
    e. If a contestable claim is incurred and there has been a change in the status quo, Respondent shall only obtain a rescission of the policy by prevailing in a court action or by all beneficiaries agreeing to rescission after being made aware of their rights to contest the rescission claim in an action.

RESTITUTION

25. Respondent will correct the violations cited herein and demonstrate to the Department's satisfaction that it has initiated the necessary corrective action within 12 months from the date of Respondent's signing of this Consent Order. Respondent will also take all necessary steps to comply with the New York Insurance Law and Regulations with respect to its insurance products in the future. Within sixty (60) days from the Respondent's signing of this Consent Order, the Company shall provide to the Department a detailed remediation plan which provides restitution to policyholders or their beneficiaries, where applicable, for each violation set forth in paragraph 22 of this Consent Order (the "Violations"). The remediation plan is subject to the Department's approval in its sole discretion. The Department may, as a condition of its approval, impose additional remediation requirements to a plan if necessary to satisfactorily rectify the Violations.

26. For all identified contestable claims that the Respondent closed without payment, Respondent shall review and pay the face amount of each such policy plus interest dating from the date of death to the date of such payment, unless the Respondent determines, that the insured made a material misrepresentation in his or her application for such policy, as provided in Insurance Law Section 3105 and designates the claim for rescission.

27. The Third-Party Administrator ("TPA") described in paragraph 31 shall review the claim files designated by the Respondent for rescission and the TPA shall make the final decision before the Respondent formally rescinds the claims.

28. The TPA will make a determination pursuant to paragraphs 35, 36, and 37 of this Consent Order based on the Department's guidance and Respondent's policy provisions that either the Respondent has a valid basis to rescind each claim or the Respondent is required to pay each claim to the named beneficiary.

29. The Respondent agrees to be bound by the determination of the TPA.

30. Any payments described in paragraph 36 shall be reduced by any amounts already paid by Respondent to beneficiaries as premium refunds for rescinded policies.

THIRD PARTY ADMINISTRATOR

31. As soon as practicable, but no later than sixty days from the execution of this Consent Order, DFS shall select an independent TPA to review and administer the contestable claims review and restitution process, as provided in paragraphs 25 through 30 of this Consent Order. Respondent will retain the TPA after the Department's review and approval of the retainer agreement. Respondent shall be fully and solely responsible for all proper fees, expenses, and disbursements of the TPA in connection with the review and restitution process provided for in this Consent Order and the TPA's retainer agreement.

32. The TPA shall, as part of its operations, establish and maintain throughout the duration of its obligations pursuant to this Consent Order, multiple cost-free means for affected beneficiaries to contact it, including an electronic mail address, a website, and a toll-free telephone number.

33. Within thirty days after retention of the TPA, Respondent shall provide the TPA for its review all information in their possession, custody, or control, including but not limited to policy records and complete claims files, for all identified claims made within the contestable period for New York policies that the Respondent has designated for rescission.

34. The TPA may request from Respondent any information and data it reasonably believes it will need to fulfill its obligations under this Consent Order, and Respondent shall provide the requested information and data within seven days of receiving such a request from the TPA.

35. The TPA shall determine, according to the provisions and standards set forth in its retainer agreement, the following:

    a. Which identified contestable claims were lawfully designated for rescission as noted above; and

    b. Which identified contestable claims were unlawfully designated for rescission.

36. For claims that Respondent unlawfully designated for rescission as described in paragraph 35 the TPA shall determine the death benefit to be paid according to the policy. If records for contestable claims unlawfully designated for rescission are incomplete and it is not known whether payment was made, the claims shall be paid according to the policy. Benefits shall be reduced by any amounts already paid by Respondent to beneficiaries, and shall include interest as required by Insurance Law Section 3214(c).

37. The TPA shall also identify and locate the beneficiaries of all identified contestable claims Respondent unlawfully designated for rescission.

38. Within thirty days of the TPA's final determination of all amounts owed to affected beneficiaries, Respondent shall wire-transfer to the TPA the total amount owed by Respondent to the beneficiaries.

39. Within thirty days of receiving the wire-transfer described in paragraph 38, the TPA shall deposit in the facilities of the U.S. Post Office, for delivery by prepaid first-class mail to each beneficiary to whom Respondent owes payment, a check in the required amount payable to the individual beneficiary. All checks must be valid for six months. Such payment shall be accompanied by a letter from the Department, in the form annexed hereto as Exhibit A.

40. For any payment to a beneficiary that is returned to the TPA as undeliverable or not deposited within six months, the TPA shall conduct a reasonable search, as provided in its retainer agreement, for a current address. The TPA may cancel checks not deposited within six months. Should the search show a more current address, the TPA shall re-issue a check valid for six months in the amount of the returned or un-deposited check and send the reissued check to the more current address within fifteen days in the manner provided in paragraph 39. After doing so, no further action shall be required by the TPA to complete the mailing process.

41. In the event that a beneficiary does not cash his or her check before the expiration date of the check or the check was returned after the TPA re-posts the check as described in paragraph 43, the TPA shall follow all applicable provisions of the New York Abandoned Property Law, including all reporting, mailing, and remittance requirements.

42. The TPA shall provide reports to the Department as provided in the retainer agreement to confirm compliance with this Consent Order.

43. The TPA's obligations under this Consent Order are satisfied when the process described in paragraphs 35 through 42 is completed.

MONETARY PENALTY

44. Within seven (7) days of the execution of this Consent Order, Respondent shall pay a civil penalty of Four Hundred Thirty-Nine Thousand Dollars ($439,000.00). Respondent agrees

that it will not claim, assert, or apply for a tax deduction or tax credit with regard to any U.S. federal, state or local tax, directly or indirectly, for any portion of the civil monetary penalty paid pursuant to this Consent Order.

45. The above referenced payment shall be payable to the New York State Department of Financial Services via electronic transfer in accordance with instructions provided by the Department.

OTHER RELIEF

46. Respondent submits to the authority of the Department to effectuate this Consent Order.

47. Respondent will cease and desist from engaging in any acts in violation of the New York Insurance Law and will comply with this and every other New York law.

