

## **MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE**

Market Regulation and Consumer Affairs (D) Committee Dec. 3, 2023, Minutes

Unfair Trade Practice Act #880 (Attachment One)

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Market Conduct Examination Guidelines (D) Working Group Nov. 8, 2023, Minutes (Attachment Eight)

Speed to Market (D) Working Group Nov. 17, 2023, Minutes (Attachment Nine)

## Draft Pending Adoption

Draft: 12/6/23

Market Regulation and Consumer Affairs (D) Committee  
Orlando, Florida  
December 3, 2023

The Market Regulation and Consumer Affairs (D) Committee met in Orlando, FL, Dec. 3, 2023. The following Committee members participated: Jon Pike, Chair (UT); Mike Causey, Co-Vice Chair, represented by Jackie Obusek and Robert Croom (NC); Michael Humphreys, Co-Vice Chair (PA); Peni Itula Sapini Teo (AS); Karima M. Woods and Philip Barlow (DC); Trinidad Navarro, represented by Susan Jennette (DE); Dean L. Cameron (ID); Sharon P. Clark (KY); Chlora Lindley-Myers represented by Jo LeDuc and Carrie Couch (MO); Jon Godfread represented by Johnny Palsgraaf (ND); Michael Wise (SC); Cassie Brown (TX); Kevin Gaffney represented by Mary Block (VT); and Jeff Rude (WY). Also participating were: Erica Weyhenmeyer (IL); Martin Swanson (NE); and Rebecca Nichols (VA).

### 1. Adopted its Summer National Meeting Minutes

Commissioner Clark made a motion, seconded by Obusek, to adopt its Aug. 15 minutes (*see NAIC Proceedings – Summer 2023, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

### 2. Adopted its 2024 Proposed Charges

Commissioner Clark made a motion, seconded by Commissioner Humphreys, to adopt the proposed 2024 charges of the Market Regulation and Consumer Affairs (D) Committee, the Antifraud (D) Task Force, the Market Information Systems (D) Task Force, and the Producer Licensing (D) Task Force. The motion passed unanimously.

### 3. Adopted Revisions to the Model #880

Swanson said the Task Force adopted the revisions to the *Unfair Trade Practice Act* (#880) with four additional edits suggested by California, which were unanimously agreed to by the Task Force. The suggested revisions were: 1) removing the word “all” from sales and virtual technology calls for Section 2 Definitions – Recording; 2) replacing the term “entity” with “person,” defined in Section 2 Definitions: (E) “Health Insurance Lead Generator”; 3) keeping the language in Section 4 – Unfair Trade Practices Defined (C) to strengthen the language within the model concerning Performance Records but adding “health insurance lead generator” to it; and 4) adding “when applicable” to Section 4 Unfair Trade Practices Defined: paragraph (J).

LeDuc made a motion, seconded by Obusek, to adopt the revisions to the Model #880 (Attachment One). The motion passed unanimously.

### 4. Adopted the MCAS Revision Process

Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group was presented with feedback that the amount of exposure time prior to the adoption of the pet insurance Market Conduct Annual Statement (MCAS) was too short for a thorough review by the Working Group. The concerns prompted a review of the MCAS Data Element Revision Process document (Attachment Two).

Weyhenmeyer said that after considering the feedback provided and discussing ways to improve the process, the Working Group adopted changes to the MCAS Data Element Revision Process that include recommendations and best practices to alleviate short exposure times.

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Obusek made a motion, seconded by Commissioner Clark, to adopt the revised MCAS Revision Process. The motion passed unanimously.

### 5. Adopted Revisions to the *Market Regulation Handbook* Chapter 23—Conducting the Life and Annuity Examination and New Travel Insurance SDRs

Weyhenmeyer said revisions to Chapter 23 of the *Market Regulation Handbook* (Attachment Three) were adopted by the Market Conduct Examination Guidelines (D) Working Group Nov. 8. She said the purpose of the revisions is to add guidance relating to the annuity suitability revisions to the *Suitability in Annuity Transactions Model Act* (#275).

Weyhenmeyer said revisions to Chapter 23 include changes to the introductory paragraphs, subsection 2 of Section C on Marketing and Sales, and Marketing and Sales standards 1 through 5, 9, 10, 12, and 13. She said the new material was also included in Chapter 23, including two new Marketing and Sales standards and four new supplemental checklists.

Weyhenmeyer also said the Working Group adopted a new travel insurance in-force standardized data request (SDR) (Attachment Four) and a new travel insurance claims SDR (Attachment Five) Nov. 8. She said the adopted SDRs will be incorporated into the reference documents of the *Market Regulation Handbook*.

Commissioner Clark made a motion, seconded by Obusek, to adopt the revisions to Chapter 23 of the *Market Regulation Handbook* and the two new travel insurance SDRs. The motion passed unanimously.

### 6. Adopted its Task Force and Working Group Reports

#### A. Market Information Systems (D) Task Force

Weyhenmeyer said the Market Information Systems (D) Task Force met Nov. 22 in lieu of the Fall National Meeting. She said the Task Force adopted its proposed 2024 charges.

Weyhenmeyer said the Task Force also heard reports from the Market Information Systems Research and Development (D) Working Group and the Market Analysis Procedures (D) Working Group on their work relating to the Market Information Systems (D) Task Force's 2023 charges. She said the Market Information Systems Research and Development (D) Working Group considered two requests for additional codes and functionality on the Complaint Database System (CDS). The Working Group approved work to begin on adding a claim handling reason code for "balanced billings" and discussed adding "insurance companies" in the drop-down description of the complainant in the SBS External Healthcare Review (EHR) portal. The Working Group also heard a report from NAIC staff support regarding iSite+ tools and reports to consider for sunset in light of other tools and data that are now available. She said the goal is to be sure the states have improved reports and visualizations of all the data and reports that they currently use and need but not maintain multiple reports that duplicate each other or are not used.

Weyhenmeyer said the Market Analysis Procedures (D) Working Group reported on its work to assess current market analysis data. The Working Group is currently interviewing NAIC jurisdictions regarding the effectiveness of the Market Analysis Prioritization Tool (MAPT) for identifying companies that need to be analyzed more closely. This is the first of the market analysis tools that the Working Group will be focusing on.

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Weyhenmeyer said the Task Force also heard a report from NAIC Information Technology Group (ITG) staff on the status of *State Connected* strategic plan projects that touch on the Market Information Systems (MIS), as well other projects requested by the MIS Research and Development Working Group.

### B. Market Analysis Procedures (D) Working Group

LeDuc said the Market Analysis Procedures (D) Working Group met three times since the Summer National Meeting. She said the Working Group sent a series of questions to all jurisdictions about their use of the MAPT and invited jurisdictions to Webex discussions of their responses. She said 27 jurisdictions agreed to interviews, and there may still be a few others. She said a summary of the discussions will be produced once they are completed. She said some suggestions that have been received include combining the financial and financial MAPT and the MCAS-MAPT, providing a glossary and embedded helps in the tools, and having all the lines of business available across MCAS, MAPT, and the Market Analysis Review System (MARS).

LeDuc said the Working Group also began a series of Lunch and Learns to help new and established analysts get together to discuss the MIS tools and share ideas on how to effectively use them. Two Lunch and Learns have been held--one on the MAPT and the other on the MCAS-MAPT. The next Lunch and Learn session will be in January 2024.

LeDuc said the Working Group is also discussing the possibility of lifting the MCAS filing exemption for fraternal organizations. There are a significant number of fraternal organizations that are larger than many life insurers currently reporting MCAS. However, typically, a fraternal organization will be quite small. So, the Working Group is considering whether to revise the \$50,000 MCAS premium reporting threshold. This would allow us to lift the fraternal organization exemption without overly burdening many of the smaller fraternal. She expects the Working Group to reach a consensus by its next meeting.

LeDuc said the pet insurance MCAS blank was adopted earlier this year, and the Working Group began drafting the standardized MCAS ratios, which will be incorporated into the public scorecards that are annually posted on the MCAS web page. Said the subject matter expert (SME) group is on target to complete its work within a couple of months.

### C. Market Conduct Annual Statement (D) Working Group

Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group approved May 31 as the uniform MCAS filing deadline for the other health and short-term, limited-duration (STLD) lines of business to be in line with the Health filing deadline. She said this filing deadline change was considered at the request of health industry representatives from America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA). She said the first submission of data for other health MCAS will be for the 2023 data year and will be due June 30, 2024. The May 31 filing deadline for Other Health will be implemented for the 2024 data year. She said STLD will implement the new May 31 filing deadline for the 2023 data year.

Weyhenmeyer said the data call and definitions for the other health MCAS line of business had two instances of duplicate data elements. She said that following a review of the duplicate data elements, an e-vote was conducted to approve the removal of the duplicate data elements from the 2023 MCAS Other Health blank. She said this change is outside the normal approval timeline but is necessary to avoid confusion. Weyhenmeyer said data elements #54 and #61 both ask for covered lives impacted by cancellations initiated by the policyholder/certificate holder during the period. The Working Group voted to remove data element #54 and retain data element #61. She said data elements #58 and #62 both ask for covered lives impacted by cancellations resulting from nonpayment. The Working Group voted to remove data element #58 and retain data element #62.

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Weyhenmeyer said the Working Group also considered concerns presented by Rhode Island relating to the instructions provided for determining the reporting of claims closed for the property and casualty (P/C) MCAS lines of business. She said that after reviewing the concerns and examining all comments given, the Working Group adopted edits that provided clarification. She said the edits are within the wording of the data elements only. The changes are non-substantive and do not have an impact on the intent of the reporting. She said these non-substantive changes will be implemented for the 2024 data year.

### E. Market Conduct Examination Guidelines (D) Working Group

Weyhenmeyer said the Market Conduct Examination Guidelines (D) Working Group met Nov. 8. She said the Working Group adopted revisions to Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook*. She said the Working Group also adopted new travel insurance-related SDRs, one for in-force policies and one for claims.

### F. Speed to Market (D) Working Group

Nichols said the Speed to Market (D) Working Group met Nov. 17 in lieu the Fall National Meeting.

Nichols said the NAIC *Product Filing Review Handbook* revisions are complete and were exposed during the Working Group's November meeting. The Working Group and interested parties were requested to review and submit comments by Jan. 12, 2024.

Nichols said the Working Group's goal is to adopt the revisions by February and present them to the Committee for adoption at the Spring National Meeting.

Commissioner Clark made a motion, seconded by Obusek, to adopt the following reports: 1) the Antifraud (D) Task Force; 2) the Market Information Systems (D) Task Force; 3) the Producer Licensing (D) Task Force; 4) the Market Analysis Procedures (D) Working Group (Attachment Six); 5) the Market Conduct Annual Statement Blanks (D) Working Group (Attachment Seven); 6) the Market Conduct Examination Guidelines (D) Working Group (Attachment Eight); and 7) the Speed to Market (D) Working Group (Attachment Nine). This included: adopting the removal of duplicate data elements from the "other health" blank; renaming the claims closed data elements in the P/C MCAS blanks; and establishing May 31 as the annual MCAS reporting deadline for the "other health" and STLD MCAS lines of business. The motion passed unanimously.

## 7. Heard a Presentation on Public Access to MCAS Data and Improving Data Collection and Related Tools for Market Analysis

Birny Birnbaum (Center for Economic Justice—CEJ) said that in contrast to the Australian Prudential Regulation Authority's (APRA's) biannual publication of company-specific life insurance data, the NAIC keeps company-specific MCAS data confidential. He said the APRA published the data to enable consumers to make informed financial decisions.

Birnbaum said the NAIC's reason for not releasing company-specific MCAS data is that it is collected under the examination authority of the various departments of insurance. He said it should be collected under general data collection authority or statistical agent authority because: 1) the data that is collected in MCAS are not trade secrets; 2) state insurance regulators and insurers are not the only entities capable of analyzing the data; and 3) public access would promote more competitive markets and enable consumer decisions on factors other than price.

Birnbaum said one common reason for keeping the MCAS data confidential is that it may be misunderstood by the public and misused in making decisions. He said the travel insurance MCAS collects loss ratio data, but it is

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kept confidential, and there is no other available source for the loss ratio. He said the given reason is that the loss ratios for travel insurance are low and could be misused if made public. He said, however, that state insurance regulators can and have misused the data they collect. Birnbaum also noted that health MCAS standardized ratio data are only published on a national basis because some states only have one or two insurers that report, but many states have three or more insurers reporting, and those state data are not published on a state-wide basis.

Birnbaum said the MCAS data is inadequate for market analysis because it is not granular enough and is received so late after the data year that it is often stale. He said the data should be collected on a more granular, transactional level basis. The state insurance regulators should also be using 21st-century technology to do their analysis.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

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*Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023*

*Adopted by the Antifraud (D) Task Force, Dec. 2, 2023*

## UNFAIR TRADE PRACTICES ACT

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**Prefatory Note:** By adopting amendments to this model act in June 1990, the NAIC separated provisions dealing with unfair claims settlement into a newly adopted Unfair Claims Settlement Practices Model Act, to make clearer distinction between general unfair trade practices and more specific unfair claim settlement issues and to focus on market conduct practices and market conduct regulation. By doing so, the NAIC is not recommending that states repeal existing acts, but states may modify them for the purpose of capturing the substantive changes. However, for those states wishing to completely rewrite their comprehensive approach to unfair claims practices, this separation of unfair claims from unfair trade practices is recommended.

### Section 1. Purpose

The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress) and the Gramm-Leach-Bliley Act (Public Law 106-102, 106<sup>th</sup> Congress), by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. Nothing herein shall be construed to create or imply a private cause of action for a violation of this Act.

### Section 2. Definitions

When used in this Act:

- A. “Affiliate” means any company that controls, is controlled by, or is under common control with another company.
- B. “Commissioner” means the commissioner of insurance of this state.

**Drafting Note:** Insert the appropriate term for the chief insurance regulatory official wherever the term “commissioner” appears.

- C. “Customer” means an individual who purchases, applies to purchase, or is solicited to purchase insurance products primarily for personal, family or household purposes.
- D. “Depository institution” means a bank or savings association. The term depository institution does not include an insurance company.
- E. [“Health Insurance Leader Generator” means a\[n\]y person that utilizes a lead-generating device to:](#)

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- (1) Publicize the availability of what is, or what purports to be, a health insurance product or service that the person is not licensed to sell directly to a customer.
- (2) Identifies a customer who may want to learn more about a health insurance product; or
- (3) Sells or transmits customer information to insurers or producers for follow-up contact and sales activity.

F. “Lead-generating device” means any communication directed to the public that, regardless of form, content, or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this State for the purchase of what is or what purports to be a health insurance product or service.

Drafting Note: Public means all the general public and any person.

E.G. “Insured” means the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy.

F.H. “Insurer” means any person, reciprocal exchange, interinsurer, Lloyd’s insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including producers, adjusters and third-party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined in Sections [insert applicable section]. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance.

**Drafting Note:** Each state may wish to consider the advisability of defining “insurance” for purposes of this Act if its present insurance code is not satisfactory in this regard. In some cases, a cross reference will be sufficient.

G.I. “Person” means a natural or artificial entity, including but not limited to, individuals, partnerships, associations, trusts, or corporations. For purposes of this act, “person” includes a health insurance lead generator operating as any such natural or artificial entity.

H.J. “Policy” or “certificate” means a contract of insurance, indemnity, medical, health or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.

H.K. “Producer” means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

L. “Recording” means recording of sales and verification of calls, including virtual technology calls, in the entirety, used in the marketing of insurance.

### **Section 3. Unfair Trade Practices Prohibited**

It is an unfair trade practice for any insurer, health insurance lead generator, or person engaged in the business of insurance to commit any practice defined in Section 4 of this Act if:

- A. It is committed flagrantly and in conscious disregard of this Act or of any rules promulgated hereunder; or
- B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

### **Section 4. Unfair Trade Practices Defined**

Any of the following practices, if committed in violation of Section 3, are hereby defined as unfair trade practices in the



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business of insurance:

- A. Misrepresentations and False Advertising of Insurance Policies. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison that:
- (1) Misrepresents the benefits, advantages, conditions, or terms of any policy; or
  - (2) Misrepresents the dividends or share of the surplus to be received on any policy; or
  - (3) Makes a false or misleading statement as to the dividends or share of surplus previously paid on any policy; or
  - (4) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates; or
  - (5) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof; or
  - (6) Is a misrepresentation, including any intentional misquote of premium rate, for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion or surrender of any policy; or
  - (7) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or
  - (8) Misrepresents any policy as being shares of stock.
- B. False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, [electronic mail](#), [internet advertisement or posting](#), or other publication, or in the form of a notice, circular, pamphlet, letter, [electronic posting of any kind](#) or poster, or over any radio or television station, [or via the internet or other electronic means](#), or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of its insurance business, which is untrue, deceptive or misleading.
- C. [Failure to Maintain Marketing and Performance Records. Failure of a health insurance lead generator to maintain its books, records, documents and other business records in such an order that data regarding complaints and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two \(2\) preceding years shall be maintained. Failure to do so shall constitute a violation of \(insert state statute\).](#)
- ~~D~~. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure such insurer.
- ~~E~~. Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.
- ~~F~~. False Statements and Entries.
- (1) Knowingly filing with any supervisory or other public official, or knowingly making, publishing,

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disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer.