48. Unless the Department consents, Respondent may not bring any claim, action, or proceeding against the TPA.

49. Respondent represents and warrants, through the signatures below, that the terms and conditions of this Consent Order are duly approved, and execution of this Consent Order is duly authorized.

BREACH OF THE CONSENT ORDER

50. In the event that the Department believes Respondent to be materially in breach of this Consent Order ("Breach"), the Department will provide written notice of such Breach to Respondent and Respondent must, within ten (10) business days from the date of receipt of said notice, or on a later date if so determined in the sole discretion of the Department, appear before the Department and have an opportunity to rebut the evidence, if any, of the Department that a Breach has occurred and, to the extent pertinent, to demonstrate that any such Breach is not material or has been cured.

51. The Respondent understands and agrees that Respondent's failure to appear before the Department to make the required demonstration within the specified period as set forth in paragraph 50 is presumptive evidence of Respondent's Breach. Upon a finding of Breach, DFS has all the remedies available to it under the New York Insurance Law, Financial

Services Law, or other applicable laws and may use any and all evidence available to DFS for all ensuing hearings, notices, orders, and other remedies that may be available under the New York Insurance Law, Financial Services Law, or other applicable laws.

OTHER PROVISIONS

52. If Respondent defaults on any of its obligations under this Consent Order, the Department may terminate the Consent Order, at its sole discretion, upon ten (10) days' written notice to Respondent. In the event of such termination, Respondent expressly agrees and acknowledges that this Consent Order shall in no way bar or otherwise preclude the Department from commencing, conducting, or prosecuting any investigation, action, or proceeding, however denominated, related to the Consent Order, against Respondent or from using in any way the statements, documents, or other materials produced or provided by Respondent prior to or after the date of this Consent Order, including, without limitation, such statements, documents, or other materials, if any, provided for purposes of settlement negotiations.

53. The Department has agreed to the terms of this Consent Order based on, among other things, representations made to the Department by Respondent and the Department's own factual examination. To the extent that representations made by Respondent are later found to be materially incomplete or inaccurate, this Consent Order or certain provisions thereof are voidable by the Department in its sole discretion.

54. Upon the request of the Department, Respondent shall provide all documentation and information reasonably necessary for the Department to verify compliance with this Consent Order.

55. All notices, reports, requests, certifications, and other communications to the Department regarding this Consent Order shall be in writing and shall be directed as follows:

If to the Department:

New York State Department of Financial Services
One State Street, 19th Floor
New York, NY 10004-1511
Attention: Laura Evangelista, Executive Deputy Superintendent for Insurance

If to the Company:

Globe Life Insurance Company of New York
1020 Seventh North Street
Liverpool, New York 13088
Attention: Joel Scarborough, Senior Vice President and Associate General Counsel

With a copy to:

Sidley Austin LLP

787 Seventh Avenue

New York, New York 10019

Attention: Ellen Dunn

56. This Consent Order and any dispute thereunder shall be governed by the laws of the State of New York without regard to any conflicts of laws principles.

57. Respondent waives its right to further notice and hearing in this matter as to any allegations of past violations up to and including the Effective Date and agrees that no provision of the Consent Order is subject to review in any court or tribunal outside the Department.

58. This Consent Order may not be amended except by an instrument in writing signed on behalf of all parties to this Consent Order.

59. This Consent Order constitutes the entire agreement between the Department and Respondent relating to the violations identified herein and supersedes any prior communication, understanding, or agreement, whether written or oral, concerning the subject matter of this Consent Order. No inducement, promise, understanding, condition, or warranty not set forth in this Consent Order has been relied upon by any party to this Consent Order.

60. In the event that one or more provisions contained in this Consent Order shall for any reason be held invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision of this Consent Order.

61. Upon execution by the parties to this Consent Order, no further action will be taken by the Department against Respondent for the conduct set forth in this Consent Order, subject to the terms of this Order.

62. This Consent Order may be executed in one or more counterparts, and shall become effective when such counterparts have been signed by each of the parties hereto and So Ordered by the Superintendent of Financial Services.

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

By: _____ Dated: JANUARY 21, 2019

Joel Scarborough
Senior Vice President and Associate General Counsel

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

By: _____ Dated: 1/25/19

Laura Evangelista
Executive Deputy Superintendent for Insurance

THE FOREGOING CONSENT ORDER IS HEREBY APPROVED.

By: _____ Dated: 1/28/19

Maria T. Vullo
Superintendent of Financial Services

State of Texas
County of COLLIN

Sworn and subscribed before me on the 21 day of 2019,
by Joel Scarborough.

_____
Notary Public's Signature

KELLY KINSER
My Notary ID # 2171722
Expires August 1, 2021

[Date]

[Beneficiary's Address]

Dear [Beneficiary],

You are receiving this notice pursuant to a settlement reached between Globe Life Insurance Company of New York ("Globe") and the New York State Department of Financial Services. The settlement concerns the contestable claims practices of Globe.

Records indicate that you are the beneficiary of a policy, [Globe Policy ####], that is affected by this settlement. We write to notify you that, pursuant to the settlement with the New York State Department of Financial Services, Globe is paying the face amount of this policy, plus interest dating from the policyholder's date of death. This amount may be reduced by amounts already paid as premium refunds for improperly rescinded policies.

This settlement was obtained by the New York State Department of Financial Services. Nothing in the settlement prevents or limits you from pursuing any right or remedy at law you may have or requires you to release any rights.

If you have any further problems regarding Policy [###], or if you have questions concerning this settlement or any refund provided, you can contact the New York State Department of Financial Services at 1-800-342-3736 and at [email address to be provided], or you may contact the Third Party Administrator, [name of TPA], that is administering this settlement at [toll-free number], [email address], or [website].

Sincerely,

Adopt Ins 306, previously effective 2-16-01 (Document #7450), and expired 2-16-09, to read as follows:

PART Ins 306 ANNUITY DISCLOSURE

Statutory Authority RSA 400-A:15, I; RSA 408:52, II

Ins 306.01 Purpose. The purpose of this part is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and foster consumer education. The rule specifies the minimum information which must be disclosed, the method for disclosing it, and the use and content of illustrations, if used, in connection with the sale of annuity contracts. The goal of this rule is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

Ins 306.02 Applicability and Scope. This part applies to all group and individual annuity contracts and certificates, including annuity riders to any life insurance policy, regardless of the issuer. This part does not apply to the following:

(a) Immediate and deferred annuities that do not contain any non-guaranteed elements.

(b) (1) Annuities used to fund:

a. An employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

b. A plan described by Sections 401(a), 40l(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

c. A governmental or church plan defined in Section 414 or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor; and

(2) Notwithstanding paragraph (b)(1), this part shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among 2 or more fixed annuity providers, and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this section, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement.

(c) Non-registered variable annuities issued exclusively to an accredited investor or qualified purchaser, as those terms are defined by the Securities Act of 1933 (15 U.S.C. Section 77a et seq.), the Investment Company Act of 1940 (15 U.S.C. Section 80a·l et seq.), or the rules promulgated under either of those acts, and offered for sale and sold in a transaction that is exempt from registration under the Securities Act of 1933 (15 U.S.C. Section 77a et seq.).

(d) (1) Transactions involving variable annuities and other registered products in compliance with Securities and Exchange Commission (SEC) rules and Financial Industry Regulatory Authority (FINRA) rules relating to disclosures and illustrations, provided that compliance with Ins 306.04 shall be required after the 2018 effective date of this part, unless or until such time as the SEC has adopted a summary prospectus rule or FINRA has approved for use a simplified disclosure form applicable to variable annuities or other registered

products; and

(2) Notwithstanding paragraph (d)(1), the delivery of the Buyer's Guide is required in sales of variable annuities and, when appropriate, in sales of other registered products.

(e) Structured settlement annuities.

(f) Charitable gift annuities.

(g) Funding agreements.

Ins 306.03 Definitions. For the purposes of this part:

(a) "Buyer's Guide" means the National Association of Insurance Commissioner's approved Annuity Buyer's Guide, available as referenced in Appendix B.

(b) "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or 2 lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes, as defined in RSA 403-E:1, but does not include a charitable remainder trust or a charitable lead trust or other similar arrangement where the charitable organization does not issue an annuity and incur a financial obligation to guarantee annuity payments.

(c) "Contract owner" means the owner named in the annuity contract or certificate holder in the case of a group annuity contract.

(d) "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges, or elements of formulas used to determine any of these. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only or from both determinable and guaranteed elements.

(e) "Funding agreement" means "funding agreement" as defined in RSA 408-E:2.

(f) "Generic name" means a short title descriptive of the annuity contract being applied for or illustrated such as "single premium deferred annuity".

(g) "Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges, or elements of formulas used to determine any of these, that are guaranteed or have determinable elements at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

(h) "Illustration" means a personalized presentation or depiction prepared for and provided to an individual consumer that includes non-guaranteed elements of an annuity contract over a period of years.

(i) "Market Value Adjustment" or "MVA" feature is a positive or negative adjustment that may be applied to the account value and/or cash value of the annuity upon withdrawal, surrender, contract annuitization, or death benefit payment based on either the movement of an external index or on the company's current guaranteed interest rate being offered on new premiums or new rates for renewal periods, if that withdrawal, surrender, contract annuitization, or death benefit payment occurs at a time other than on a specified guaranteed benefit date.

(j) "Non-guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, dividends, non-interest based credits, charges, or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

(k) "Registered product" means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

(l) "Structured settlement annuity" means a "qualified funding asset" as defined in section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

Ins 306.04 Standards for the Disclosure Document and Buyer's Guide.

(a) (1) Where the application for an annuity contract is taken in a face-to-face meeting, the applicant shall, at or before the time of application, be given both the disclosure document described in Ins 306.04(b) and the Buyer's Guide, if any; or

(2) Where the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the Buyer's Guide no later than 5 business days after the completed application is received by the insurer; and:

a. With respect to an application received as a result of a direct solicitation through the mail:

1. Providing a Buyer's Guide in a mailing, inviting prospective applicants to apply for an annuity contract, shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than 5 business days after receipt of the application; and

2. Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than 5 business days after receipt of the application;

b. With respect to an application received via the Internet:

1. Taking reasonable steps to make the Buyer's Guide available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than 5 business days after receipt of the application; and

2. Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's website shall be deemed to satisfy the requirement that the disclosure document be provided no later than 5 business days after receipt of the application;

c. A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the New Hampshire insurance department for a free annuity Buyer's Guide, available at https://www.nh.gov/insurance/consumers/annuitieslife.htm. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity Buyer's Guide; and

d. Where the Buyer's Guide and disclosure document are not provided at or before the

time of application, a free look period of no less than 15 days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look as provided under state law or rule.

(b) Aside from the foregoing, an insurer, including direct response insurers, shall provide a disclosure document to any prospective purchaser upon request.

(c) At a minimum, the following information shall be included in the disclosure document required to be provided under this regulation:

(1) The generic name of the contract, the company product name, if different, and form number, and the fact that it is an annuity;

(2) The insurer's legal name, physical address, website address, and telephone number;

(3) A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate, for:

a. The guaranteed and non-guaranteed elements of the contract, and their limitations, if any, including for fixed indexed annuities, the elements used to determine the index-based interest, such as the participation rates, caps, or spread, and an explanation of how they operate;

b. An explanation of the initial crediting rate or, for fixed indexed annuities, an explanation of how the index-based interest is determined, specifying any bonus or introduction portion, the duration of the rate, and the fact that rates may change from time to time and are not guaranteed;

c. Periodic income options, both on a guaranteed and non-guaranteed basis;

d. Any value reductions caused by withdrawals from or surrender of the contract;

e. How values in the contract can be accessed;

f. The death benefit, if available, and how it will be calculated;

g. A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

h. Impact of any rider, including, but not limited to, a guaranteed living benefit or long-term care rider;

(4) Specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply; and

(5) Information about the current guaranteed rate or indexed crediting rate formula, if applicable, for new contracts that contains a clear notice that the rate is subject to change.

(d) Insurers shall define term s used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.