- (2) Knowingly making any false entry of a material fact in any book, report or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer, or knowingly making any false material statement to any insurance department official.

**FG.** Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to purchase insurance.

**GH.** Unfair Discrimination.

- (1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such policy.
- (2) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or conditions of such policy, or in any other manner.

**Drafting Note:** In the event that unfair discrimination in connection with accident and health coverage is treated in other statutes, this paragraph should be omitted.

- (3) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless such action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.
- (4) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property.
- (5) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex, marital status, race, religion or national origin of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this section shall prohibit or limit the operation of fraternal benefit societies.
- (6) To terminate, or to modify coverage or to refuse to issue or refuse to renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subsection shall not apply to accident and health insurance sold by a casualty insurer and, provided further, that this subsection shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract.
- (7) Refusing to insure solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy in which that person was the named insured. Nothing

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herein contained shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

- (8) Violation of the state's rescission laws at [insert reference to appropriate code section].

**Drafting Note:** A state may wish to include this section if it has existing state laws covering rescission and to insert a reference to a particular code section.

**H.** Rebates.

- (1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any life insurance policy or annuity, or accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such policy, any rebate of premiums payable on the policy, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith, any stocks, bonds or other securities of any company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the policy.
- (2) Nothing in Subsection G, or Paragraph (1) of Subsection H shall be construed as including within the definition of discrimination or rebates any of the following practices:
- (a) In the case of life insurance policies or annuities, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;
- (b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;
- (c) Readjusting the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or
- (d) Engaging in an arrangement that would not violate Section 106 of the Bank Holding Company Act Amendments of 1972 (12 U.S.C. 1972), as interpreted by the Board of Governors of the Federal Reserve System, or Section 5(q) of the Home Owners' Loan Act, 12 U.S.C. 1464(q).
- (e) The offer or provision by insurers or producers, by or through employees, affiliates or third-party representatives, of value-added products or services at no or reduced cost when such products or services are not specified in the policy of insurance if the product or service:
- (i) Relates to the insurance coverage; and
- (ii) Is primarily designed to satisfy one or more of the following:
- (I) Provide loss mitigation or loss control;

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- (II) Reduce claim costs or claim settlement costs;
  - (III) Provide education about liability risks or risk of loss to persons or property;
  - (IV) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
  - (V) Enhance health;
  - (VI) Enhance financial wellness through items such as education or financial planning services;
  - (VII) Provide post-loss services;
  - (VIII) Incent behavioral changes to improve the health or reduce the risk of death or disability of a customer (defined for purposes of this subsection as policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured or applicant); or
  - (IX) Assist in the administration of the employee or retiree benefit insurance coverage.
- (iii) The cost to the insurer or producer offering the product or service to any given customer must be reasonable in comparison to that customer's premiums or insurance coverage for the policy class.
  - (iv) If the insurer or producer is providing the product or service offered, the insurer or producer must ensure that the customer is provided with contact information to assist the customer with questions regarding the product or service.
  - (v) The commissioner may adopt regulations when implementing the permitted practices set forth in this statute to ensure consumer protection. Such regulations, consistent with applicable law, may address, among other issues, consumer data protections and privacy, consumer disclosure and unfair discrimination.
  - (vi) The availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory. The documented criteria must be maintained by the insurer or producer and produced upon request by the Department.

**Drafting Note:** States may wish to consider alternative language based on their filing requirements.

- (vii) If an insurer or producer does not have sufficient evidence but has a good-faith belief that the product or service meets the criteria in H(2)(e)(ii), the insurer or producer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year. An insurer or producer must notify the Department of such a pilot or testing program offered to consumers in this state prior to launching and may proceed with the program unless the Department objects within twenty-one days of notice.

**Drafting Note:** This Section is not intended to limit or curtail existing value-added services in the marketplace. It is intended to promote innovation in connection with the offering of value-added services while maintaining strong consumer protections.

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- (f) An insurer or a producer may:
- (i) Offer or give non-cash gifts, items, or services, including meals to or charitable donations on behalf of a customer, in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost does not exceed an amount determined to be reasonable by the commissioner per policy year per term. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.
  - (ii) Offer or give non-cash gifts, items, or services including meals to or charitable donations on behalf of a customer, to commercial or institutional customers in connection with the marketing, sale, purchase, or retention of contracts of insurance, as long as the cost is reasonable in comparison to the premium or proposed premium and the cost of the gift or service is not included in any amounts charged to another person or entity. The offer must be made in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.
  - (iii) Conduct raffles or drawings to the extent permitted by state law, as long as there is no financial cost to entrants to participate, the drawing or raffle does not obligate participants to purchase insurance, the prizes are not valued in excess of a reasonable amount determined by the commissioner and the drawing or raffle is open to the public. The raffle or drawing must be offered in a manner that is not unfairly discriminatory. The customer may not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service.

**Drafting Note:** If a state wishes to limit (f) to a stated monetary limit the committee would suggest that, at the time of the drafting of this model, the lesser of 5% of the current or projected policyholder premium or \$250 would be an appropriate limit, however specific prohibitions may exist related to transactions governed by the Real Estate Settlement Procedures Act of 1974 and the laws and regulations governing the Federal Crop Insurance Corporation Risk Management Agency. States may want to consider a limit for commercial or institutional customers.

- (3) An insurer, producer or representative of either may not offer or provide insurance as an inducement to the purchase of another policy or otherwise use the words “free”, “no cost” or words of similar import, in an advertisement.

**Drafting Note:** Section 104 (d)(2)(B)(viii) of the Gramm-Leach-Bliley Act provides that any state restrictions on anti-tying may not prevent a depository institution or affiliate from engaging in any activity that would not violate Section 106 of the Bank Holding Company Act Amendments of 1970, as interpreted by the Board of Governors of the Federal Reserve System. The Board of Governors of the Federal Reserve System has stated that nothing in its interpretation on combined-balance discount arrangements is intended to override any other applicable state and federal law. FRB SR 95-32 (SUP). Section 5(q) of the Home Owners’ Loan Act is the analogous provision to Section 106 for thrift institutions. The Office of Thrift Supervision has a regulation 12 C.F.R. 563.36 that allows combined-balance discounts if certain requirements are met.

**Drafting Note:** Each state may wish to examine its rating laws to ensure that it contains sufficient provisions against rebating. If a state does not, this section may be expanded to cover all lines of insurance.

- I.** Prohibited Group Enrollments. No insurer shall offer more than one group policy of insurance through any person unless such person is licensed, at a minimum, as a limited insurance representative. However, this prohibition shall not apply to employer/employee relationships, nor to any such enrollments.
- J.** Failure to Maintain Marketing and Performance Records. Failure ~~of an insurer~~ to maintain its books, records, documents and other business records, including any recordings, when applicable, in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years (or insert state requirement) shall be maintained.

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- KL**. Failure to Maintain Complaint Handling Procedures. Failure of any insurer to maintain a complete record of all the complaints it received since the date of its last examination under Section [insert applicable section]. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subsection, “complaint” shall mean any written communication primarily expressing a grievance.
- LM**. Misrepresentation in Insurance Applications. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money or other benefit from any provider or individual person.
- MN**. Unfair Financial Planning Practices. An insurance producer:
- (1) Holding himself or herself out, directly or indirectly, to the public as a “financial planner,” “investment adviser,” “consultant,” “financial counselor,” or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when such person is in fact engaged only in the sale of policies. This provision does not preclude persons who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance. This does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.
  - (2)
    - (a) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Paragraph 3, or solicitation of the sale of a product or service that
      - (i) He or she is also an insurance salesperson, and
      - (ii) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.
    - (b) The disclosure requirement under this subsection may be met by including it in any disclosure required by federal or state securities law.
  - (3)
    - (a) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by the party.
      - (i) The services for which the fee is to be charged must be specifically stated in the agreement.
      - (ii) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.
      - (iii) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

**Drafting Note:** This subsection is intended to apply only to persons engaged in personal financial planning.

- (b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner

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upon request.

**NO.** Failure to file or to certify information regarding the endorsement or sale of long-term care insurance. Failure of any insurer to:

- (1) File with the insurance department the following material:
  - (a) The policy and certificate;
  - (b) A corresponding outline of coverage; and
  - (c) All advertisements requested by the insurance department; or
- (2) Certify annually that the association has complied with the responsibilities for disclosure, advertising, compensation arrangements, or other information required by the commissioner, as set forth by regulation.

**OP.** Failure to Provide Claims History

- (1) Loss Information—Property and Casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three (3) previous policy years to the first named insured within thirty (30) days of receipt of the first named insured's written request:
  - (a) On all claims, date and description of occurrence, and total amount of payments; and
  - (b) For any occurrence not included in Subparagraph (a) of this paragraph, the date and description of occurrence.
- (2) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Paragraph (1), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this subparagraph to the first named insured as soon as possible, but in no event later than twenty (20) days of receipt of the written request. Notwithstanding any other provision of this section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.
- (3) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Paragraph (1) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance, or where the provision of loss information otherwise is required by law.

**Drafting Note:** Loss information on workers' compensation is an example in some states of loss information otherwise required by law.

- (4) Information provided under Paragraph (2) shall not be subject to discovery by any party other than the insured, the insurer and the prospective insurer.

**Drafting Note:** This provision may not be required in states that have a privacy act that governs consumer access to this information. Those states considering applying this requirement to life, accident and health lines of insurance should first review their state privacy act related to issues of confidentiality of individual insured information.**PQ.** Violating any one of Sections [insert applicable sections].**Drafting Note:** Insert section numbers of any other sections of the state's insurance laws deemed desirable or necessary to include as an unfair trade

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practice, such as cancellation and nonrenewal laws.

**Section 5. Favored Agent or Insurer; Coercion of Debtors**

- A. No person or depository institution, or affiliate of a depository institution may require as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation a creditor is to acquire or finance, negotiate any policy or renewal thereof through a particular insurer or group of insurers or agent or broker or group of agents or brokers. Further, no person or depository institution, or affiliate of a depository institution, may reject an insurance policy solely because the policy has been issued or underwritten by a person who is not associated with the depository institution or affiliate when insurance is required in connection with a loan or extension of credit.
- B. No person or depository institution, or affiliate of a depository institution, who lends money or extends credit may:
- (1) As a condition for extending credit or offering any product or service that is equivalent to an extension of credit, require that a customer obtain insurance from a depository institution or an affiliate of a depository institution, or a particular insurer or producer. However, this provision does not prohibit a person or depository institution, or affiliate of a depository institution, from informing a customer or prospective customer that insurance is required in order to obtain a loan or credit, or that loan or credit approval is contingent upon the procurement by the customer of acceptable insurance, or that insurance is available from the person or depository institution, or affiliate of a depository institution;
  - (2) Unreasonably reject a policy furnished by the customer or borrower for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for rejection of a policy because it contains coverage in addition to that required in the credit transaction;
  - (3) Require that any customer, borrower, mortgagor, purchaser, insurer, broker or agent pay a separate charge, in connection with the handling of any policy required as security for a loan on real estate or pay a separate charge to substitute the policy of one insurer for that of another. This paragraph does not include the interest that may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document. Further, this paragraph does not apply to charges that would be required when the person or depository institution or affiliate of a depository institution is the licensed producer providing the insurance;
  - (4) Require any procedures or conditions of duly licensed producers or insurers not customarily required of those producers or insurers affiliated or in any way connected with the person who lends money or extends credit;
  - (4) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state is responsible for the insurance sales activity of, or stands behind the credit of, the person, depository institution or its affiliate;
  - (6) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state guarantees any returns on insurance products or is a source of payment on any insurance obligation of or sold by the person, depository institution or its affiliate;



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- (7) Act as a producer unless properly licensed in accordance with [insert appropriate statutory provisions for producer licensing];
- (8) Pay or receive any commission, brokerage fee or other compensation as a producer, unless the person holds a valid producer's license for the applicable class of insurance. However, an unlicensed person may make a referral to a licensed producer provided that the person does not discuss specific insurance policy terms and conditions. The unlicensed person may be compensated for the referral; however, in the case of a referral of a customer, the unlicensed person may be compensated only if the compensation is a fixed dollar amount for each referral that does not depend on whether the customer purchases the insurance product from the licensed producer. Furthermore, any person who accepts deposits from the public in an area where such transactions are routinely conducted in the depository institution may receive for each customer referral no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a transaction;

**Drafting Note:** The last sentence of this paragraph further limits the referral for customers of personal, family and household insurance products as a result of Section 305 of the Gramm-Leach-Bliley Act and the subsequent adoption of regulations by the federal banking regulators at 12 C.F.R. 14.50, 208.85, 343.50 and 536.50. By including this language the paragraph will be consistent with the Gramm-Leach-Bliley Act and the federal regulations while maintaining the integrity of Section 104(d)(2)(B)(iv) and (v) of the Gramm-Leach-Bliley Act.

- (9) Solicit or sell insurance, other than credit insurance or flood insurance, unless the solicitation or sale is completed through documents separate from any credit transactions;
- (10) Include the expense of insurance premiums, other than credit insurance premiums or flood insurance premiums, in the primary credit transaction without the express written consent of the customer;
- (11) Solicit or sell insurance unless its insurance sales activities are, to the extent practicable, physically separated from areas where retail deposits are routinely accepted by depository institutions; or
- (12) Solicit or sell insurance unless it maintains separate and distinct books and records relating to the insurance transactions, including all files relating to and reflecting consumer complaints.

**Drafting Note:** The Gramm-Leach-Bliley Act contains two "safe harbors" that relate to information sharing. Section 104(d)(2)(B)(vi) describes the circumstances surrounding the release of a customer's insurance information. Section 104(d)(2)(B)(vii) describes the circumstances surrounding the use of a customer's health information obtained from the insurance records of the customer. If a state has adopted the NAIC's Privacy of Consumer Financial and Health Information Model Regulation, no further action is needed. If not, language implementing the two safe harbors should be considered. It should be noted, however, that during the drafting process, there were concerns expressed about the application of the preemption provisions of the Fair Credit Reporting Act (FCRA) in circumstances involving the sharing of information with affiliates. Nothing in this Act shall be construed to modify, limit or supersede the operation of the FCRA (15 U.S.C. 1681 *et seq.*). In addition, no inference shall be drawn on the basis of the provisions of this Act regarding whether information is transaction or experience information under Section 603 of FCRA.

- C. Every person or depository institution, or affiliate of a depository institution that lends money or extends credit and who solicits insurance primarily for personal, family or household purposes shall disclose to the customer in writing that the insurance related to the credit extension may be purchased from an insurer or producer of the customer's choice, subject only to the lender's right to reject a given insurer or agent as provided in Subsection B(2). Further, the disclosure shall inform the customer that the customer's choice of insurer or producer will not affect the credit decision or credit terms in any way, except that the depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the scope of coverage chosen as provided in Subsection B(2).
- D. (1) A depository institution that solicits, sells, advertises or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall disclose to the customer in writing, where practicable and in a clear and conspicuous manner, prior to a sale, that the insurance:

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- (a) Is not a deposit;
  - (b) Is not insured by the Federal Deposit Insurance Corporation or any other federal government agency;
  - (c) Is not guaranteed by the depository institution, its affiliate (if applicable) or any person that is soliciting, selling, advertising or offering insurance (if applicable); and
  - (d) Where appropriate, involves investment risk, including the possible loss of value.
- (2) For purposes of these requirements, an affiliate of a depository institution is subject to these requirements only to the extent that it sells, solicits, advertises, or offers insurance products or annuities at an office of a depository institution or on behalf of a depository institution. These requirements apply only when an individual purchases, applies to purchase, or is solicited to purchase insurance products or annuities primarily for personal, family or household purposes and only to the extent that the disclosure would be accurate.

**Drafting Note:** The requirements of this provision are meant to apply only when the consumer may have a reasonable belief that the product is a deposit; that it is insured by the Federal Deposit Insurance Corporation; that it is guaranteed by the person or depository institution; and that, where appropriate, it involves investment risk, including the possible loss of value. This provision is not intended to require every entity or person in a financial holding company to provide the disclosure as a result of having both solicitation of insurance and extending of credit or lending of money occurring within an entity in the financial holding company group.

- (3) A depository institution that solicits, sells, advertises, or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall obtain written acknowledgement of the receipt of the disclosure from the customer at the time the customer receives the disclosure or at the time of the initial purchase of the insurance policy. If the solicitation is conducted by telephone, the person or depository institution shall obtain an oral acknowledgement of receipt of the disclosure, maintain sufficient documentation to show that the acknowledgment was given by the customer, and make reasonable efforts to obtain a written acknowledgment from the customer. If a customer affirmatively consents to receiving the disclosures electronically and if the disclosures are provided in a format that the customer may retain or obtain later, the person or depository institution may provide the disclosure and obtain acknowledgement of the receipt of the disclosure from the customer using electronic media.
  - (4) For the purposes of Paragraph (1), a person is selling, soliciting, advertising or offering insurance on behalf of a depository institution, whether at an office of the depository institution or another location, if at least one of the following applies:
    - (a) The person represents to the customer that the sale, solicitation, advertisement or offer of the insurance is by or on behalf of the depository institution;
    - (b) The depository institution refers a customer to the person who sells insurance, and the depository institution has a contractual arrangement to receive commissions or fees derived from the sale of insurance resulting from the referral; or
    - (c) Documents evidencing the sale, solicitation, advertisement or offer of insurance identify or refer to the depository institution.
- E. The commissioner shall have the power to examine and investigate those insurance activities of any person, depository institution, affiliate of a depository institution or insurer that the commissioner believes may be in violation of this section. The person, depository institution, affiliate of a depository institution or insurer

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shall make its insurance books and records available to the commissioner and the commissioner's staff for inspection upon reasonable notice. An affected person may submit to the commissioner a complaint or material pertinent to the enforcement of this section.