(e) The name, age, and sex of the proposed annuitant and the date on which the disclosure document was prepared.

Ins 306.05 Standards for Annuity Illustrations. Please see Appendix I for an example.

(a) An insurer or producer may elect to provide a consumer an illustration at any time, provided that the illustration is in compliance with this section and:

(1) Clearly labeled as an illustration;

(2) Includes a statement referring consumers to the disclosure document and Buyer's Guide provided to them at time of purchase for additional information about their annuity; and

(3) Is prepared by the insurer or third party using software that is authorized by the insurer prior to its use, provided that the insurer maintains a system of control over the use of illustrations.

(b) An illustration furnished to an applicant for a group annuity contract or contracts issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

(c) The illustration shall not be provided unless accompanied by the disclosure document referenced in Ins 306.04.

(d) When using an illustration, the illustration shall not:

(1) Describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

(2) State or imply that the payment or amount of non-guaranteed elements is guaranteed; or

(3) Be incomplete.

(e) Costs and fees of any type shall be individually noted and explained.

(f) An illustration shall conform to the following requirements:

(1) The illustration shall be labeled with the date on which it was prepared;

(2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled "page 4 of 7 pages");

(3) The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;

(4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the contract is assumed to have been in force;

(5) The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;

(6) Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;

(7) Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled “guaranteed”;

(8) The non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;

(9) In determining the non-guaranteed illustrated values for a fixed indexed annuity:

a. The index-based interest rate and account value shall be calculated for three different scenarios:

1. One to reflect historical performance of the index for the most recent 10 calendar years;

2. One to reflect the historical performance of the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the least index value growth (the "low scenario"); and

3. one to reflect the historical performance of the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the most index value growth (the "high scenario"); and

b. The following requirements apply:

1. The most recent 10 calendar years and the last 20 calendar years are defined to end on the prior December 31, except for illustrations prepared during the first 3 months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;

2. If any index utilized in determination of an account value has not been in existence for at least 10 calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least 10 calendar years, the allocation to such indexed account(s) shall be assumed to be zero;

3. If any index utilized in determination of an account value has been in existence for at least 10 calendar years but less than 20 calendar years, the 10 calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;

4. The non-guaranteed element(s), such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element(s);

5. If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:

(i) The allocation used in the illustration shall be the same for all three scenarios; and

(ii) The 10 calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account

option;

6. The geometric mean annual effective rate of the account value growth over the 10 calendar year period shall be shown for each scenario;

7. If the most recent 10 calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of Ins 306.05(h), the most recent 10 calendar year historical period experience of the index shall be used for each subsequent 10 calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;

8. A graphical presentation shall also be included comparing the movement of the account value over the 10 calendar year period for the low scenario, the high scenario, and the most recent 10 calendar year scenario. The low and high scenarios:

(i) Need not show surrender values, if different than account values;

(ii) Shall not extend beyond 10 calendar years, and therefore are not subject to the requirements of Ins 306.05(h) beyond Ins 306.05(h)(1)a.; and

(iii) May be shown on a separate page; and

9. The low and high scenarios should reflect the irregular nature of the index performance and should trigger every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration, because no historical values of the index in the required illustration range would have triggered it, the illustration shall so state;

(10) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements, e.g., "see page 1 for guaranteed elements";

(11) The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;

(12) The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest, and application of any market value adjustment, as applicable;

(13) Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;

(14) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

a. The benefits and values are not guaranteed;

b. The assumptions on which they are based are subject to change by the insurer; and

c. Actual results may be higher or lower;

(15) Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps, or spreads for fixed indexed annuities;

(16) The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are, in fact, more favorable ;

(17) Illustrations shall be concise and easy to read;

(18) Key terms shall be defined and then used consistently throughout the illustration;

(19) Illustrations shall not depict values beyond the maximum annuitization age or date;

(20) Annuitization benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and

(21) Illustrations shall show both annuity income rates per $1000.00 and the dollar amounts of the periodic income payable.

(g) An annuity illustration shall include a narrative summary that includes the following, unless provided at the same time in a disclosure document:

(1) A brief description of any contract features, riders, or options, guaranteed and/or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the contract;

(2) A brief description of any other optional benefits or features that are selected, but not shown in the illustration, and the impact they have on the benefits and values of the contract;

(3) Identification and a brief definition of column headings and key terms used in the illustration;

(4) A statement containing, in substance, the following:

a. For other than fixed indexed annuities:

"This illustration assumes the annuity's current non-guaranteed elements will not change. It is likely that they will change and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

"The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information"; or

b. For fixed indexed annuities:

"This illustration assumes the index will repeat historical performance and that the annuity's current non-guaranteed elements, such as caps, spreads, participation rates, or other interest crediting adjustments, will not change. It is likely that the index will not repeat historical performance, the non-guaranteed elements will change, and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

"The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information"; and

(5) Additional explanations as follows:

a. Minimum guarantees shall be clearly explained;

b. The effect on contract values of contract surrender prior to maturity shall be explained;

c. Any conditions on the payment of bonuses shall be explained;

d. For annuities sold as an IRA, qualified plan, or in another arrangement subject to the required minimum distribution (RMD) requirements of the Internal Revenue Code, the effect of RMDs on the contract values shall be explained;

e. For annuities with recurring surrender charge schedules, a clear and concise explanation of what circumstances will cause the surrender charge to recur; and

f. A brief description of the types of annuity income options available shall be explained, including:

1. The earliest or only maturity date for annuitization, as the term is defined in the contract;

2. For contracts with an optional maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract, at the later of age 70 or 10 years after issue, but in no case later than the maximum annuitization age or date in the contract;

3. For contracts with a fixed maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract at the fixed maturity date; and

4. The periodic income amount based on the currently available periodic income rates for the annuity income option in item 2. or item 3., above, if desired;

(h) Following the narrative summary, an illustration shall include a numeric summary which shall include at minimum, numeric values at the following durations:

(1) First 10 contract years or surrender charge period, if longer than 10 years, including any renewal surrender charge period(s);

(2) Every tenth contract year, up to the later of 30 years or age 70;

(3) Required annuitization age or required annuitization date.