- F. Nothing herein shall prevent a person or depository institution, or affiliate of a depository institution, who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.
- G. Nothing contained in this section shall apply to credit related insurance.

**Drafting Note:** The consumer protection rules promulgated by the banking regulatory agencies pursuant to Section 305 of the Gramm-Leach-Bliley Act apply to retail sales practices, solicitations, advertising or offers of any insurance product or annuity. If a state has adopted the NAIC's Consumer Credit Insurance Model Act and Consumer Credit Insurance Model Regulation, no further action is needed. If not, the state should consider eliminating Subsection G.

## **Section 6. Power of Commissioner**

The commissioner shall have power to examine and investigate the affairs of every person or insurer [or health insurance lead generator](#) in this state in order to determine whether such person, ~~or insurer,~~ [or health insurance lead generator](#) has been or is engaged in any unfair trade practice prohibited by this Act. However, in the case of depository institutions, the commissioner shall have the power to examine and investigate the insurance activities of depository institutions, in order to determine whether the depository institution has been or is engaged in any unfair trade practice prohibited by this Act. The commissioner shall notify the appropriate federal banking agency of the commissioner's intent to examine or investigate a depository institution and advise the appropriate federal banking agency of the suspected violations of state law prior to commencing the examination or investigation.

## **Section 7. Hearings, Witnesses, Appearances, Production of Books, and Service of Process**

- A. Whenever the commissioner shall have reason to believe that any insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution has been engaged or is engaging in this state in any unfair trade practice whether or not defined in this Act, and that a proceeding by the commissioner in respect thereto would be in the interest of the public, the commissioner shall issue and serve upon such insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution, a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than [insert number] days after the date of the service thereof. With respect to a depository institution, the commissioner's authority to call a hearing is limited to the depository institution's insurance underwriting, sales, solicitation and cross marketing activities. The commissioner shall provide a copy of the notice of hearing to the appropriate federal banking agency when a depository institution is involved.
- B. At the time and place fixed for the hearing, the insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring the insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.
- C. Nothing contained in this Act shall require the observance at the hearing of formal rules of pleading or evidence.
- D. The commissioner, at the hearing, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence or other documents the commissioner deems relevant to the inquiry, provided, however, that in the case of depository institutions, the

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- commissioner shall have the power to require the production of books, papers, records, correspondence or other documents that the commissioner deems relevant to the inquiry only on the insurance activities of the depository institution. The commissioner, may, and upon the request of any party, shall cause to be made a stenographic record of all the evidence and all the proceedings at the hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena or to testify with respect to any matter concerning which he may be lawfully interrogated, the [insert title] Court of [insert county] County or the county where the person resides, on application of the commissioner, may issue an order requiring such person to comply with the subpoena and to testify; and any failure to obey any order of the court may be punished by the court as contempt.
- E. Statements of charges, notices, orders and other processes of the commissioner under this Act may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by the statement, notice, order or other process at the person's residence or principal office or place of business. The verified return by the person so serving the statement, notice, order, or other process, setting forth the manner of service, shall be proof of the same, and the return postcard receipt for the statement, notice, order or other process, registered and mailed as specified, shall be proof of the service of the same.

## **Section 8. Cease and Desist and Penalty Orders**

- A. If, after a hearing, the commissioner finds that an insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution has engaged in an unfair trade practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution charged with the violation, a copy of the findings in an order requiring the insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution to cease and desist from engaging in the act or practice and the commissioner may, at the commissioner's discretion order:
- (1) Payment of a monetary penalty of not more than \$1,000 for each violation, but not to exceed an aggregate penalty of \$100,000, unless the violation was committed flagrantly in a conscious disregard of this Act, in which case the penalty shall not be more than \$25,000 for each violation not to exceed an aggregate penalty of \$250,000; and/or
  - (2) Suspension or revocation of the insurer's license if the insurer knew or reasonably should have known that it was in violation of this Act.
- B. In the case of a depository institution, the commissioner shall, if practicable, notify the appropriate federal regulator before imposing a monetary penalty on a depository institution or suspending or revoking the depository institution's insurer's license, and provide to the federal regulator a copy of the findings.

## **Section 9. Judicial Review of Orders**

- A. An insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution subject to an order of the commissioner under Section 8 or Section 11 may obtain a review of the order by filing in the [insert title] Court of [insert county] County, within [insert number] days from the date of the service of the order, a written petition praying that the order of the commissioner be set aside. A copy of the petition shall be served upon the commissioner, and thereupon the commissioner shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the commissioner. Upon filing of the petition and transcript, the court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of the petition shall operate as a stay of the order of the commissioner, and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in the transcript a decree modifying, affirming or reversing the order of the commissioner, in whole or in part. The findings of the commissioner as to the

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facts, if supported by [insert type] evidence, shall be conclusive.

**Drafting Note:** Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination.

- B. To the extent that the order of the commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of the order of the commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that the additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as the court may deem proper. The commissioner may modify the findings of fact, or make new findings by reason of the additional evidence so taken, and shall file the modified or new findings that are supported by [insert type] evidence with a recommendation if any, for the modification or setting aside of the original order, with the return of the additional evidence.

**Drafting Note:** Insert appropriate language to accommodate to local procedure the effect given the commissioner's determination. In a state where final judgment, order or decree would not be subject to review by an appellate court provision therefor should be inserted here.

- C. An order issued by the commissioner under Section 8 shall become final:
- (1) Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the commissioner may thereafter modify or set aside the order to the extent provided in Section 9B; or
  - (2) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review dismissed.
- D. No order of the commissioner under this Act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

#### **Section 10. Judicial Review by Intervenor**

If after any hearing under Section 7 or Section 11, the report of the commissioner does not charge a violation of this Act, then any intervenor in the proceedings may within [insert number] days after the service of the report, cause a petition [notice of appeal] [petition for writ of certiorari] to be filed in the [insert title] Court of [insert county] County for a review of the report. Upon review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act or practice which it finds, notwithstanding the report of the commissioner, constitutes a violation of this Act, and containing penalties pursuant to Section 8.

**Drafting Note:** The type of procedure should conform to state procedure. See also note to Section 9 concerning review by appellate courts.

#### **Section 11. Penalty for Violation of Cease and Desist Orders**

Any insurer, [health insurance lead generator](#), person, depository institution or affiliate of a depository institution that violates a cease and desist order of the commissioner and while such order is in effect, may after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to:

- A. A monetary penalty of not more than \$25,000 for each and every act or violation not to exceed an aggregate of \$250,000 pursuant to any such hearing; and/or
- B. Suspension or revocation of the insurer's license.

#### **Section 12. Regulations**

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The commissioner may, after notice and hearing, promulgate reasonable rules, regulations and orders as are necessary or proper to carry out and effectuate the provisions of this Act. Such regulations shall be subject to review in accordance with Section [insert applicable section].

**Drafting Note:** Insert section number providing for review of administrative orders.

### **Section 13. Provisions of Act Additional to Existing Law**

The powers vested in the commissioner by this Act shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

### **Section 14. Immunity from Prosecution**

If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required may tend to incriminate or subject the person to a penalty or forfeiture, and shall notwithstanding be directed to give testimony or produce evidence, the person shall nonetheless comply with the direction, but shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which the person may testify or produce evidence thereto, and no testimony so given or evidence produced shall be received against the person upon any criminal action, investigation or proceeding; provided, however, that no person so testifying shall be exempt from prosecution or punishment for any perjury committed while so testifying and the testimony or evidence so given or produced shall be admissible against the person upon any criminal action, investigation or proceeding concerning such perjury, nor shall the person be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the Insurance Law of this state. Any such person may execute, acknowledge and file in the office of the commissioner a statement expressly waiving immunity or privilege in respect to any transaction, matter or thing specified in the statement and thereupon the testimony of the person or evidence in relation to the transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced the person shall not be entitled to any immunity or privilege on account of any testimony the person may give or evidence produced.

### **Section 15. Separability Provision**

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

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*Chronological Summary of Actions (all references are to the Proceedings of the NAIC).*

1947 Proc. 383, 392-400, 413 (adopted).  
 1960 Proc. II 485-487, 509-515, 516 (reprinted).  
 1972 Proc. I 15, 16, 443-444, 491, 493-501 (amended and reprinted).  
 1977 Proc. I 26, 28, 211, 226-227 (amended).  
 1979 Proc. II 31, 34, 38, 39, 525 (amended).  
 1985 Proc. I 19, 39, 85-86 (amended).  
 1989 Proc. II 13, 21, 129-130, 132, 133-140 (amended and reprinted).  
 1990 Proc. I 6, 25, 122, 146 (changed name of model).  
 1990 Proc. II 7, 13-14, 160, 169-177 (amended and reprinted).  
 1991 Proc. I 9, 16, 192-193, 196-203 (amended and reprinted).  
 1993 Proc. I 8, 136, 242, 246-254 (amended and reprinted).  
 1993 Proc. 1<sup>st</sup> Quarter 3, 34, 267, 274, 276 (amended).  
 2001 Proc. 2<sup>nd</sup> Quarter 7, 9, 836, 843-853 (amended and reprinted).  
 2021 Spring National Meeting (amended).

*Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023*  
*Adopted by the Market Conduct Annual Statement Working Group, Oct. 10, 2023*

## Market Conduct Annual Statement Data Element Revision Process

Adopted by the  
Market Conduct Annual Statement Blanks (D) Working Group on  
~~May 10, 2018~~ October 10, 2023

The following establishes the procedures of the Market Regulation and Consumer Affairs (D) Committee's Market Conduct Annual Statement Blanks (D) Working Group ([MCAS Blanks WG](#)) for the a) development of new Market Conduct Annual Statement (MCAS) interrogatories, data elements, and definitions for the collection of data for new approved lines of business; and b) proposed changes to the MCAS data elements for existing lines of business. ~~The procedures are for substantive changes only—such as the addition of data elements or significant (non-technical) changes to their definitions.~~

The following best practices are encouraged to ensure the timelines for adoption are successfully met

- A minimum of five Working Group jurisdictions should volunteer and participate in subject matter expert (SME) group meetings during the creation of reporting for new MCAS line of business or blank changes to an existing line of business.
  - SME group draft documents and a summary of progress should be exposed to Working Group members, interested regulators and interested parties monthly.
  - Weekly (SME) meetings should be encouraged from the beginning of SME work.
  - A formal meeting should be held after the conclusion of the SME group meetings and prior to the voting deadline to present the draft document to the Working Group members, interested state insurance regulators, and interested parties to increase exposure, facilitate discussion, and proactively identify any concerns.
1. The MCAS Blanks WG may consider relevant changes to the annual statement blank and instructions at any scheduled Working Group conference call or meeting. The MCAS Blanks WG chair will determine which suggested changes are considered.
  2. Suggested changes and amendments to the MCAS data elements or

*Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023*

*Adopted by the Market Conduct Annual Statement Working Group, Oct. 10, 2023*

definitions may be submitted ([using the MCAS Proposal Submission Form located on the Working Group's web page](#)) to the NAIC support staff for the MCAS Blanks WG at any time during the year.

3. All recommended changes shall include all of the following:
  - A concise statement of the proposed change.
  - The statement type of the suggested change (Life and Annuity, Property and Casualty, Long Term Care, Health, etc.).
  - The reason for the change.
  - Any supporting information relating to the change.
4. Changes that have been adopted by the MCAS Blanks WG prior to June 1 and subsequently adopted by the Market Regulation and Consumer Affairs (D) Committee by August 1 and by the NAIC Plenary by December 31 of the same year will become effective for the following year's experience reporting.

[Additional information for drafts to be considered by the Working Group:](#)

- [To provide sufficient time for the Working Group to review, discuss, and consider MCAS reporting data call and definitions for new lines of business, substantial additions, and/or changes to existing lines of business, drafts should be provided to the Working Group by April 1.](#)
  - [All other draft MCAS edits/changes should be provided to the Working Group by May 1.](#)
  - [If these new drafts are provided to the Working Group later than the suggested April 1 or May 1 dates, the Working Group can determine on a case-by-case basis if there is group consensus to adopt prior to June 1 for use in the following data year or if additional time is needed for revisions prior to adoption.](#)
5. If the MCAS Blanks WG or the Market Regulation and Consumer Affairs (D) Committee do not adopt a recommended change by their respective date (June 1 or August 1), any adopted change will be effective the second calendar year after the adoption of the change. (For example, if MCAS Blanks WG adopts a change during July ~~2017~~2024 and the ~~D~~-Committee adopts it in September ~~2017~~2024, the change will be effective January 1, ~~2019~~2026 and would be reported in the data filed in ~~2020~~2027).
  6. All suggested changes will be made available for comment at least 30 days prior to adoption by the Market Regulation and Consumer Affairs (D) Committee.



*Adopted by the Market Regulation and Consumer Affairs (D) Committee, Dec. 3, 2023*  
*Adopted by the Market Conduct Annual Statement Working Group, Oct. 10, 2023*

## Chapter 23—Conducting the Life and Annuity Examination

### IMPORTANT NOTE:

The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a format for conducting life insurance and annuity company examinations. Procedures for conducting property/casualty insurance company examinations and other types of specialized examinations—such as managed care organizations, third-party administrators and surplus lines brokers—may be found in separate chapters.

The examination of life insurance/annuity operations may involve any review of one or a combination of the following business areas:

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales ([Several specialized Supplemental Checklists are available in Sections H–N of this chapter](#))
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims (~~Several specialized checklists are available in Sections H–J of this chapter~~)
- H. [Supplemental Checklist for Marketing and Sales Standard #1](#)
- I. [Supplemental Checklist for Marketing and Sales Standard #4](#)
- J. [Supplemental Checklist for Marketing and Sales Standard #8](#)
- K. [Supplemental Checklist for Marketing and Sales Standard #10](#)
- L. [Supplemental Checklist for Marketing and Sales Standard #12](#)
- M. [Supplemental Checklist for Marketing and Sales Standard #16](#)
- ~~J~~.N. [Supplemental Checklist for Marketing and Sales Standard #17](#)

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

### IIPRC-Approved Products

When conducting an exam that includes products approved by the Interstate Insurance Product Regulation Commission (Compact) on behalf of a compacting state, it is important to keep in mind that the uniform standards—and not state-specific statutes, rules and regulations—are applicable to the content and approval of the product. The Compact website is [www.insurancecompact.org](http://www.insurancecompact.org) and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rates and Forms Filing (SERFF) to product filings submitted to the Compact for approval and use in their respective state or

jurisdiction and can also use the export tool in SERFF to extract relevant information. Each Compact-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The Compact office should be included when a compacting state(s) is concerned that a Compact-approved product constitutes a violation of the provisions, standards or requirements of the Compact (including the uniform standards).

### **A. Operations/Management**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

**STANDARDS  
OPERATIONS/MANAGEMENT**

**Standard 1**

**The regulated entity files all certifications with the insurance department, as required by statutes, rules and regulations.**

**Apply to:** All regulated entities

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Insurance department records of certifications made by the regulated entity

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Advertisements of Life Insurance and Annuities Model Regulation (#570)*  
*Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49)*

**Review Procedures and Criteria**

The illustration actuary should file a certification with the insurance department annually for all policies for which illustrations are used (Model #582, Section 11). For indexed universal life (IUL) illustrations, AG 49 expands upon and supersedes the illustration requirements in Model #582.

A responsible officer of the insurer, other than the illustration actuary, should certify annually that the illustration formats meet all applicable requirements and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary. In addition, the officer must certify that the regulated entity has provided its producers with information about the expense allocation method used and disclosed by the regulated entity in its illustrations (Model #582, Section 11).

Note: The annual certifications should be provided each year by a date determined by the insurer.

Each insurer should file with its annual statement a certificate of compliance executed by an authorized officer stating that the advertisements which were disseminated by or on behalf of the insurer during the statement year complied, or were made to comply, in all respects with the rules governing the advertising of life insurance (Model #570, Section 9C).

## B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

## C. Marketing and Sales

### 1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the company about its product(s). It is not typically based on sampling techniques, but it can be. The areas to be considered in this kind of review include all written and verbal advertising and sales materials.

### 2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every insurance company is required to have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained by or for and authorized by the insurer are the responsibility of the insurer.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a company's Internet advertisements, it is important to also review the safeguards implemented by the company.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

There may be special requirements for applicants age 60 or older. The examiner should refer to statutes, rules and regulations to determine what requirements apply.

In addition to reviewing advertising, examiners should be aware that several NAIC models impose additional duties on regulated entities which go beyond the delivery of accurate information to consumers. If an insurance product is involved and a regulated entity, producer or a registered representative makes a recommendation regarding that insurance product, both insurance suitability laws and insurance replacement laws may apply to the transaction. A person who is advising a consumer about an insurance product, even if it is to replace it with a non-insurance product, must hold an insurance license. An insurance producer who does not hold a license as a registered representative should not give advice or recommendations about securities products.

The *Life Insurance and Annuities Replacement Model Regulation* (#613) was thoroughly updated and expanded in 1998. The new model applies to annuities and life insurance products and requires delivery of certain notices if the proposed purchaser has any existing life insurance or annuity products. Under the new model, insurers are required to have systems in place to monitor compliance with replacement procedures. Under the old model, which is still in place in a number of states, producers generally make a

decision at the point of sale as to whether the transaction involves a replacement. Under either model, market regulators should review insurer systems and should also sample transactions that are not reported as replacements to verify that the insurer's system is effective in properly identifying replacement transactions.

Historically, replacement ratios were quite low. This was due in part to the fact that the definition of a replacement under the "old" *Life Insurance and Annuities Replacement Model Regulation* (#613) only applied to life insurance products and external replacements. Under the prior model, either the producer or the insurer made a decision as to whether the transaction involved a "replacement."

The new model covers internal and external replacement and, if any funds for the new product come from an existing product, the transaction is a replacement and must be reported as such. There are several limited exceptions. Another factor in the increase in replacement activity is the tendency of consumers to move funds between investment and insurance products when the stock market fluctuates. In such transactions, an analysis should be performed to determine whether the insurer has systems in place to supervise its producers. Regulators should review transactions involving the sale or replacement of variable products involving the insurer and its products to verify that a system is in place to confirm that its producers are properly licensed. In the context of the examination, an examiner or analyst is only responsible for reviewing the conduct of insurance producers and conduct which requires an insurance producer license.

~~The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2006. Previously, this model was known as the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to "senior." The model has been adopted in some states in various forms. Model #275 was revised in 2010 to include new provisions regarding insurer supervision and monitoring of annuity recommendations and continuing education and training requirements for producers. While the previous version of the model imposed a duty on insurers and producers, or the entities they subcontract with, the revised model places the responsibility of supervision and monitoring on the insurer. The language of the revised model provides that an insurer's issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued. The model was also updated to include a revised definition of annuity, a definition of "replacement" and provisions expanding the scope of the model to include replacement of annuity products.~~

The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2020. But it was initially adopted in 2006, and revised in 2010, and was a successor to the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to seniors among other improvements. Variations of the 2020 model have been adopted in some jurisdictions. Section 989J of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 ("Dodd-Frank Act") specifically refers to this model regulation as the "Suitability in Annuity Transactions Model Regulation." Section 989J of the Dodd-Frank Act confirmed this exemption of certain annuities from the Securities Act of 1933 and confirmed state regulatory authority. This model also specifically identifies annuities which are exempt. This regulation is a successor regulation that exceeds the requirements of the 2010 model regulation. Examiners should reference their own jurisdiction's versions and adjust review standards accordingly.

The 2020 version of Model #275 requires producers to act in the best interest of consumers when making a sale or recommendation of an annuity and requires insurers to maintain a system of supervision, and the model lays out specific steps that are required to meet that best interest standard. Provisions of the model set forth duties for insurers and producers and indicate insurers are responsible for compliance with the regulation. The model also indicates the commissioner may order corrective action be taken by the insurer, producer, general agency, contracting agency or independent agency. Because of the different types of requirements, review standards are designed separately for examination of insurers and producers.

Licensees are required to maintain, or be able to make available to the commissioner, records of the information required in Model #275 that are collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures and other information used in making the recommendations that were the basis for insurance transactions for state-specific numbers of years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of a producer. Records required to be maintained by this regulation may be maintained in paper, photographic, micro-process, magnetic, mechanical, or electronic media or by any process that accurately reproduces the actual document.

Market regulators should also be aware that sales of products, such as fixed-index annuities (formerly referred to as equity-indexed annuities) and index life insurance products (such as universal index life insurance) continue to increase. These products typically include features that require an understanding of bonuses, guaranteed elements and an array of interest-crediting methods. In some cases, existing NAIC model laws and regulations may not give specific guidance on all aspects of all products. In such instances, examiners may rely on general principles found in Model #880, the *Life Insurance Disclosure Model Regulation* (#580) and the *Annuity Disclosure Model Regulation* (#245).

Model #582 sets out a variety of requirements to prevent insurers from using misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582. It provides guidance and limitations for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

Evaluation of compliance with annuity suitability may best be accomplished through a process and procedure review coupled with sampling. The process and procedure portion of the review is a good example of a function where states may wish to coordinate their reviews and share responsibilities. A continuum approach, such as use of a desk audit, may also be appropriate. Sampling enables examiners to evaluate whether the established processes have been clearly communicated and implemented rather than to function as a means to "second-guess" each individual suitability determination. Company programs for reviewing suitability may vary widely and should not be considered a "once-size-fits-all" approach. Annuity products can be designed or tailored to serve a wide variety of clientele and customer objectives.

Some insurers may outsource the administration of their suitability review, while maintaining ultimate responsibility for the outcomes. It may be instructive for examiners to become familiar with the structure and practices of commonly used services that perform suitability reviews. Examiners may also want to become familiar with vendor-owned services commonly used by insurers to document their suitability reviews.

The NAIC *Stranger-Originated Annuity Transactions Sample Bulletin* was adopted by the NAIC in October 2011. The bulletin was developed to address stranger-originated annuity transactions (STOA). Similar to stranger-originated life insurance transactions (STOLI), STOA transactions provide annuity contracts for the benefit of investors.

In STOAs, insurance producers and/or investors offer an individual, who is usually a “stranger” to the producer and/or investor, a nominal fee for the use of the individual’s identity as the annuitant in an investment-oriented annuity.

Typically, individuals targeted to serve as annuitants are in extremely poor health and are not expected to live beyond the first year of the policy. In order to find individuals who meet the aforementioned criteria, producers and/or investors have been known to take out advertisements in papers as well as solicit individuals residing in nursing homes or hospice facilities.

Once an individual has agreed to the set of conditions posed, the producer will complete the annuity application, ensuring that particular riders, such as a bonus rider or a guaranteed minimum death benefit, are in place to maximize the rate of return for those financing the transaction. Depending on the number of companies the producer represents and the commission policies in effect, the producer may seek to use multiple policies from various companies.

To avoid added scrutiny of the policy or detection of the scheme, producers and/or investors involved in STOAs will often take precautions to ensure that the dollar amount of the annuity falls below specific underwriting guidelines, while other annuities above these dollar amounts are subject to more stringent underwriting. After the annuity is issued, then the investor will significantly increase their investment in the annuity. A trust or an organization may additionally be named as beneficiary of the annuity in order to hide the true identity of those who will benefit from the annuitant’s death.

As the financial implications of STOA transactions could be detrimental to both companies and consumers, the adopted bulletin recommends that insurance companies take certain actions to mitigate their exposure to STOA transactions, which are outlined in the NAIC *Stranger-Originated Annuity Transactions Sample Bulletin*.

It is appropriate for the examiner to remind annuity insurers of this bulletin and to ask if the insurer has considered this bulletin when implementing compliance and/or enterprise risk management procedures.

### **3. Tests and Standards**

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.



**STANDARDS  
MARKETING AND SALES**

**Standard 1**

**All advertising and sales materials are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ All company advertising and sales materials, including radio and audiovisual items, such as television commercials, telemarketing scripts and pictorial materials

\_\_\_\_\_ Policy forms, including any required buyers' guides as they coincide with advertising and sales materials

\_\_\_\_\_ Producers' own advertising and sales materials

\_\_\_\_\_ All documents related to the development of crediting rates used in illustrations

**Others Reviewed**

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*

*Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B*

*Modified Guaranteed Annuity Model Regulation (#255), Section 4B*

*Life Insurance Disclosure Model Regulation (#580), Section 8C*

*Unfair Trade Practices Act (#880)*

*Annuity Disclosure Model Regulation (#245), Section 6 plus appendix*

*Long-Term Care Insurance Model Act (#640)*

*Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)*

~~*Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)*~~

~~*Suitability in Annuity Transactions Model Regulation (#275)*~~

~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

*Military Sales Practices Model Regulation (#568)*

**Review Procedures and Criteria**

Evaluate the company's system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements—regardless of by whom written, created, designed or presented—are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either 4 years or until the filing of the next regular report on examination of the company, whichever is the longer period of time.

Review advertising materials in conjunction with the appropriate policy form.

Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead a prospective buyer to believe that he/she is purchasing an investment or savings plan. Problematic terminology may include such terms as: investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required" if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. Enrollment periods may not be described as terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised, because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate the fact, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in an advertisement;

- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact;
- Contain an assertion, representation or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation;
- Use the existence of the insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the association;
- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- Misrepresent any policy as being shares of stock; and
- Illustrations of benefits payable under any modified guaranteed life insurance<sup>28</sup> shall not include projections of past investment experience. Hypothetical assumed interest credits may only be used if it is made clear that such are hypothetical only.

Materials should:

- Clearly disclose name and address of insurer;
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to a policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed;
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact, and any proprietary relationship or payment for the testimonial must be disclosed; and
- The sales material for any modified guaranteed life insurance must clearly illustrate there can be both upward and downward adjustments to nonforfeiture benefits, due to the application of the market value adjustment formula.

Determine if the company approves producer sales materials and advertising. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as a life insurance agent. Improper terms may include financial planner, investment advisor, financial consultant or financial counseling, if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Determine if the company has procedures in place to monitor the use of senior-specific certifications or professional designations used by producers that solicit for the company.

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<sup>28</sup> "Modified Guaranteed Life Insurance Policy" means an individual policy of life insurance, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market value adjustment formula if held for shorter periods. The formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the policy must be in a separate account during the period or periods when the policyholder can surrender the policy.

Determine if the company allows its life and annuity products to be marketed to the military. If so, review the company procedures to ensure that the procedures are in compliance with all applicable laws and regulations regarding sales to military personnel.

Determine if analogies between a life insurance policy's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments are complete and accurate.

Determine if the advertisement states or implies in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable or in any manner an incorrect or an improper practice.

If nonforfeiture values are shown in any advertisement, ensure the values are shown, either for the entire amount of the basic life policy death benefit, or for each \$1,000 of initial death benefit.

Review the use of the words/phrases "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words/phrases of similar import. Such words/phrases should not be used with respect to any benefit or service being made available with a policy, unless true. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

If an advertisement represents a pure endowment benefit as a "profit" or "return" on the premium paid, rather than as a policy benefit for which a specified premium is paid, it is deemed deceptive and misleading and is prohibited.

Determine that company procedures and materials relative to long-term care (LTC) products comply with "right to free look" requirements.

Review the company and producer's websites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised product is (or is not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?

For the review of Internet advertisements:

- Run an inquiry with the company's name;
- Review the company's home page;
- Identify all lines of business referenced on the company's home page;
- Research the ability to request more information about a particular product and verify the information provided is accurate; and
- Review the company's procedures related to producers' advertising on the Internet and ensure the company requires prior approval of the producer pages, if the company name is used.

A summary of special requirements is available for the following:

- Products sold using enrollment periods;
- Direct response products;
- Graded or modified benefit policies;
- Policies with premium changes;
- Policies with non-guaranteed elements;
- Products sold to students;
- Individual deferred annuity products or deposit funds; and
- Combination life insurance and annuity products.

Review advertising carefully for use of the term “guarantee.” Verify that the scope and duration of any guarantee is accurately described. Determine that the regulated entity has accurately portrayed non-guaranteed elements. Verify that complete information is provided regarding the scope and duration of guarantees.

Review advertising carefully for use of the term “bonus.” Review the functioning of any such bonus payments and verify that the information provided is accurate in describing the amount and the conditions for payment, retention or recoupment of the bonus.

Review advertising carefully for explanations of surrender periods and charges. Review the functioning of any such surrender charge and, in particular, how the charge is calculated in death claims. Verify that the information provided regarding the amount of the charge and the conditions for assessment are accurate.

#### Index products

For advertising for interest-sensitive products, review explanations of the crediting methods and terms. Review the functioning of the crediting methods to determine that the explanations are understandable and accurate. Verify that accurate information is provided regarding the options available to the consumer and the methods by which the consumer is to exercise the options.

In addition to reviewing the advertising of indexed products, the examiner should review the illustration for compliance with Model #582 to ensure that, among other things, unreasonable or deceptive crediting rates are not being used in the illustrations and that the illustrations provide the consumer with the information required by Model #582 and, for indexed universal life (IUL) products, AG 49. Determine whether the explanations and information provided regarding the options available to the consumer are consistent with the requirements and limitations of Model #582 in AG 49.

Review the methods used by the regulated entity, annually or otherwise, to convey ongoing information about policy/contract values and options available to the consumer to change interest-crediting methods or exercise other policy/contract features in future terms.

**STANDARDS  
MARKETING AND SALES**

**Standard 2**

**The insurer's rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Replacement register/Data

\_\_\_\_\_ Policy/Underwriting files

\_\_\_\_\_ Loan and surrender files

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Life Insurance and Annuities Replacement Model Regulation* (as adopted 1998) (#613)

*Suitability in Annuity Transactions Model Regulation* (#275)

~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

*Military Sales Practices Model Regulation* (#568)

**Review Procedures and Criteria**

Review loan and surrender files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm receipt of sales material or required statement. Copies of sales material other than regulated entity-approved sales material, if permitted, must also be in the file.

Review replacement disclosure forms for completeness and signatures, as required.

If the applicable state's definition of "recommendation" encompasses replacements, review policy/underwriting files to verify that the producer's treatment of and classification of replacements is in compliance with the applicable state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of

reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer’s suitability information.

Ensure that producer written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
  - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
  - The consumer would benefit from product enhancements and improvements; and
  - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding ~~36~~60 months.

Review policy/underwriting files to determine that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurance producer has made reasonable efforts to obtain the consumer’s suitability information.

Examiners should be familiar with the term “suitability information” as defined in applicable state statutes, rules or regulations. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer’s procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer’s suitability information.

**STANDARDS  
MARKETING AND SALES**

**Standard 3**

**The insurer's rules pertaining to replacements are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Replacement register/Data
- \_\_\_\_\_ Policy/Underwriting files
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Agency sales/lapse records
- \_\_\_\_\_ Regulated entity systems manual

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

- Life Insurance and Annuities Replacement Model Regulation* (as adopted 1998) (#613)
- Suitability in Annuity Transactions Model Regulation* (#275)
- ~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~
- Military Sales Practices Model Regulation* (#568)
- Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin*

**Review Procedures and Criteria**

- Determine if the regulated entity has advised its producers of its replacement policy.
- Determine if the regulated entity has provided timely notice to the existing insurer(s) of the replacement.
- Examine for effectiveness the regulated entity's system of identifying undisclosed replacements.
- Determine if the regulated entity has the capacity to produce data required by replacement regulation to assess producer replacement activity.



Determine if the regulated entity has issued letters in a timely manner to policyholders, advising of the effects of loans and other disbursements on policy values.

Review policy/underwriting files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the regulated entity provides required credit for suicide and contestability periods on replacements.

If the applicable state's definition of "recommendation" encompasses replacements, review regulated entity procedures to verify that the regulated entity's treatment of and classification of replacements is in compliance with the state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that regulated entity written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information.
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
  - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
  - The consumer would benefit from product enhancements and improvements; and
  - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding ~~36~~60 months.

Review policy/underwriting files to ensure that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurer, where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term “suitability information” as defined in applicable state statutes, rules or regulations. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer’s procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer’s suitability information.

Note: All documents necessary to review the appropriateness of a sale may not be in the insurer’s possession. It may be necessary to give the insurer additional lead time to obtain the documents from a producer, a third party reviewer or other entity.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

**STANDARDS  
MARKETING AND SALES**

**Standard 4**

**An illustration used in the sale of a policy contains all required information and is delivered in accordance with statutes, rules and regulations.**

**Apply to:** All life products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Actuarial records

\_\_\_\_\_ All documents related to the development of crediting rates used in illustrations

\_\_\_\_\_ Underwriting file

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)*

*Universal Life Insurance Model Regulation (#585)*

*Variable Life Insurance Model Regulation (#270)*

*Life Insurance Disclosure Model Regulation (#580)*

*~~Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)~~*

**Review Procedures and Criteria**

Note: Some policies may be deemed to be sold without an illustration.

If a jurisdiction continues to require surrender cost indices, ensure it is appropriately disclosed in the Statement of Policy Cost and Benefit.

Ensure that the insurer, its producers or authorized representatives do not:

- Represent the policy as anything other than a life insurance policy;
- Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;
- State or imply that the payment or amount of non-guaranteed elements is guaranteed;
- Use an illustration that does not comply with statutes;
- Use an illustration that at any policy duration depicts policy performance more favorable to the policyowner than that produced by the illustrated scale of the insurer whose policy is being illustrated;
- Provide an applicant with an incomplete illustration;
- Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

- Use the terms “vanish,” “vanishing premium” or similar terms that imply that the policy becomes paid-up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;
- Except for policies that can never develop nonforfeiture values, use an illustration that is “lapse-supported”; or
- Use an illustration that is not “self-supporting.”

Ensure that the insurer has a documented, reasonable methodology for the manner in which it determines its indexing strategy. Verify that the insurer has a system which monitors the interest rates used by its insurance producers in illustrations for compliance with the insurer’s credited interest rates.