(i) If the annuity contains a market value adjustment, hereafter referred to as MVA, the following provisions apply to the illustration:

(1) The MVA shall be referred to as such throughout the illustration;

(2) The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the value available upon surrender;

(3) The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the death benefit;

(4) A statement shall be included, containing, in substance, the following:

"When you make a withdrawal, the amount you receive may be increased or decreased by a Market Value Adjustment (MVA). If interest rates on which the MVA is based go up after you buy your annuity, the MVA likely will decrease the amount you receive. If interest rates go down, the MVA will likely increase the amount you receive";

(5) Illustrations shall describe both the upside and the downside aspects of the contract features relating to the market value adjustment;

(6) The illustrative effect of the MVA shall be shown under at least one positive and one negative scenario. This demonstration shall appear on a separate page and be clearly labeled that it is information demonstrating the potential impact of a MVA, as the example in Appendix II shows;

(7) Actual MVA floors and ceilings as listed in the contract shall be illustrated; and

(8) If the MVA has significant characteristics not addressed by subparagraphs (1) – (6) above, the effect of such characteristics shall be shown in the illustration.

(j) Unless provided at the same time in a disclosure document, a narrative summary for a fixed indexed annuity illustration shall also include the following:

(1) An explanation, in simple terms, of the elements used to determine the index-based interest, including but not limited to the following elements:

a. The Index(es) which will be used to determine the index-based interest;

b. The Indexing Method, such as point-to-point, daily averaging, or monthly averaging;

c. The Index Term, which is the period over which indexed-based interest is calculated;

d. The Participation Rate, if applicable;

e. The Cap, if applicable; and

(f) The Spread, if applicable;

(2) The narrative shall include an explanation, in simple terms, of how index-based interest is credited in the indexed annuity;

(3) The narrative shall include a brief description of the frequency with which the company can re-set the elements used to determine the index-based credits, including the participation rate, the cap, and the spread, if applicable; and

(4) If the product allows the contract holder to make allocations to declared-rate segment, then the narrative shall include a brief description of:

a. Any options to make allocations to a declared-rate segment, both for new premiums and for transfers from the indexed-based segments; and

b. Differences in guarantees applicable to the declared-rate segment and the indexed-

based segments.

(k) A numeric summary for a fixed indexed annuity illustration shall include, at a minimum, the following elements:

(1) The assumed growth rate of the index in accordance with Ins 306.05(f)(9);

(2) The assumed values for the participation rate, cap and spread, if applicable; and

(3) The assumed allocation between indexed-based segments and declared-rate segments, if applicable, in accordance with Ins 306.05(f)(9).

(l) If the contract is issued other than as applied for, a revised illustration conforming to the contract as issued shall be sent with the contract, except that non-substantive changes, including but not limited to changes in the amount of expected initial or additional premiums, any changes in amounts of exchanges pursuant to Section 1035 of the Internal Revenue Code, and rollovers or transfers which do not alter the key benefits and features of the annuity as applied for, will not require a revised illustration unless requested by the applicant.

Ins 306.06 Report to Contract Owners. For annuities in the payout period that include non-guaranteed elements, and for deferred annuities in the accumulation period, the insurer shall provide each contract owner with a report on the status of the contract, at least annually, that contains at least the following information:

(a) The beginning and the end date of the current report period;

(b) The accumulation and cash surrender value;

(c) The total amounts, if any, that have been credited, charged to the contract value, or paid during the current report period; and

(d) The amount of outstanding loans, if any, as of the end of the current report period.

Ins 306.07 Penalties. In addition to any other penalties provided by RSA 400-A15, III, an insurer or producer that violates a requirement of Ins 306 shall also be subject to the provisions of RSA 417:3 and 4.

Ins 306.08 Waiver or Suspension of Rules.

(a) The commissioner, upon the commissioner's own initiative or upon request by an insurer, shall waive any requirement of Ins 306 if such waiver does not contradict the objective or intent of the rule and:

(1) Applying the rule provision would cause confusion or would be misleading to consumers;

(2) The rule provision is in whole or in part inapplicable to the given circumstances;

(3) There are specific circumstances unique to the situation such that strict compliance with the rule would be onerous without promoting the objective or intent of the rule provision; or

(4) Any other similar extenuating circumstances exist such that application of an alternative standard or procedure better promotes the objective or intent of the rule provision.

(b) No requirement prescribed by statute shall be waived unless expressly authorized by law.

(c) Any person or entity seeking a waiver shall make a request in writing.

(d) A request for a waiver shall specify the basis for the waiver and proposed alternative, if any.

APPENDIX I
Sample illustration of flexible premium fixed deferred annuity with a market value adjustment

Annuity Illustration Example
[The following illustration is an example only
And does not reflect specific characteristics of any actual product for sale by any company]

ABC Life Insurance Company
Company Product Name
Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)
An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy
(Contact us at Policyownerservice@ABCLife.com or 555-555-5555)

Sex: Male	Initial Premium Payment: $100,000.00
Age at Issue: 54	Planned Annual Premium Payments: None
Annuitant: John Doe	Tax Status: Nonqualified
Oldest Age at Which Annuity Payments Can Begin: 95	Withdrawals: None Illustrated

Initial Interest Guarantee Period	5 Years
Initial Guaranteed Interest Crediting Rates	
First Year (reflects first year only interest bonus credit of 0.75%):	4.15%
Remainder of Initial Interest Guarantee Period:	3.40%
Market Value Adjustment Period:	5 Years
Minimum Guaranteed Interest Rate after Initial Interest Guarantee Period *:	3%

* After the Initial Interest Guarantee Period, a new interest rate will be declared annually. This rate cannot be lower than the Minimum Guaranteed Interest Rate.

Annuity Income Options and Illustrated Monthly Income Values

This annuity is designed to pay an income that is guaranteed to last as long as the Annuitant lives. When annuity income payments are to begin, the income payment amounts will be determined by applying an annuity income rate to the annuity Account Value.