Model #582 sets out a variety of requirements to prevent insurers from using unreasonable or misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582 for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

The examiner may be able to test implementation compliance issues by confirming that IUL illustration changes were made on or before the effective dates set out above. For example:

- Did the insurer implement on or before Sept. 15, 2015, a compliant crediting rate methodology for new and in force illustrations on policies sold on or after Sept. 15, 2015?
- Did the insurer implement on or before March 1, 2016, a compliant credit rate methodology for all new illustrations produced on or after March 1, 2016, on in force policies?
- Did the insurer implement the policy loan and additional illustration scales requirement of Section 6 and Section 7 of AG 49 on or before March 1, 2016?

The following are more complex requirements of AG 49, which may require the assistance of an actuary or other person with expertise in evaluating illustration crediting methodologies and calculations:

- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the credited rate for the Illustrated Scale has been limited according to the requirements of Section 4;
- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the earned interest rate for the Disciplined Current Scale has been limited according to the requirements of Section 5;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that if the illustration includes a loan, the illustrated rate credited as compared to the illustrated loan charge has been limited according to the requirements of Section 6;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a ledger using the Alternate Scale shown alongside a ledger using the illustrated scale with equal prominence according to the requirements of Section 7.A;

- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates as referenced in Section 7.B; and
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated, as required by Section 7.C.

Ensure that the insurer has established requirements for producers to provide universal life applicants with a “Statement of Policy Information.” The statement should substantially follow the format set forth in the *Universal Life Insurance Model Regulation* (#585). Insurers that use direct response solicitation of universal life insurance products should provide such a statement at the time of policy delivery.

Ensure illustrations are retained in accordance with statutes, rules and regulations. A copy of the basic illustration and a revised basic illustration (if any) signed, as applicable, or a certification that either no illustration was used or that the policy was applied for other than as illustrated, should be retained until 3 years after the policy is no longer in force.

Determine if the illustration is submitted to the regulated entity as required.

- If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of the illustration must be submitted to the insurer at the time of policy application. A copy must also be provided to the applicant.
- If the policy is issued other than as applied for:
  - A revised basic illustration conforming to the policy as issued should be sent with the policy;
  - The revised illustration should be labeled “Revised Illustration”;
  - The illustration should be signed and dated by the applicant or policyowner and producer or other authorized representative of the insurer no later than the time the policy is delivered; and
  - A copy must be provided to the insurer and the policyowner.
- If no illustration is used by an insurance producer or other authorized representative, or if the policy is applied for other than as illustrated:
  - The producer or representative must certify to that effect in writing on a form provided by the insurer;
  - The applicant should acknowledge (on the same form) that no illustration conforming to the policy applied for was provided and also acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than the time of policy delivery; and
  - The form must be submitted to the insurer at the time of application.
- If the basic or revised illustration is sent by mail from the insurer:
  - It should include instructions for the applicant/policyowner to sign the duplicate copy of the numeric summary page and return the signed copy; and
  - An insurer’s obligation will be satisfied if it demonstrates a diligent effort to obtain the signature. Diligent effort includes the mailing of a self-addressed postage-prepaid envelope with instructions for the return of the signed page.

Ensure a signed copy of the basic illustration and revised basic illustration, if any, or a certification that either no illustration was used or that the policy was applied for other than as illustrated is retained until 3 years after the policy is no longer in force. (A copy does not have to be retained if the policy is not issued.)

A summary of illustration requirements is available with special requirements for:

- Basic illustrations;
- Supplemental illustrations;
- Interest-indexed universal life;
- Universal life; and
- Variable life.

**STANDARDS  
MARKETING AND SALES**

**Standard 5**

**The insurer has suitability standards for its products, when required by applicable statutes, rules and regulations.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Producer records

\_\_\_\_\_ Training materials

\_\_\_\_\_ Procedure manuals

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Variable Life Insurance Model Regulation (#270), Section 3C*

*Suitability in Annuity Transactions Model Regulation (#275)*

~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

*Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin*

**Review Procedures and Criteria**

Determine if multiple sales of the same product have been made to individuals. Identify and review a random sample of policyholders for which multiple policies exist.

Determine if underwriting guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine whether marketing materials encourage multiple issues of policies; e.g., use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used.

Determine if the regulated entity has a system to discourage “over-insurance” of policyholders as defined by the regulated entity’s underwriting requirements.

For annuity products, ensure the regulated entity maintains a written statement specifying the standards of suitability used by the insurer. The standards should specify that an insurer’s issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their jurisdiction.

Inquire if the company has detected any STOA transactions and if so, the examiner may want to determine if there were any suitability issues surrounding the sale of the STOA. If there were suitability issues, the examiner may want to inquire as to what actions were taken by the company to prevent further suitability issues and if the company took any action against the producer.

Note: Sales made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. Examiners should be mindful of the fact that both variable annuity sales and variable life sales are typically sold using FINRA requirements.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions NAIC Sample Bulletin* because sales of stranger-originated annuities may result in adverse suitability situations.



**STANDARDS  
MARKETING AND SALES**

**Standard 6**

**Preneed funeral contracts or prearrangement disclosures and advertisements are in compliance with statutes, rules and regulations.**

**Apply to:** All preneed products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

*Life Insurance Disclosure Model Regulation (#580), Section 7*

*Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 5Y*

**Review Procedures and Criteria**

Ensure there is evidence that the disclosures have been made in accordance with statutes, rules and regulations.

A summary of special requirements for preneed disclosures is available.

Advertisements for a preneed funeral contract or prearrangement that is funded or is to be funded by a life insurance policy or annuity contract should disclose the following:

- The fact that a life insurance or annuity contract is involved or being used to fund a prearrangement; and
- The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

**STANDARDS  
MARKETING AND SALES**

**Standard 7**

**The regulated entity's policy forms provide required disclosure material regarding accelerated benefit provisions.**

**Apply to:** All individual and group life insurance

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

\_\_\_\_\_ Claim procedure/underwriting manuals

\_\_\_\_\_ Claim files

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Accelerated Benefits Model Regulation (#620)*

**Review Procedures and Criteria**

The terminology “accelerated benefit” shall be included in the descriptive title.

Disclosure is required that receipt of accelerated benefits may be a taxable event, and assistance should be sought from a personal tax advisor.

Disclosure providing description of accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant.

Products marketed under this regulation shall not be described as long-term care insurance (LTCI) or as providing LTC benefits.

**STANDARDS  
MARKETING AND SALES**

**Standard 8**  
**Policy and contract application forms used by depository institutions provide required disclosure material regarding insurance sales.**

**Apply to:** All individual and group life insurers and depository institutions

All covered persons<sup>29</sup> as defined by the Gramm-Leach-Bliley Act. This includes any person who sells, solicits, advertises or offers an insurance product or annuity to a consumer at an office of the depository institution or on behalf of a depository institution.

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

\_\_\_\_\_ Underwriting manuals

\_\_\_\_\_ Policy and contract application forms

\_\_\_\_\_ Policy files

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act*

**Review Procedures and Criteria**

One notice provides the written disclosures that must be given to a consumer in connection with an initial purchase of an insurance or annuity product that is unrelated to an extension of credit.

The other notice provides the written disclosures that must be given to a consumer in connection with the solicitation, offer or sale of an insurance or annuity product that is related to an extension of credit.

For notices unrelated to an extension of credit: (1) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (2) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank or any affiliate; and (3) that there is the potential for investment risk, including the possible loss of value. (Note: The last requirement may not be required for all products.)

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<sup>29</sup> Please refer to the bulletin for a detailed explanation of what constitutes a covered person.

For notices related to an extension of credit (which includes solicited, offered or sold): (1) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer also purchasing an insurance product or annuity from the bank or the bank's affiliate; (2) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer not obtaining an insurance product or annuity from an entity not affiliated with the bank. In addition, (3) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (4) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank, or any affiliate; and (5) that there is the potential for investment risk, including the possible loss of value. Note: The last requirement may not be required for all products.

**STANDARDS  
MARKETING AND SALES**

**Standard 9**

**Insurer rules pertaining to producer requirements with regard to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Policy/Other relevant files

\_\_\_\_\_ New business reports

\_\_\_\_\_ Policy/Underwriting files

Others Reviewed

\_\_\_\_\_  
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**NAIC Model References**

*Suitability in Annuity Transactions Model Regulation (#275)*

~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

**Review Procedures and Criteria**

[As of November 2023, the Annuity Suitability \(A\) Working Group is still discussing the issue of how the Safe Harbor provisions of the Suitability in Annuity Transactions Model Regulation \(#275\), Section 6E may apply. This examination standard may be revisited after those discussions are complete.](#)

If the insurer has a business rule that calls for completion of a fact-finder or similar disclosure document, review policy files to determine if forms have been completed regarding suitability.

Review policy files. Copies of sales material other than insurer-approved materials, if permitted, must also be in the file or made available to the regulator upon request.

Examine for effectiveness the insurer’s system of verifying that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer’s suitability information.

Examiners should be familiar with the term “suitability information” as defined in applicable state statutes, rules or regulations. “Suitability information” means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;

- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

~~Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.~~

~~Note: Noncompliance with FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.~~

~~Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:~~

- ~~• Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and~~
- ~~• Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.~~

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with comparable standards as defined in Section 6(E)(5) of Model #275. The regulation identifies four comparable standards:

- The Securities and Exchange Commission (SEC)'s Regulation Best Interest;
- The Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions;
- SEC standards of conduct (including fiduciary duties) imposed upon federally registered investment advisors or investment advisor representatives; and for plan fiduciaries;
- The Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC); and
- The model also allows for an optional fifth comparable standard, covering state registered investment advisors subject to the state's securities laws. Whether this fifth option exists in any state would depend how each jurisdiction adopted the regulation.

Sales made in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. For instance, a broker-dealer could approve a fixed or fixed indexed annuity transaction if it had adopted business rules addressing fixed annuities and applied the same level of scrutiny that the broker-dealer would apply to a variable annuity. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with comparable standards means that the recommendation or sale is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.

Review the insurer’s system of monitoring sales made in compliance with comparable standards and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the relevant conduct of the financial professional seeking to rely on the safe harbor or the entity responsible for supervising the financial professional using information collected in the normal course of an insurer’s business; and
- Providing to the entity responsible for supervising the financial professional seeking to rely on the safe harbor information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

Note: The definition of “financial professional” in Model 275 means a producer that is regulated and acting as:

- A broker-dealer registered under federal [or state] securities laws or a registered representative of a broker-dealer;
- An investment adviser registered under federal [or state] securities laws or an investment adviser representative associated with the federal [or state] registered investment adviser; or
- A plan fiduciary under Section 3(21) of the Employee Retirement Income Security Act of 1974 (ERISA) or fiduciary under Section 4975(e)(3) of the Internal Revenue Code (IRC) or any amendments or successor statutes thereto.

The definition of “financial professional” in Model 275 was left as variable on whether a state did or did not want to exempt state-registered investment advisors. That was a policy question that the Annuity Suitability (A) Working Group split on, and thus left it to each state to decide as they adopted the model. If a state includes “federal and state securities laws” in its safe harbor language, then both federal and state-registered investment advisors would be included in the definition of “financial professional.” However, if a state only lists “federal securities laws” in its safe harbor language, then state-registered investment advisors would not be included in the definition of “financial professional,” and as such, the safe harbor would not apply to a recommendation from a state-registered investment advisor.

Examine for effectiveness the insurer’s system for review or oversight of annuity transactions that either may have violated the insurer’s suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A customer refused to provide relevant suitability information and the annuity transaction was not recommended; or;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Review completed annuity transactions and compare the information obtained by the insurance producer to the type of product purchased to verify that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another transaction or series of transactions, the insurance producer, or the insurer, where no producer is involved, had reasonable grounds for believing that the product was suitable on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer’s suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
  - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
  - The consumer would benefit from product enhancements and improvements; and
  - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding ~~36~~60 months.

Review policy/underwriting/other files to verify that an insurance producer has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and
- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.



**STANDARDS  
MARKETING AND SALES**

**Standard 10**  
**Insurer rules pertaining to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All annuity products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Policy/Underwriting files
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Complaint log
- \_\_\_\_\_ Agency sales/lapse records
- \_\_\_\_\_ Regulated entity’s systems manual
- \_\_\_\_\_ Regulated entity’s producer training materials

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

*Suitability in Annuity Transactions Model Regulation (#275)*  
~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

**Review Procedures and Criteria**

[As of November 2023, the Annuity Suitability \(A\) Working Group is still discussing the issue of how the Safe Harbor provisions of the \*Suitability in Annuity Transactions Model Regulation\* \(#275\), Section 6E may apply. This examination standard may be revisited after those discussions are complete.](#)

~~Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer’s product specific standards, policy and procedures regarding verification of suitability of annuity products.~~

[Determine if the insurer has established a system of supervision that includes but is not limited to requirements outlined in Supplemental Checklist K and has advised its producers of applicable state statutes, rules and](#)

regulations regarding suitability of annuity products and the insurer's product-specific standards, policy and procedures regarding verification of suitability of annuity products.

It is useful to become acquainted with the definitions in the *Suitability in Annuity Transactions Model Regulation* (#275).

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation* (#275) have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

~~Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Examine for effectiveness the insurer's system of monitoring and reviewing that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:~~

- ~~• The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245)).~~
- ~~• The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;~~
- ~~• The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and~~
- ~~• In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
  - ~~• The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;~~
  - ~~• The consumer would benefit from product enhancements and improvements; and~~
  - ~~• The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.~~~~

~~Monitor and determine that an insurance producer or, where no insurance producer is involved, the responsible insurer representative, has at the time of sale:~~

- ~~• Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;~~
- ~~• Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and~~
- ~~• Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.~~

~~Monitor and determine that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.~~

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- ~~• Age;~~
- ~~• Annual income;~~
- ~~• Financial situation and needs, including the financial resources used for the funding of the annuity;~~
- ~~• Financial experience;~~
- ~~• Financial objectives;~~
- ~~• Intended use of the annuity;~~
- ~~• Financial time horizon;~~
- ~~• Existing assets, including investment and life insurance holdings;~~
- ~~• Liquidity needs;~~
- ~~• Liquid net worth;~~
- ~~• Risk tolerance; and~~
- ~~• Tax status.~~

~~Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.~~

~~Examine for effectiveness the insurer's system of recording or monitoring whether an insurance producer or an insurer, proceeded with an annuity transaction that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:~~

- ~~• No recommendation was made;~~
- ~~• A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;~~
- ~~• A consumer refused to provide relevant suitability information and the annuity transaction was not recommended;~~
- ~~• A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.~~

Verify that the insurer has established a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with applicable state suitability statutes, rules and regulations, including, but not limited to the following criteria:

- Examine the regulated entity's suitability policies and procedures to verify that the insurer maintains reasonable procedures to inform its insurance producers of the requirements of applicable state suitability statutes, rules and regulations. Verify that the requirements of applicable state suitability statutes, rules and regulations are incorporated into relevant insurance producer training manuals;
- ~~• Review the regulated entity's producer training materials to verify that the insurer establishes standards for insurance producer product training and maintains reasonable procedures to require its insurance producers to comply with the requirements of Section 7 of the *Suitability in Annuity Transactions Model Regulation* (#275). For more information on the requirements of Section 7 of Model #275, see Marketing and Sales Standard 11 in this chapter;~~
- ~~• Examine the regulated entity's producer training materials to ensure that the insurer provides adequate product-specific training and training materials which fully explain all material features of its annuity products to its insurance producers;~~
- Review the regulated entity's suitability policies and procedures to ensure that the insurer maintains adequate procedures for review of each recommendation, prior to issuance of an annuity, that are

designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. An insurer's review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and the insurer's review process may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified ~~for additional review~~ by the selection criteria;

- Verify suitability review procedures include a review of all internal transactions for the consumer, even if those transactions occur or occurred in multiple states;
- Verify that the insurer maintains reasonable procedures to detect recommendations that are not suitable. Insurer procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. If there is no provision in applicable state suitability statutes, rules or regulations to the contrary, an insurer may demonstrate compliance in this area by reviewing all transactions flagged for further internal review while either applying sampling procedures, or by confirming suitability information after issuance or delivery of the annuity; and
- Verify that the insurer annually provides a report to senior management (per Supplemental Checklist K), including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

An insurer may contract for performance of one or more functions (including maintenance of procedures) under the criteria set forth in Section 6F(1) of the *Suitability in Annuity Transactions Model Regulation* (#275). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of Model #275 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph (b) of Section 6F(2) of Model #275.

An insurer's supervision system as described above should include supervision of contractual performance by third parties. This includes, but is not limited to, the following criteria:

- Verify that the insurer is monitoring and, as appropriate, conducting audits to assure that contracted function(s) are properly performed; and
- Review insurer procedures to verify that the insurer is annually obtaining a certification from a senior manager who has responsibility for the contracted function(s) that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

Review agency files and related documentation to verify that insurance producers do not dissuade, or attempt to dissuade, a consumer from:

- Truthfully responding to an insurer's request for confirmation of suitability information;
- Filing a complaint; or
- Cooperating with the investigation of a complaint.

~~Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.~~

~~Note: Noncompliance with FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.~~

~~Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:~~

- ~~• Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and~~
- ~~• Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.~~

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with comparable standards as defined in Section 6(E)(5) of Model #275. The regulation identifies four comparable standards:

- The Securities and Exchange Commission (SEC)'s Regulation Best Interest;
- The Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions;
- SEC standards of conduct (including fiduciary duties) imposed upon federally registered investment advisors or investment advisor representatives; and for plan fiduciaries;
- The Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC); and
- The model also allows for an optional fifth comparable standard, covering state registered investment advisors subject to the state's securities laws. Whether this fifth option exists in any state would depend how each jurisdiction adopted the regulation.

Sales made in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. For instance, a broker-dealer could approve a fixed or fixed indexed annuity transaction if it had adopted business rules addressing fixed annuities and applied the same level of scrutiny that the broker-dealer would apply to a variable annuity. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with comparable standards means that the recommendation or sale is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.

Review the insurer's system of monitoring sales made in compliance with comparable standards and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the relevant conduct of the financial professional seeking to rely on the safe harbor or the entity responsible for supervising the financial professional using information collected in the normal course of an insurer's business; and
- Providing to the entity responsible for supervising the financial professional seeking to rely on the safe harbor information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

Note: The definition of "financial professional" in Model 275 means a producer that is regulated and acting as:

- A broker-dealer registered under federal [or state] securities laws or a registered representative of a broker-dealer;
- An investment adviser registered under federal [or state] securities laws or an investment adviser representative associated with the federal [or state] registered investment adviser; or
- A plan fiduciary under Section 3(21) of the Employee Retirement Income Security Act of 1974 (ERISA) or fiduciary under Section 4975(e)(3) of the Internal Revenue Code (IRC) or any amendments or successor statutes thereto.

The definition of "financial professional" in Model 275 was left as variable on whether a state did or did not want to exempt state-registered investment advisors. That was a policy question that the Annuity Suitability (A)

Working Group split on, and thus left it to each state to decide as they adopted the model. If a state includes “federal and state securities laws” in its safe harbor language, then both federal and state-registered investment advisors would be included in the definition of “financial professional.” However, if a state only lists “federal securities laws” in its safe harbor language, then state-registered investment advisors would not be included in the definition of “financial professional,” and as such, the safe harbor would not apply to a recommendation from a state-registered investment advisor.

Review insurer records of corrective action taken in mitigation of apparent violations of suitability standards for sales directly by the insurer and by any insurance producers who are acting as agents for the entity.

Determine whether the insurer has elected to maintain records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions, or if the insurer has elected to require its producers to maintain these records. Verify that such a system is in place and is monitored by the insurer.

Note: Review the insurer’s denials for suitability reasons. Review underwriting data to determine if an annuity was subsequently issued to the client. If an annuity was subsequently issued, the examiner may want to select a ~~sampling~~ sample of those files to ensure the sale was appropriate.

It should be noted that the model’s supervision system does not require the insurer to address the following:

- A producer’s recommendations to consumers of products *other than* the annuities offered by the insurer;  
or
- Include consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.

**STANDARDS  
MARKETING AND SALES**

**Standard 11**

**The insurer has procedures in place to educate and monitor compliance with insurer-specific education and training requirements and with applicable statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.**

**Apply to:** All annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Regulated entity producer education/training files

\_\_\_\_\_ Producer continuing education files

\_\_\_\_\_ Producer new business/replacement log

\_\_\_\_\_ Regulated entity producer training materials

\_\_\_\_\_ Regulated entity standards for product training

\_\_\_\_\_ Regulated entity policies and procedures

\_\_\_\_\_ Complaint logs, complaint files and producer complaint logs/producer investigation files, if applicable

**Others Reviewed**

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Suitability in Annuity Transactions Model Regulation (#275)*

*Unfair Trade Practices Act (#880)*

*Producer Licensing Model Act (#218)*

**Review Procedures and Criteria**

Review regulated entity policies and procedures to ensure that the regulated entity has adequate procedures in place to provide training, including product-specific training that is appropriate to the specific product being sold. Review the regulated entity's procedures to inform producers of the regulated entity's standards for annuity product training and of applicable state statutes, rules or regulations regarding the solicitation, recommendation and sale of the annuity product.

Monitor and determine if the insurer has taken any actions against producers who lack adequate product knowledge and if so, was the action appropriate for the circumstances.

Compare data in producer continuing education files to applicable data in state insurance department producer continuing education records to monitor and determine that any insurance producer who engages in the sale of annuity products has met the one-time 4 hour credit training course in accordance with applicable state statutes, rules and regulations.

Determine that the regulated entity has adequate procedures in place to verify that a producer has completed necessary training, as required by applicable state statutes, rules and regulations, before allowing the producer to sell an annuity product for that insurer.

Review content of producer training materials for compliance with applicable state statutes, rules and regulations regarding solicitation, recommendation and sales of annuity products. Determine if the insurer product-specific training materials are appropriate and accurately reflect the features of the specific annuity.

Review complaint logs, any applicable complaint files and any producer investigation files for allegations of unsuitable, improper or misleading sales.

**Automation Tip:**

Examiners should request underwriting, policy and claim data using the NAIC standardized data requests for a period of three to five years. The expanded time frame allows the examiner to trend sales practices for a number of years.

Examiners should then use a program such as ACL to review underwriting data, product data and claims data for possible unsuitable sales.

Examiners can review and trend this data for:

- Sales from producers who were the subject of complaints and/or investigations that alleged unsuitable sales, misrepresentations, or improper sales activities;
- Sales of producers who had a materially large number of replacements or exchanges;
- Sales of producers who sell a materially large number of annuities that pay the highest commissions and have the longest surrender period or have the highest surrender amounts;
- Sales of producers who have had previous sales denied based on suitability reasons;
- Sales of producers who had disciplinary actions – Financial Industry Regulatory Authority (FINRA) and state disciplinary actions;
- Sales from producers who have sold a materially large number of deferred annuities to consumers over age 75;
- Withdrawals from products where the consumer incurred a penalty (a contractual penalty or IRS tax penalty) for taking the withdrawal within two years of purchase of the annuity; and
- Sales from producers who have sold multiple annuities to the same consumer.

Examiners should realize that trending data is not a definitive means to identify unsuitable sales. Further review of the individual transaction will be necessary to determine suitability.

Examiners should cross-reference new business data and data in the replacement logs with the regulated entity's producer education/training files to ensure that prior to a sale of an annuity product the insurance producer has been trained in the regulated entity's standards for the specific annuity product and trained in the applicable state statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.



**STANDARDS  
MARKETING AND SALES**

**Standard 12**

**The insurer has product-specific training standards and materials designed to provide producers with adequate knowledge of the annuity products recommended prior to soliciting the sale of annuity products. The insurer also must have reasonable procedures in place to require its producers to comply with applicable producer training requirements.**

**Apply to:** All annuity products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ Agency sales/lapse records
- \_\_\_\_\_ Systems manuals
- \_\_\_\_\_ Producer training materials
- \_\_\_\_\_ Contracts with third-party vendors with compliance responsibilities

**Others Reviewed**

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

- Suitability in Annuity Transactions Model Regulation (#275)*
- Unfair Trade Practices Act (#880)*
- Producer Licensing Model Act (#218)*
- Suitability of Sales of Life Insurance and Annuities White Paper*

**Review Procedures and Criteria**

Contact other regulators that may have conducted a recent review of the insurer's training standards.

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation (#275)*.

[Determine if the insurer has required appropriate training, as outlined in Supplemental Checklist L of this chapter, for its producers.](#)

[The satisfaction of the training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements.](#)

An insurer shall verify that a producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Per Supplemental Checklist L of this chapter, Review regulated entity's records to confirm that it verifies producers complete a one-time 4 credit hour general annuity training course prior to soliciting the sale of an annuity product.

Determine if the insurer product-specific training materials are appropriate and accurately reflect the specific annuity being recommended. Review regulated entity's records to determine if, when and how product-specific training occurred prior to a producer recommending an annuity.

Note: Testing is not a requirement of the *Suitability in Annuity Transactions Model Regulation* (#275). Assessing compliance with this standard may require the examiner to access compliance with many facets of Model #275. The insurance producer training requirement of the model regulation requires that producers not solicit the sale of an annuity product unless the producer has adequate product knowledge to recommend the annuity. It is the insurer's responsibility to establish standards for product specific training for its producers. Insurers must also establish reasonable procedures to require its producers to have adequate product knowledge prior to the producer recommending an annuity.

If the examiners believe an unsuitable sale may have occurred, the examiner may need to determine the cause of the unsuitable sale.

Examiners will need to assess the product-specific training materials and determine if the materials were appropriate for the specific product. According to *Suitability in Annuity Transactions Model Regulation* (#275), insurance producers may rely on insurer-provided product-specific training materials and standards to comply with Section 7 of Model #275.

Examiners will also need to assess the procedures the insurer established to require its producers have an adequate product knowledge before the producer recommends the annuity. Specifically the examiners will need to determine if the training for the specific product took place before the recommendation of an annuity, how the producer was trained and if the training was reasonably designed to require the producer to have adequate product knowledge prior to the sale.

Based upon the complexity of the product being offered, there is an expectation that the content of training materials and the way the training occurs may differ.

**STANDARDS  
MARKETING AND SALES**

**Standard 13**

**The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving fixed-index annuity products, and all sales are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All fixed-index annuity products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Policy/Underwriting file
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Complaint log
- \_\_\_\_\_ Agency sales/lapse records
- \_\_\_\_\_ Systems manuals
- \_\_\_\_\_ Producer training materials
- \_\_\_\_\_ Contracts with third-party vendors with compliance responsibilities

**Others Reviewed**

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

- Unfair Trade Practices Act (#880)*
- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*
- Annuity Disclosure Model Regulation (#245), Section 6 plus appendix*
- Suitability in Annuity Transactions Model Regulation (#275)*
- ~~*Suitability of Sales of Life Insurance and Annuities White Paper*~~

**Review Procedures and Criteria**

Review policy files to determine that required records are retained for required time frames.

Examine procedures for verifying producer compliance with established policies and procedures.

Review complaint log for complaints alleging improper or misleading sales practices.

Review claim files for proper crediting and computation of surrender charges at death.

Review commission structure and note any differences between indexed and non-indexed annuity products. If it appears that the difference may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

**STANDARDS  
MARKETING AND SALES**

**Standard 14**

**The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving index life, and all sales are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All index life products

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Policy/Underwriting file
- \_\_\_\_\_ Agency correspondence file/Agency bulletins
- \_\_\_\_\_ Agency procedural manual
- \_\_\_\_\_ All documentation demonstrating the development of crediting rates used in illustrations
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Complaint log
- \_\_\_\_\_ Agency sales/lapse records
- \_\_\_\_\_ Regulated entity’s systems manual
- \_\_\_\_\_ Regulated entity’s producer training materials
- \_\_\_\_\_ Contracts with third-party vendors with compliance responsibilities

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*
- Life Insurance Disclosure Model Regulation (#580), Section 8C*
- Unfair Trade Practices Act (#880)*
- Life Insurance Illustrations Model Regulation (#582) and Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest (AG 49)*

**Review Procedures and Criteria**

Review policy files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with the regulated entity's policy and procedures

Review complaint log for complaints alleging improper or misleading sales practices.

Review documentation to ensure compliance of the insurer's illustration methodologies with Model #582, generally, and with AG 49, specifically for indexed universal life (IUL) products. Review documentation to confirm implementation of AG 49 at required effective dates.

Review claim files for proper interest crediting and computation of death claims.

Review commission structure and note any differences between indexed and non-indexed life insurance products. If it appears that differences noted may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

**STANDARDS  
MARKETING AND SALES**

**Standard 15**

**The insurer’s underwriting requirements and guidelines pertaining to travel are in compliance with applicable statutes, rules and regulations.**

**Apply to:** All life products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Life insurance applications and related disclosure and consent forms

\_\_\_\_\_ Related questionnaires for applicants

\_\_\_\_\_ Underwriting guidelines and field underwriting guidelines for producers

\_\_\_\_\_ Review contracts with reinsurers of life insurance and all applicable guidelines from the reinsurer

\_\_\_\_\_ Regulated entity’s guidelines regarding lawful travel

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Unfair Trade Practices Act (#880)*

**Review Procedures and Criteria**

Ensure the regulated entity does not discriminate against individuals by using an individual’s past lawful travel to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual.

Ensure the regulated entity does not discriminate against individuals by using an individual’s future lawful travel plans to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual, unless:

- The risk of loss for individuals who travel to a specified destination at a specific time is reasonably anticipated to be greater than if the individuals did not travel to that destination at the time; and
- The risk classification is based on sound actuarial principles and actual or reasonably anticipated experience.

Examples of the exceptions outlined above are future lawful travel plans to areas where the Centers for Disease Control and Prevention (CDC) have issued a highest level alert, including a recommendation for non-essential travel or to areas where there is an ongoing armed conflict involving the military of a sovereign nation foreign to the country of conflict.

Review the life insurers' and reinsurers' underwriting guidelines for guidelines pertaining to past and future travel.

Review applications and any related questionnaires for questions related to past and future travel plans.

Review contracts with applicable reinsurers for content regarding past and future lawful travel plans.



**STANDARDS**  
**MARKETING AND SALES**

**Standard 16**

**The insurer issues annuities to consumers that are in the best interest of the consumer under the circumstances known to the producer at the time, the recommendation is made, without placing the producer’s or the insurer’s financial interests ahead of the consumer’s interest. The insurer shall establish and maintain reasonable procedures to ensure recommendations comply with the best interest obligations of care, disclosure, conflict of interest and documentation.**

**Apply to:** All annuity sales and recommendations for products not otherwise excluded by the *Suitability in Annuity Transactions Regulation*

**Priority:** Essential

**Documents to be Reviewed**

Applicable statutes, rules and regulations

Policy/Underwriting files including customer profile (if applicable). Note that insurers may (but are not required to) maintain documentation on behalf of their producers. It may be necessary to obtain applicable customer profiles and related materials from the producer(s)

Business entity producer correspondence file/Business entity producer bulletins

Business entity producer procedural manual

Business entity producer sales/lapse records

Regulated entity’s systems manual

Regulated entity’s producer training materials

**Others Reviewed**

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Suitability in Annuity Transactions Model Regulation (#275)*

**Review Procedures and Criteria**

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and the insurer’s product-specific standards, policy and procedures regarding verification of the suitability of annuity products.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation (#275)* have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Producer supervision and compliance requirements are set forth in Supplemental Checklist M.

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation* (#275).

Transactions not based on a recommendation (*Editor's Note to TPR, the previous language "Transactions not based..." is a section heading in the *Suitability in Annuity Transactions Model Regulation* (#275) Section 6(B) and is underlined in this exam standard*)

- Except as provided under paragraph (2), a producer shall have no obligation to a consumer under subsection A(1) related to any annuity transaction if:
  - No recommendation is made;
  - A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;
  - A consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended; or
  - A consumer decides to enter into an annuity transaction that is not based on a recommendation of the producer.
- An insurer's issuance of an annuity subject to paragraph (1) shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Application of the best interest obligation (*Editor's Note to TPR, the previous language "Application of the..." is a section heading in the *Suitability in Annuity Transactions Model Regulation* (#275) Section 6(A (5)) and is underlined in this exam standard*)

- Any requirement applicable to a producer under this subsection shall apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

Notes:

- The requirements set forth in Supplemental Checklist M apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any. The requirements do not mean the annuity with the lowest one-time or multiple occurrence compensation structures shall necessarily be recommended.
- The requirements set forth in Supplemental Checklist M do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising or financial planning agreement between the consumer and the producer.
- Nothing in the *Suitability in Annuity Transactions Model Regulation* (#275) should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

**STANDARDS**  
**MARKETING AND SALES**

**Standard 17**

**The insurer has taken steps to ensure that prior to the recommendation or sale of an annuity, the producer has prominently disclosed to the consumer on a form similar to that set forth in the *Suitability in Annuity Transactions Model Regulation Appendix A.***

**Apply to:** All annuity sales and recommendations for products not otherwise excluded by the *Suitability in Annuity Transactions Regulation*

**Priority:** Essential

**Documents to be Reviewed**

Applicable statutes, rules and regulations

Policy/Underwriting files including customer profile (if applicable). Note that insurers may (but are not required to) maintain documentation on behalf of their producers. It may be necessary to obtain applicable customer profiles and related materials from the producer(s)

Agency correspondence file/Agency bulletins

Agency procedural manual

Agency sales/lapse records

Regulated entity's systems manual

Regulated entity's producer training materials

**Others Reviewed**

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Suitability in Annuity Transactions Model Regulation (#275)*

**Review Procedures and Criteria**

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer's product-specific standards, policy and procedures regarding annuity product disclosure requirements.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation (#275)* have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability. Producer supervision and compliance requirements are set forth in Supplemental Checklist N.

It is useful to become acquainted with the definitions and appendices set forth in the *Suitability in Annuity Transactions Model Regulation* (#275).

If a state has adopted the *Annuity Disclosure Model Regulation* (#245), the state may have also adopted an additional phrase to explain that the requirements of this section are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation*. The examiner should refer to the applicable state's specific regulation.

**D. Producer Licensing**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

**E. Policyholder Service**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 1**  
**Reinstatement is applied consistently and in accordance with policy provisions.**

**Apply to:** All life products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

\_\_\_\_\_ Notice of reinstatement

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

**Review Procedures and Criteria**

Determine that notices were sent out in a timely manner.