Annuity income options include the following:
- Periodic payments for Annuitant's life
- Periodic payments for Annuitant's life with payments guaranteed for a certain number of years
- Periodic payments for Annuitant's life with payments continuing for the life of a survivor annuitant

Illustrated Annuity Income Option: Monthly payments for annuitant's life with payments guaranteed for 10-year period.
Assumed Age When Payments Start: 70

	Account Value	Monthly Annuity Income Rate/$1,000 of Account Value *	Monthly Annuity Income
Based on Rates Guaranteed in the Contract	$164,798	$5.00	$823.99
Based on Rates Currently Offered by the Company	$171,976	$6.50	$1,117.84

* If, at the time of annuitization, the annuity income rates currently offered by the company are higher than the annuity income rates guaranteed in the contract, the current rates will apply.

ABC Life Insurance Company

Company Product Name

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

Contact us at Policyownerservice@ABCLife.com or 555-555-5555

		Values Based on Guaranteed Rates				Values Based on Assumption that Initial Guaranteed Rates Continue		
Contract Year/Age	Premium Payment	Interest Crediting Rate	Account Value	Cash Surrender Value Before MVA	Minimum Cash Surrender Value After MVA	Interest Crediting Rate	Account Value	Cash Surrender Value Before and After MVA
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1 / 55	$ 100,000	4.15%	$ 104,150	$ 95,818	$ 92,000	4.15%	$ 104,150	$ 95,818
2 / 56	0	3.40%	107,691	100,153	93,000	3.40%	107,691	100,153
3 / 57	0	3.40%	111,353	104,671	95,614	3.40%	111,353	104,671
4 / 58	0	3.40%	115,139	109,382	98,482	3.40%	115,139	109,382
5 / 59	0	3.40%	119,053	114,291	114,291	3.40%	119,053	114,291
6 / 60	0	3.00%	122,625	118,946	118,946	3.40%	123,101	119,408
7 / 61	0	3.00%	126,304	123,778	123,778	3.40%	127,287	124,741
8 / 62	0	3.00%	130,093	130,093	130,093	3.40%	131,614	131,614
9 / 63	0	3.00%	133,996	133,996	133,996	3.40%	136,089	136,089
10 / 64	0	3.00%	138,015	138,015	138,015	3.40%	140,716	140,716
11 / 65	0	3.00%	142,156	142,156	142,156	3.40%	145,501	145,501
16 / 70	0	3.00%	164,798	164,798	164,798	3.40%	171,976	171,976
21 / 75	0	3.00%	191,046	191,046	191,046	3.40%	203,268	203,268
26 / 80	0	3.00%	221,474	221,474	221,474	3.40%	240,255	240,255
31 / 85	0	3.00%	256,749	256,749	256,749	3.40%	283,972	283,972
36 / 90	0	3.00%	297,643	297,643	297,643	3.40%	335,643	335,643
41 / 95	0	3.00%	345,050	345,050	345,050	3.40%	396,717	396,717

For column descriptions, see next page

Column Descriptions

(1) **Ages** shown are measured from the Annuitant's age at issue

(2) **Premium Payments** are assumed to be made at the beginning of the Contract Year shown

Values Based on Guaranteed Rates

(3) **Interest Crediting Rates** shown are annual rates; however, interest is credited daily. During the Initial Interest Guarantee Period, values developed from the Initial Premium Payment are illustrated using the Initial Guaranteed Interest Rate(s) declared by the insurance company, which include an additional first year only interest bonus credit of 0.75%. The interest rates will be guaranteed for the Initial Interest Guarantee Period, subject to an MVA. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually, but can never be less than the Minimum Guaranteed Interest Rate shown.

(4) **Account Value** is the amount you have at the end of each year if you leave your money in the contract until you start receiving annuity payments. It is also the amount available upon the Annuitant's death if it occurs before annuity payments begin. The death benefit is not affected by surrender charges or the MVA.

(5) **Cash Surrender Value Before MVA** is the amount available at the end of each year if you surrender the contract (after deduction of any Surrender Charge) but before the application of any MVA. Surrender charges are applied to the Account Value according to the schedule below until the surrender charge period ends, which may be after the Initial Interest Guarantee Period has ended.

Years Measured from Premium Payment:	1	2	3	4	5	6	7	8+
Surrender Charges:	8%	7%	6%	5%	4%	3%	2%	0%

(6) **Minimum Cash Surrender Value After MVA** is the minimum amount available at the end of each year if you surrender your contract before the end of five years, no matter what the MVA is. The minimum is set by law. The amount you receive may be higher or lower than the cash surrender value due to the application of the MVA, but never lower than this minimum. Otherwise the MVA works as follows: If the interest rate available on new contracts offered by the company is LOWER than your Initial Guaranteed Interest Rate, the MVA will INCREASE the amount you receive. If the interest rate available on new contracts offered by the company is HIGHER than your initial guaranteed interest rate, the MVA will DECREASE the amount you receive. Page 4 of this illustration provides additional information concerning the MVA.

Values Based on Assumption that Initial Guaranteed Rates Continue

(7) **Interest Crediting Rates** are the same as in Column (3) for the Initial Interest Guarantee Period. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually. For the purposes of calculating the values in this column, it is assumed that the Initial Guaranteed Interest Rate (without the bonus) will continue as the new renewal interest rate in all years. The actual renewal interest rates are not subject to an MVA and will very likely NOT be the same as the illustrated renewal interest rates.

(8) **Account Value** is calculated the same way as column (4).

(9) **Cash Surrender Value Before and After MVA** is the Cash Surrender Value at the end of each year assuming that Initial Guaranteed Interest Rates continue, and that the continuing rates are the rates offered by the company on new contracts. In this case the MVA would be zero, and Cash Surrender Values before and after the MVA would be the same.

Important Note: This illustration assumes you will take **no** withdrawals from your annuity before you begin to receive periodic income payments. **Withdrawals will reduce both the annuity Account Value and the Cash Surrender Value.** You may make partial withdrawals of up to 10% of your account value each contract year without paying surrender charges. Excess withdrawals (above 10%) and full withdrawals will be subject to surrender charges.

This illustration assumes the annuity's current interest crediting rates will not change. It is likely that they will change and actual values may be higher or lower than those in the illustration.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. For more information, read the annuity disclosure and annuity buyer's guide.

APPENDIX II
Sample illustrations of cash surrender values of market value adjusted annuities

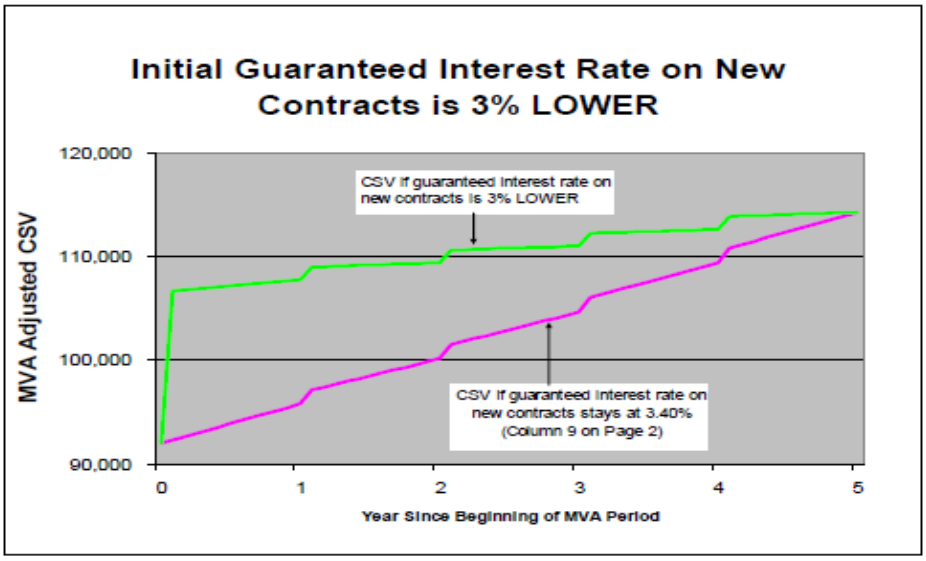
MVA-adjusted Cash Surrender Values (CSVs) Under Sample Scenarios

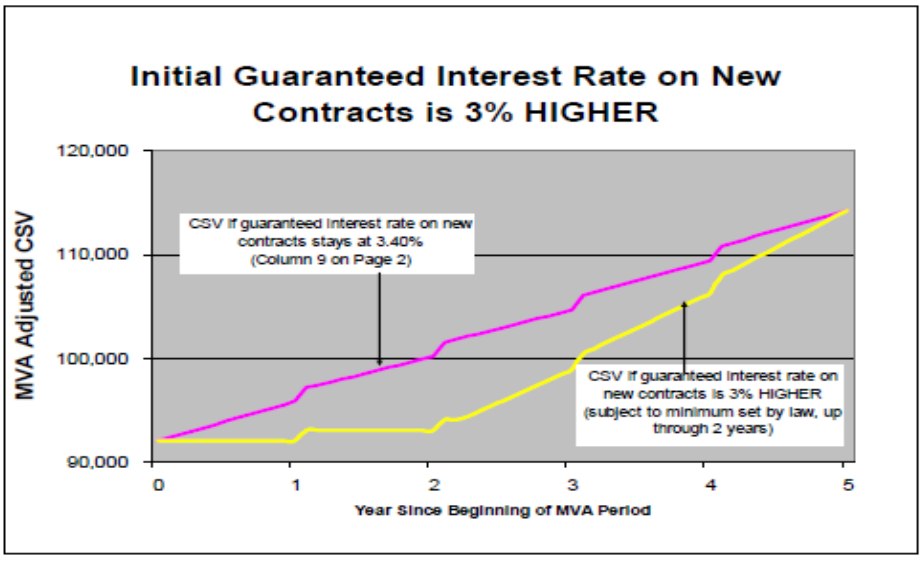
The graphs below show MVA-adjusted Cashu Surrender Values (CSVs) during the first five years of the contract, as illustrated on page 2 of the Annuity Illustration example ($100,000 single premium, a 5-year MVA Period) under two sample scenarios, as described below.

Graph #1 shows if the interest rate on new contracts is 3% LOWER than you Initial Guaranteed Interest Rate, the MVA will increase the amount you receive (upper line). The lower line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (From Column 9 on Page 2 of the Annuity Illustration example).

Graph #2 shows if the interest rate on new contracts is 3% HIGHER than your Initial Guaranteed Interest Rate, the MVA will decrease the amount you receive, but not below the minimum set by law (Column 6 on Page 2 of the Annuity Illustration example), which, in this scenario, limits the decrease for the first 2 years (lower line). The upper line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from column 9 on Page 2 of the Annuity Illustration example).

These graphs and the sample guaranteed interest rates on new contracts used are for demonstration purposes only and are not intended to be a projection of how guaranteed interest rates on new contracts are likely to behave.





APPENDIX A

Rule	Statute
Ins 306.01	RSA 400-A:15, I; RSA 408:52, II; RSA 417:3 & 4;
Ins 306.02	RSA 400-A:15, I; Securities Act of 1933 (15 U.S.C. Section 77a et seq.); Investment Company Act of 1940 (15 U.S.C. Section 80a·1 et seq.)
Ins 306.03	RSA 400-A:15, I; RSA 403-E; RSA 408-E
Ins 306.04	RSA 400-A:15, I; RSA 408:29; RSA 417:3 & 4
Ins 306.05	RSA 400-A:15, I; RSA 417:3 & 4
Ins 306.06	RSA 400-A:15, I; RSA 417:3 & 4
Ins 306.07	RSA 400-A:15, I & III; RSA 417:3 & 4
Ins 306.08	RSA 400-A:15, I
Appendix I	RSA 400-A:15, I
Appendix II	RSA 400-A:15, I

Appendix B Incorporation by Reference Information

Rule	Title of Material	Publisher; How to Obtain; and Cost
Ins 306.03(a)	Annuity Buyer's Guide © 1999, 2007, 2013 developed by the National Association of Insurance Commissioners	Published by the NAIC Available for no cost at: http://www.naic.org/documents/prod_serv_consumer_anb_la.pdf

DEPARTMENT OF INSURANCE

Legal Division, Enforcement Bureau
45 Fremont Street, 21st Floor
San Francisco, CA 94105

NOTICE

To: Life Insurers and Life Agents

Date: February 4, 2019

Subject: Sales of Annuities and other Life Insurance Products to Veterans

1. Amendment to Department of Veterans Affairs' Regulations Governing Veterans' Net-Worth-Eligibility Requirements for Need Based Benefit Programs, Including the Veterans Aid and Attendance Program

Effective October 18, 2018, the Department of Veterans Affairs ("VA") amended its regulations on net-worth-eligibility requirements for need based veterans pensions, including the eligibility requirements to qualify for the Veterans Aid and Attendance Program. The amended regulations of the Department of Veterans Affairs can be found at: https://www.federalregister.gov/documents/2018/09/18/2018-19895/net-worth-asset-transfers-and-income-exclusions-for-needs-based-benefits (the "Amended Regulations").