Verify that reinstatement provisions were applied consistently and in a non-discriminatory manner.

Reinstatements should be applied per policy provisions.

**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 2**

**Nonforfeiture options are communicated to the policyholder and contractholder and correctly applied in accordance with the policy contract.**

**Apply to:** All life products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

\_\_\_\_\_ Underwriting file

\_\_\_\_\_ Policy and contract history file

\_\_\_\_\_ Regulated entity's procedures manual

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Standard Nonforfeiture Law for Life Insurance* (#808)

*NAIC Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables* (#811)

*Life Insurance Disclosure Model Regulation* (#580)

*Variable Life Insurance Model Regulation* (#270)

*Model Policy Loan Interest Rate Bill* (#590)

*Standard Nonforfeiture Law for Individual Deferred Annuities* (#805)

*Annuity Nonforfeiture Model Regulation* (#806)

**Review Procedures and Criteria**

Determine if the correct policy option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to the nonforfeiture values, refer to statutes, rules and regulations regarding the calculation of nonforfeiture values for details on calculating the values.

Review the regulated entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

### Cash Surrender Values

- Review the issue date of the policy to determine whether the policy is mature enough to provide surrender values (usually by the end of the second or third year);
- Calculate the service time to process the surrender by subtracting the date the request was received from the date the surrender check was mailed (should be within 60 days);
- Review the calculation of the net cash value to determine the appropriate surrender value (include any outstanding policy loans, policy loan interest and policy dividends);
- Compare calculated surrender value with illustration surrender value. Confirm that any variance can be explained and is in accordance with policy provisions (i.e., interest rates, surrender charges, policy fees);
- Confirm with the regulated entity that there is an audit procedure in place to verify the calculation of surrender values (they are usually calculated systematically);
- Review cash surrender check for accuracy, including mail date; and
- Review returned mail procedures.

### Extended Term Insurance (ETI)

- Determine if the ETI was automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Confirm the regulated entity's calculated policy value by taking the face value of the policy adjusted for any indebtedness, such as policy loans or paid-up additions;
- Check to make sure the regulated entity issued the correct amount of term insurance; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

### Reduced Paid-Up (RPU)

- Determine how the RPU option came about, whether automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Review the calculation of net cash value (including years the policy was in force) to verify the amount used as the net single premium to purchase the paid-up life insurance. Verify that the paid-up insurance is of the same type of policy as the original policy; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

### Additional Paid-Up

- Review the policy for content and time schedule for allowed increases in coverage;
- Review the policyowner's request to elect the additional paid-up option benefit; and
- Check that evidence of insurability was required before the rider was added to the in force policy.

### Automatic Premium Loan (APL)

- Review the policy's contract language for content;
- Review the application to see if the insured elected another option. If not, verify that the grace period expired prior to the initiation of the APL;
- Check the net cash value calculation to make sure that the proper amount was used to deduct the overdue premium; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Note: The examiner should be alert to occurrences of producers automatically selecting the APL option on the insurance application.

Ensure the regulated entity notifies policyowners of material changes to any non-guaranteed factors in accordance with statutes, rules and regulations.



For variable life products with flexible premiums, ensure that a report is sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following processing day. The report should include the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of the amount.

Ensure that at the time of processing policy loans, the insurer notifies policyholders of the initial rate of interest, maximum interest rates and the frequency at which rates may be adjusted. Such notice is to be provided within a reasonable time after processing premium loans.

Ensure the insurer sends advance notice to policyholders with loans, advising of any increases in loan rates.

For annuity contracts that provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall any cash value benefit be less than the minimum nonforfeiture amount. The death benefit shall be at least equal to the cash surrender benefit.

For annuity contracts that do not provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall the present value of a paid-up annuity be less than the minimum nonforfeiture amount.

**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 3**

**The regulated entity provides each policyowner with an annual report of policy values in accordance with statutes, rules and regulations and, upon request, an in force illustration or contract policy summary.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Life Insurance Illustrations Model Regulation (#582), Section 10*  
*Life Insurance Disclosure Model Regulation (#580), Section 5C(1)*  
*Variable Annuity Model Regulation (#250), Section 8*  
*Variable Life Insurance Model Regulation (#270), Section 9*  
*Modified Guaranteed Annuity Model Regulation (#255) Section 11*  
*Universal Life Insurance Model Regulation (#585), Section 9*

**Review Procedures and Criteria**

Note: Traditional life (not universal or variable life) products that are not illustrated or that were issued prior to a jurisdiction's adoption of the equivalent of the *Life Insurance Illustrations Model Regulation (#582)* may not be required to provide annual reports.

If required, ensure annual reports are being provided annually.

For universal life, ensure the report includes:

- The beginning and end date of the current report period;
- The policy value at the end of the previous report period and at the end of the current report period;
- The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);
- The current death benefit at the end of the current report period on each life covered by the policy;
- The net cash surrender value of the policy as of the end of the current report period; and
- The amount of outstanding loans, if any, as of the end of the current report period.

For fixed premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect should be included in the report.

For flexible premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period, unless further premium payments are made, a notice to this effect should be included in the report.

For traditional life policies, where applicable, ensure the report includes:

- Current death benefit;
- Annual contract premium;
- Current cash surrender value;
- Current dividend;
- Application of current dividend; and
- Amount of outstanding loan.

Ensure that if there are policies that do not build nonforfeiture values, an annual report is provided for those years when a change has been made to non-guaranteed policy elements by the insurer.

Determine if the annual report includes an in force illustration. If it does not, it should contain the following notice displayed prominently: “**IMPORTANT POLICYOWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling (insurer's telephone number), writing to (insurer's name) at (insurer's address) or contacting your producer. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department.” The insurer may vary the sequential order of the methods for obtaining an in force illustration.

If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report should contain a notice of that fact and the nature of the change prominently displayed.

For variable annuity products, ensure there is a statement or statements reporting the investments held in a separate account. The statement report period should be not more than 4 months prior to the date of mailing. The statement should also include the number of accumulation units and the dollar value of an individual unit or the value of the contractholder's account.

For variable life products, ensure the annual report includes the following:

- The cash surrender value;
- Death benefit;
- Any partial withdrawal or policy loan;
- Any interest charge; and
- Any optional payments.
- The following disclosures:
  - In accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease;
  - Prominent identification of any value which may be recomputed prior to the next annual report;
  - A statement if the policy guarantees the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in the report;
  - For flexible premium policies, a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made to the cash value;

- The projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report, assuming that planned periodic premiums, if any, are paid as scheduled;
- Guaranteed costs of insurance are deducted;
- The net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero;
- If the projected value is less than zero, a warning message should be included that the policy may be in danger of terminating without value in the next 12 months, unless additional premium is paid;
- A summary of the financial statement of the separate account based on the last annual statement filed with the insurance department;
- The net investment return of the separate account for the last year, and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than 5 years, when available;
- A list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the insurance department;
- Any charges levied against the separate account during the previous year; and
- A statement of any change since the last report in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or to the investment advisor of the separate account.

Annual reports for modified guaranteed life insurance policies shall state that the cash value may increase or decrease and shall prominently identify any value that may be recomputed prior to the next statement.

Determine if, upon the request of the policyowner, the insurer furnishes an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. No signature or other acknowledgment of receipt of this illustration is required.

Also, determine, if a policyowner requests one, the insurer provides policy data for the policy. Unless otherwise requested, the data should be provided for 20 consecutive years beginning with the previous policy anniversary and include cash dividends according to the current dividend scale, the amount of outstanding policy loans and the current policy loan interest rate. Values shown should be based on the dividend option in effect at the time of the request. A reasonable fee may be charged for the preparation of the statement.

**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 4**

**Upon receipt of a request from a policyholder for accelerated benefit payment, the regulated entity must disclose to the policyholder the effect of the request on the policy’s cash value, accumulation account, death benefit, premium, policy loans and liens. The regulated entity must also advise that the request may adversely affect the recipient’s eligibility for Medicaid or other government benefits or entitlements.**

**Apply to:** All individual and group life products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Underwriting files

\_\_\_\_\_ Policy files

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Accelerated Benefits Model Regulation (#620), Sections 4, 6D and 8*

**Review Procedures and Criteria**

Review the above documents to determine that proper disclosure has been made.

Verify that prior to payment of accelerated benefits the insurer has obtained from any assignee or irrevocable beneficiary a signed acknowledgment of concurrence for accelerated benefit payout.

The regulated entity may offer waiver of premium in absence of such provision in an existing policy. At the time accelerated benefits are claimed, the insurer must explain any continuing premium requirements to maintain the policy in force.

Unfair discrimination is prohibited.

## **F. Underwriting and Rating**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 1**  
**Pertinent information on applications that form a part of the policy and contract is complete and accurate.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

\_\_\_\_\_ All applications

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

**Review Procedures and Criteria**

Determine if the requested coverage is issued.

Determine if the regulated entity has a verification process in place to determine the accuracy of application information.

Verify if applicable nonforfeiture options and dividend options are indicated on the application.

Determine how automatic premium loan options are disclosed on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

**STANDARDS  
UNDERWRITING AND RATING**

**Standard 2**

**The regulated entity complies with the specific requirements for Acquired Immune Deficiency Syndrome (AIDS)-related concerns in accordance with statutes, rules and regulations.**

**Apply to:** All life and annuity products

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Life insurance applications and related disclosure and consent forms

\_\_\_\_\_ Health questionnaires for applicants

\_\_\_\_\_ Medical underwriting guidelines

\_\_\_\_\_ Regulated entity's guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

**Review Procedures and Criteria**

Ensure the regulated entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

- Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional;
- Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test and should be a part of the underwriting file; and
- Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the regulated entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

- Questions may ask if the applicant has been diagnosed with AIDS or AIDS-Related Complex (ARC), if they are designed to establish the existence of the condition, but are not used as a proxy to establish sexual orientation of the applicant.

Ensure the regulated entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.



Underwriting guidelines must not consider an applicant's sexual orientation to be a factor in the determination of insurability.

A sample of underwriting files for denied applications should be reviewed to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the regulated entity's guidelines (e.g., based on the amount of insurance).

Neither the marital status, living arrangements, occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

## **G. Claims**

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

**STANDARDS  
CLAIMS**

**Standard 1**

**The regulated entity provides the required disclosure material to policyholders at the time an accelerated benefit payment is requested.**

**Apply to:** All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Claim procedure manuals
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Claim complaint records

Others Reviewed

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

*Accelerated Benefits Model Regulation (#620)*

**Review Procedures and Criteria**

Review the regulated entity’s procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Disclosure of possible tax consequences and advice that the claimant seek assistance from a tax advisor;
- A written statement to the policyowner and to the irrevocable beneficiary explaining any effect the payment will have on the policy’s cash value, accumulation account, death benefit, premium, policy loans and policy liens;
- A statement warning that receipt of accelerated benefits may adversely affect claimant eligibility for government benefits or entitlements;
- Administrative expense charges, if any, applicable to the payment of accelerated benefits;
- Any continuing premium requirement to keep the policy in force;
- Lump sum settlement options are required; and
- Any accidental death benefits remain intact.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from policyowners not receiving required disclosure material.

Accelerated benefits are available on the effective date of the policy or rider for accidents and no more than 30 days following the effective date for illness.

No restrictions are permitted on use of accelerated benefit proceeds.

**STANDARDS  
CLAIMS**

**Standard 2**

**The regulated entity does not discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy.**

**Apply to:** All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Applicable statutes, rules and regulations

\_\_\_\_\_ Regulated entity’s claim procedures manual and claim bulletins

\_\_\_\_\_ Claims training manual

\_\_\_\_\_ Claim files

Others Reviewed

\_\_\_\_\_  
\_\_\_\_\_

**NAIC Model References**

*Accelerated Benefits Model Regulation (#620)*

**Review Procedures and Criteria**

Review procedure manuals, training manuals and the regulated entity’s internal claim bulletins to determine if regulated entity standards exist for consistent evaluation of criteria for approval of accelerated benefits payments.

Review claim files to verify that the regulated entity does not apply further conditions on the payment of accelerated benefits beyond those conditions specified in the policy or benefit rider.

**STANDARDS  
CLAIMS**

**Standard 3**

**The regulated entity provides the beneficiary, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the settlement options.**

**Apply to:** All life insurance companies

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable statutes, rules and regulations
- \_\_\_\_\_ Claim procedure manuals/claim training manuals/claim bulletins
- \_\_\_\_\_ Claim files
- \_\_\_\_\_ Claim complaint records
- \_\_\_\_\_ Disclosures provided to beneficiaries

**Others Reviewed**

- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

*Retained Asset Accounts Sample Bulletin (#573)*

**Review Procedures and Criteria**

Review the regulated entity's procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Written information provided to the beneficiary describing available settlement options under the policy; and
- Written information provided to the beneficiary informing the beneficiary how to obtain specific details regarding available settlement options;

A "retained asset account" as defined in the *Retained Asset Accounts Sample Bulletin (#573)* means any mechanism whereby the settlement of proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits.

If the regulated entity settles benefits through a retained asset account, examiners should review and verify in accordance with the applicable state’s record retention requirements that the regulated entity has established and implemented procedures to ensure that the regulated entity has:

- a) Provided the following written disclosures to the beneficiary before the account is selected, if optional, or established, if not:
  - Payment of the full benefit amount is accomplished by delivery of the “draft book”/“check book”;
  - One draft or check may be written to access the entire amount, including interest, of the retained asset account at any time;
  - Whether other available settlement options are preserved until the entire balance is withdrawn or the balance drops below the regulated entity’s minimum balance requirements;
  - A statement identifying the account as either a checking or draft account and an explanation of how the account works;
  - Information about the account services provided and contact information where the beneficiary may request and obtain more details about such services;
  - A description of fees charged, if applicable;
  - The frequency of statements showing the current account balance, the interest credited, drafts/checks written and any other account activity;
  - The minimum interest rate to be credited to the account and how the actual interest rate will be determined;
  - The interest earned on the account may be taxable;
  - Retained asset account funds held by regulated entities are not guaranteed by the Federal Deposit Insurance Corporation (FDIC) but are guaranteed by the state guaranty associations (where permitted by state law). The beneficiary should be advised to contact the National Organization of Life and Health Insurance Guaranty Associations ([www.nolhga.com](http://www.nolhga.com)) to learn more about the coverage limitations to his or her account;
  - A description of the regulated entity’s policy regarding retained asset accounts that may become inactive; and
- b) Provided the beneficiary with a supplemental contract that clearly discloses the rights of the beneficiary and obligations of the regulated entity under the contract.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from beneficiaries not receiving required disclosure material.

## H. Supplemental Checklist for Marketing and Sales Standard #1

Yes	No	Requirement
<b>For companies that use enrollment periods:</b>		
		Advertisements should specify the date by which the applicant must mail the application, which should be not less than 10 days and not more than 40 days from the date the enrollment period is advertised for the first time.
<b>For direct response policies:</b>		
		The advertisement should not state or imply there is a cost savings because there is no insurance producer or commission, unless true.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older when the policy is guaranteed issue.
<b>For graded or modified benefit policies:</b>		
		The advertisement must prominently display any limitation of benefits.
		If the premium is level and coverage decreases or increases with age or duration, that fact must be prominently disclosed.
		If the death benefit varies with the length of time the policy has been in force, the advertisement should accurately describe and clearly call attention to the amount of minimum death benefit under the policy.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older, when the policy is guaranteed issue.
<b>For policies with premium changes:</b>		
		The advertisement for a policy with non-level premiums should prominently describe the premium changes.
		An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.
<b>For policies with non-guaranteed policy elements:</b>		
		An advertisement should not utilize or describe non-guaranteed policy elements in a manner that is misleading or has the capacity or tendency to mislead.
		An advertisement should not state or imply that the payment or amount of non-guaranteed policy elements is guaranteed. If non-guaranteed policy elements are illustrated, they must be based on the insurer’s current scale, and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.



**H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)**

		An advertisement that includes any illustrations or statements containing or based upon non-guaranteed elements should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed elements.
		If an advertisement refers to any non-guaranteed policy element, it should indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way—such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer’s current or anticipated experience—the advertisement may indicate any such limitation on the insurer’s right.
		An advertisement should not refer to dividends as “tax free” or use words of similar import, unless the tax treatment of dividends is fully explained, and the nature of the dividend as a return of premium is indicated clearly.
<b>For policies sold to students:</b>		
		The envelope in which insurance solicitation material is contained may be addressed to the parent(s) of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution, nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student, unless such is a correct and truthful statement.
		All advertisements including, but not limited to, informational flyers used in the solicitation of insurance must be identified clearly as coming from an insurer or insurance producer, if such is the case, and these entities must be clearly identified as such.
		The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.
<b>For individual deferred annuity products or deposit funds:</b>		
		Any illustrations or statements containing or based upon interest rates higher than the guaranteed accumulation interest rates should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The higher interest rates should not be greater than those currently being credited by the company, unless the higher rates have been publicly declared by the company with an effective date for new issues not more than 3 months subsequent to the date of declaration.