The VA specifically described the rulemaking as "an effort to discourage those who are financially secure from transferring assets to qualify for VA pensions." 83 Fed. Reg. 47254 (September 18, 2018). The Amended Regulations also provide that a pension is a needs-based benefit and is not intended to preserve the estates of individuals who can support themselves. Accordingly, a claimant may not create pension entitlement by transferring covered assets. 83 Fed. Reg. 47272.

The Amended Regulations impose a three-year look-back period in connection with the Net Worth calculation. If during the three-year look-back period, voluntary transfers are made to an annuity, and the applicant's net worth would have been in excess of the permitted amount without the transfer, a penalty period of up to five years may be imposed. The length of the assessed penalty period is based on the value of the transferred assets as of the transfer date in excess of the maximum net worth to qualify for a Veterans Aid and Attendance Benefit. During the penalty period, the VA will not pay the Veterans Aid and Attendance Benefit. Effective October 18, 2018, the maximum dollar amount of net worth an eligible applicant to the Veterans Aid and Attendance Program may have is $123,600. The VA may increase the maximum dollar amount of net worth. The primary residence is excluded from the net worth calculation.

2. Pertinent California Laws

a. Insurance Code section 785.5: Procedural Safeguards Required to Ensure that Insurance Agents and Brokers Have No Financial Incentive to Refer Seniors to Veterans Benefit Programs Offered through the Government

California Insurance Code section 785.5 prohibits insurance brokers and agents from participating in, being associated with, or employing anyone who participates in, or is associated with obtaining veterans benefits for seniors, unless procedural safeguards are maintained and designed to ensure that the insurance agent or broker has no financial incentive to refer the policyholder or prospective policyholder, to any veterans benefit program offered through the government.

b. Insurance Code section 787: Limitations on Advertisements

Insurance Code section 787 includes several prohibitions against advertisements directed at veterans. Specifically, Insurance Code section 787 prohibits, among other things, advertisements employing words, letters, initials, symbols, or other devices that are so similar to those used by governmental agencies, a nonprofit or charitable institution, veterans organization or agency, senior organization, or other insurer that they could have the capacity or tendency to mislead the public by implying that: (1) the coverages are provided by or are endorsed by any governmental agencies, nonprofit or charitable institutions, veterans organizations or agencies, or senior organizations; or (2) the advertiser is the same as, is connected with, or is endorsed by: nonprofit or charitable institutions, veterans organizations or agencies, senior organizations, or a governmental agency, such as the federal Social Security Administration or the United States Department of Veterans Affairs.

c. Civil Code section 1770(a) (25): Failure to Provide Required Disclosures Constitutes Unfair Method of Competition

Any advertisement for an event, presentation, seminar, workshop, or other public gathering regarding veterans' benefits or entitlements is also required to comply with the requirements of Civil Code section 1770(a) (25). This law provides in pertinent part that advertising or promoting any event, presentation, seminar, workshop, or other public gathering regarding veterans' benefits or entitlements that does not include the following statement in the same type size and font as the term "veteran" or any variation of that term is an unfair method of competition and unfair and deceptive acts or practices in a transaction intended to result or that results in the sale or lease of goods or services to any consumer:

> "I am not authorized to file an initial application for Veterans' Aid and Attendance benefits on your behalf, or to represent you before the Board of Veterans' Appeals within the United States Department of Veterans Affairs in any proceeding on any matter, including an application for such benefits. It would be illegal for me to accept a fee for preparing that application on your behalf." The requirements of this clause do not apply to a person licensed to act as an agent or attorney in proceedings before the Agency of Original Jurisdiction and the Board

> of Veterans' Appeals within the United States Department of Veterans Affairs when that person is offering those services at the advertised event.

The foregoing statement must be disseminated, both orally and in writing, at the beginning of any event, presentation, seminar, workshop, or public gathering regarding veterans' benefits or entitlements.

Additionally, subject to certain exceptions, advertising or promoting any event, presentation, seminar, workshop, or other public gathering regarding veterans' benefits or entitlements that is not sponsored by, or affiliated with, the United States Department of Veterans Affairs, the California Department of Veterans Affairs, or any other congressionally chartered or recognized organization of honorably discharged members of the Armed Forces of the United States, or any of their auxiliaries that does not include the following statement, in the same type size and font as the term "veteran" or the variation of that term is an unfair method of competition and unfair and deceptive acts or practices:

> "This event is not sponsored by, or affiliated with, the United States Department of Veterans Affairs, the California Department of Veterans Affairs, or any other congressionally chartered or recognized organization of honorably discharged members of the Armed Forces of the United States, or any of their auxiliaries. None of the insurance products promoted at this sales event are endorsed by those organizations, all of which offer free advice to veterans about how to qualify and apply for benefits." *Id.*

Similar to the disclosure regarding the lack of authorization to file for Veterans' Aid and Attendance benefits on behalf of a veteran, or to represent a veteran before the Board of Veterans' Appeals within the United States Department of Veterans Affairs in any proceeding on any matter, the foregoing statement must be disseminated, both orally and in writing, at the beginning of any event, presentation, seminar, workshop, or public gathering regarding veterans' benefits or entitlements.

Questions regarding this Notice should be directed to Jodi Lerner at (415) 538-4122 or Jodi.Lerner@insurance.ca.gov.