## H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it should also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.
		If a contract does not provide a cash surrender benefit prior to commencement of payment of annuity benefits, an illustration or statement concerning such contract should prominently state that cash surrender benefits are not provided.
<b>For combination life insurance and annuity products:</b>		
		An advertisement of a life insurance product and an annuity as a single policy or life insurance policy with an annuity rider should include a disclosure before the application is taken (if the policy contains an unconditional refund provision of at least 10 days, the disclosure statement can be delivered with the policy, or upon the applicant's request, whichever occurs sooner). The disclosure defines the gross annual life and premium annuity percentages and guaranteed cash value of the annuity and should include the first 5 policy years, the tenth and twentieth policy years, at least one age from 60 to 70 and the scheduled commencement of annuity payments.

## I. Supplemental Checklist for Marketing and Sales Standard #4

**For all illustrations:** Determine if the illustration contains the following:

Yes	No	Requirement
		The illustration should be clearly labeled "life insurance illustration."
		Name of insurer.
		Name and business address of producer or insurer's authorized representative, if any.
		Name, age and gender of proposed insured except where a composite illustration is permitted.
		Underwriting or rating classification upon which the illustration is based.
		Generic name of the policy, the company product name, if different, and the policy form number.
		Initial death benefit.
		Dividend option election or application of non-guaranteed elements, if applicable.

*(Life Insurance Illustrations Model Regulation (#582), Section 6A)*

Note: "Generic name" means a short title descriptive of the policy being illustrated, such as "whole life," "term life" or "flexible premium adjustable life."

## I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

**Determine if the *basic* illustration contains or complies with the following:**

Yes	No	Requirement
		Date illustration prepared.
		Page numbers for entire illustration and explanatory notes.
		Assumed dates of payment receipt and benefit payout within a policy year.
		The issue age plus the number of years the policy is assumed to have been in force, if the age is shown as a component of tabular detail.
		Assumed payments on which the illustrated benefits and values are based are identified as premium outlay or contract premium. For policies that do not require a specific contract premium, the illustrated payments should be identified as premium outlay.
		Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium should be shown and clearly labeled guaranteed.
		Non-guaranteed elements should not be based on a scale more favorable to the policyowner than the insurer's illustrated scale at any duration. These elements should be clearly labeled non-guaranteed.
		Guaranteed elements, if any, should be shown before corresponding non-guaranteed elements, and should be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements.
		Account or accumulation value of a policy, if shown, should be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.
		Value available upon surrender should be identified by the name this value is given in the policy being illustrated and should be the amount available to the policyowner in a lump sum after deduction of surrender charges, policy loans and policy interest, as applicable.
		Illustration may show policy benefits and values in graphic or chart form in addition to tabular form.
		Non-guaranteed elements should be accompanied by a statement indicating that, "The benefits and values are not guaranteed; the assumptions on which they are based are subject to change by the insurer, and actual results may be more or less favorable."

## I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

		If the illustration shows that the premium payor may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on the actual results, the premium payor may need to continue or resume premium outlays. Similar disclosure should be made for premium outlay of lesser amounts or shorter duration than the contract premium. If a contract premium is due, the premium outlay should not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid.
		If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium policy charges, or for any other purpose, the illustration may reflect those plans and the effect on future policy benefits and values.
		A brief description of the policy being illustrated, including a statement that it is a life insurance policy.
		A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration should show the premium outlay that must be paid to guarantee coverage for the term of the policy, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code.
		A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration, and the effect they may have on the benefits and values of the policy.
		Identification and a brief definition of column headings and key terms used in the illustration.
		The following statement, "This illustration assumes that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur. Actual results may be more or less favorable than those shown."
		Following the narrative summary, a basic illustration should include a numeric summary of the death benefits and values and the premium outlay and contract premium as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values should be based on the contract premium. This summary should be shown for at least policy years 5, 10, 20 and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary should show policy years 5, 10, 20 and 30.

## I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

		<p>The columns of the numeric summary should include:</p> <p>Bases 1: Policy guarantees</p> <p>Bases 2: Insurer's illustrated scale</p> <p>Bases 3: Insurer's illustrated scale used, but with the non-guaranteed elements reduced as follows:</p> <ul style="list-style-type: none"> <li>• Dividends at 50 percent of the dividends contained in the illustrated scale used;</li> <li>• Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and</li> <li>• All non-guaranteed charges, including, but not limited to, term insurance charges and mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.</li> </ul>
		<p>If coverage would cease before policy maturity or age 100, the year in which coverage ceases should be identified for each of the three bases.</p>
		<p>The following statement signed and dated by the applicant or policyowner: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."</p>
		<p>The following statement signed and dated by the insurance producer or other authorized representative of the insurer: "I certify that this illustration has been presented to the applicant, and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."</p>
		<p>A basic illustration must include the following for at least each policy year from one to 10 and for every fifth policy year thereafter, ending at age 100, policy maturity or final expiration, and except for term insurance beyond the 20<sup>th</sup> year, for any year in which the premium outlay and contract premium, if applicable, is to change:</p> <ul style="list-style-type: none"> <li>• Premium outlay and mode the applicant plans to pay and the contract premium as applicable;</li> <li>• The corresponding guaranteed death benefit, as provided in the policy;</li> <li>• Corresponding guaranteed value available upon surrender, as provided in the policy;</li> <li>• Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any; and</li> <li>• If no guaranteed benefit value is available at any duration for which a non-guaranteed benefit or value is shown, a zero should be displayed in the guaranteed column.</li> </ul>

"Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

## I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

**A supplemental illustration may be provided as long as:**

Yes	No	Requirement
		It is appended to, accompanied by, or preceded by a basic illustration.
		The non-guaranteed elements shown are not more favorable to the policyowner than the corresponding elements in the basic illustration.
		It contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed.
		The premium outlay/contract premium must be equal to the premium outlay/contract premium shown in the basic illustration.
		A notice is included referring to the basic illustration for guaranteed elements and other important information.

“Supplemental illustration” means an illustration furnished in addition to a basic illustration that meets the applicable requirements of [*Life Insurance Illustrations Model Regulation* (#582)], and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

## I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

**Determine if the universal life illustration has the following:**

Yes	No	Requirement
		<p>Any statement of policy cost factors or benefits shall contain:</p> <ul style="list-style-type: none"> <li>• The corresponding guaranteed policy cost factors or benefits, clearly identified;</li> <li>• A statement explaining the non-guaranteed nature of any current interest rates, charges or other fees applied to the policy, including the insurer’s rights to alter any of these factors;</li> <li>• Any limitations on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited;</li> <li>• Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value;</li> <li>• Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined;</li> <li>• If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index in arriving at the interest rate credited under the policy;</li> <li>• Any illustrated benefits based upon non-guaranteed interest, mortality or expense factors shall be accompanied by a statement indicating that these benefits are not guaranteed; and</li> <li>• If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy’s maturity date, such fact shall be disclosed, including notice that coverage will terminate under such circumstances.</li> </ul>

(*Universal Life Insurance Model Regulation* (#585), Section 8A)

## I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine whether, in addition to all other illustration requirements, indexed universal life (IUL) illustrations contain or comply with the following requirements specified in *Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49). (Section 4 and Section 5 apply to new business and in force illustrations for policies sold on or after Sept. 1, 2015, and Section 6 and Section 7 apply to new business and in force illustrations for policies sold on or after March 1, 2016.)

Yes	No	N/A	Requirement
			The illustration actuary uses the current annual cap for the Benchmark Index Account offered with the illustrated policy (AG 49, Section 4.A.i.).
			The illustration actuary uses a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index Account (AG 49, Section 4.A.ii.). Note: Actuarial judgment may be used by the illustration actuary. Support for the determination of the hypothetical cap may be requested of the illustration actuary by the examiner. The examiner may refer this support to an actuarial or investment specialist for review as necessary.
			The maximum credited rate used for the Illustrated Scale is the arithmetic mean of the geometric average annual credited rates calculated in 4.A. (per AG 49, Section 4.B.). Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
			Where other Index Accounts are used in illustrations, the illustration actuary determined the Illustrated Scale (according to AG 49, Section 4.C.). Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
			The insurer updated the credited rate for each Index Account (in accordance with AG 49 Section 4.B. and Section 4.C.) within three months of the beginning of the calendar year of the illustration (AG 49, Section 4.D.).
			The illustrated rate credited to the loan balance shall not exceed the illustrated loan charge by more than 100 basis points (AG 49, Section 6).
			The basic illustration includes a ledger using the Alternate Scale shown alongside the ledger using the Illustrated Scale with equal prominence (AG 49, Section 7.A.).
			The basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates calculated in AG 49, Section 4.A. (AG 49, Section 7.B.).
			The basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated (AG 49, Section 7.C.).

(*Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest*)

## I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

**Ensure *variable life* illustrations contain or comply with the following:**

Yes	No	Requirement
		The hypothetical interest rates used to illustrate accumulated policy values must be an annual effective gross rate after brokerage expenses and prior to any deduction for taxes, expenses and contract charges.
		If illustrations of accumulated policy values are shown, then for the highest interest rate used, one illustration must be based solely upon guarantees contained in the policy contract being illustrated.
		Except for illustrations contained in the prospectus, the pattern of premium payments used in an illustration should be the initial pattern requested by the proposed policyholder at inception or upon changes in face amount requested by the policyholder.
		If the illustrated policy contract provides for a variety of investment options, the illustration may either use an asset charge, which is reasonably representative, or use the asset charge of a particular option. The illustration should clearly identify the asset charge and either label it "hypothetical" or identify the fund.
		The illustration must disclose the transaction charges that will be levied against the contract because of transactions requested in accordance with rights and privileges specified in the policy contract. Any charge for the exercise of a right or privilege upon which the illustration is based must be reflected in the illustrated values. The nature of any other such charges must be disclosed in a clear statement accompanying such illustrations.
		A clear statement must be made following the table of illustrated accumulated policy values that use of hypothetical investment results does not in any way represent actual results or suggest that such results will be achieved and must indicate that the policy values which actually arise will differ from those shown, whenever the actual investment results differ from the hypothetical rates illustrated. Assumptions upon which illustrations are based must be clearly disclosed.
		Any sales illustration to a prospective policyholder must reflect the policy being presented accurately. Misleading statements or captions or other misrepresentations are prohibited.
		The requested sales illustration must be printed clearly and legibly on hard paper copy. An illustration displayed on a computer screen may be used in addition to, but not as a substitute for, hard paper copy.



**I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)**

	<p>In connection with variable life insurance contracts offering both fixed and variable funding options:</p> <ul style="list-style-type: none"> <li>• An illustration of the variable funding option must comply with these guidelines;</li> <li>• If an illustration of the fixed funding option is shown, accumulated policy values must be shown on the basis of guaranteed rates. One or more additional rates may also be shown, but such rates may not exceed current rates; and</li> <li>• A summary illustration may be given in which results from comparable illustrated and hypothetical interest rates are combined. Such summary must cross-reference to the accompanying separate illustrations of the fixed and variable funding options.</li> </ul>
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*(Life Insurance Illustrations Model Regulation (#582))*

**J. Supplemental Checklist for Marketing and Sales Standard #8**

Yes	No	Requirement
<b>Ensure the disclosures include:</b>		
		The fact that a life insurance policy is involved or being used to fund a prearrangement.
		The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.
		The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement.
		<p>The impact on the prearrangement of the following:</p> <ul style="list-style-type: none"> <li>• Any changes in the life insurance policy including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;</li> <li>• Any penalties to be incurred by the policyholder as a result of failure to make premium payments;</li> <li>• Any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy;</li> <li>• A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;</li> <li>• All relevant information concerning what occurs and whether any entitlements or obligations arise, if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement;</li> <li>• Any penalties or restrictions, including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and</li> <li>• The fact that a sales commission or other form of compensation is being paid and, if so, the identity of such individuals or entities to whom it is paid.</li> </ul>

## K. Supplemental Checklist for Marketing and Sales Standard #10

Yes	No	Requirement
<b><u>Ensure the insurer's system of annuity suitability supervision includes from Model #275</u></b>		
		<u>The insurer shall establish and maintain reasonable procedures to inform its producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant producer training manuals.</u>
		<u>The insurer shall establish and maintain standards for producer product training and shall establish and maintain reasonable procedures to require its producers to comply with the requirements of Section 7 of this regulation.</u>
		<u>The insurer shall provide product-specific training and training materials that explain all material features of its annuity products to its producers.</u>
		<u>The insurer shall establish and maintain procedures for the review of each recommendation prior to the issuance of an annuity that is designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system to identify selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. These electronic or other monitoring techniques may be designed to require additional review only of those transactions identified for additional review by the selection criteria.</u>
		<u>The insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with Subsections A, B, D, and E. This may include, but is not limited to, confirmation of the consumer's consumer profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the consumer profile information or other required information under this section after issuance or delivery of the annuity.</u>  <u>Note: In addition to this language from Model #275, examiners should make sure that the company is reviewing all transactions that have been flagged for further internal review.</u>
		<u>The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section.</u>
		<u>The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information.</u>
		<u>The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time. This <i>does not</i> prohibit the receipt of health insurance, office rent, office support, retirement benefits, or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time.</u>  <u>Note: The intent of this subparagraph (h) is to prohibit sales contests, sales quotas, bonuses, and non-cash compensation based on the sale of a particular</u>

		<u>product within a limited period of time, but not to prohibit general incentives regarding the sales of a company’s products with no emphasis on any particular product.</u>
		<u>The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details the results of a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended if any.</u>
		<u>Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer’s compliance with subparagraph (b) of this paragraph.</u>
		<u>An insurer’s supervision system under this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:</u> <ul style="list-style-type: none"> <li>• <u>Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and</u></li> <li>• <u>Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.</u></li> </ul>

**L. Supplemental Checklist for Marketing and Sales Standard #12**

<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>Requirement</u></b>
<b><u>Ensure the insurer’s and applicable producer’s system of annuity suitability supervision and training include from Model #275:</u></b>		
		<u>A producer who engages in the sale of annuity products shall complete a one-time four (4) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider to comply with Section 7 of this regulation.</u>
		<u>Producers who hold a life insurance line of authority on the effective date of the <i>Suitability in Annuity Transactions Model Regulation</i> (#275) and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of the regulation. Individuals who obtain a life insurance line of authority on or after the effective date of the regulation may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.</u>
		<u>The training required under this subsection shall include information on the following topics:</u> <ul style="list-style-type: none"> <li>• <u>The types of annuities and various classifications of annuities;</u></li> <li>• <u>Identification of the parties to an annuity;</u></li> <li>• <u>How product-specific annuity contract features affect consumers;</u></li> <li>• <u>The application of income taxation of qualified and non-qualified annuities;</u></li> <li>• <u>The primary uses of annuities; and</u></li> <li>• <u>Appropriate standard of conduct, sales practices, replacement and disclosure requirements.</u></li> </ul>
		<u>A producer who has completed an annuity training course approved by the</u>

		<p><u>department of insurance prior to the effective date of the regulation shall, within six (6) months after the effective date of the regulation, complete either:</u></p> <ul style="list-style-type: none"> <li>• <u>A new four (4) credit training course approved by the department of insurance after the effective date of the regulation; or</u></li> <li>• <u>An additional one-time one (1) credit training course approved by the department of insurance and provided by the department of insurance-approved education provider on appropriate sales practices, replacement and disclosure requirements under the amended regulation.</u></li> </ul>
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**M. Supplemental Checklist for Marketing and Sales Standard #16**

<u>Yes</u>	<u>No</u>	<u>Requirement</u>
<b><u>Ensure the insurer's and applicable producer's system of annuity suitability supervision include the following, with appropriate testing as needed (per Model #275):</u></b>		
		<p><u>Care Obligation. The producer, in making a recommendation shall exercise reasonable diligence, care and skill to:</u></p> <ul style="list-style-type: none"> <li>• <u>Know the consumer's financial situation, insurance needs and financial objectives;</u></li> <li>• <u>Understand the available recommendation options after making a reasonable inquiry into options available to the producer;</u></li> <li>• <u>Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and</u></li> <li>• <u>Communicate the basis or bases of the recommendation.</u></li> </ul>
		<u>The producer has made reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.</u>
		<u>The producer considered the types of products the producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers shall be held to standards applicable to producers with similar authority and licensure.</u>
		<u>The consumer profile information, characteristics of the insurer, and product costs, rates, benefits and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.</u>
		<u>The producer has a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.</u>
		<p><u>In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:</u></p> <ul style="list-style-type: none"> <li>• <u>The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living or other contractual benefits, or be subject to increased fees, investment advisory fees or charges for riders and similar product</u></li> </ul>

		<p><u>enhancements:</u></p> <ul style="list-style-type: none"> <li>• <u>The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and</u></li> <li>• <u>The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.</u></li> </ul>
		<p><u>Conflict of interest obligation. A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.</u></p>
		<p><u>Documentation obligation. A producer shall at the time of recommendation or sale:</u></p> <ul style="list-style-type: none"> <li>• <u>Make a written record of any recommendation and the basis for the recommendation subject to this regulation;</u></li> <li>• <u>Obtain a consumer signed statement on a form substantially similar to Appendix B documenting:</u> <ul style="list-style-type: none"> <li>• <u>A customer’s refusal to provide the consumer profile information, if any; and</u></li> <li>• <u>A customer’s understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information; and</u></li> </ul> </li> <li>• <u>Obtain a consumer signed statement on a form substantially similar to Appendix C acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer’s recommendation.</u></li> </ul> <p><u>Note: Examiners should be alert for trends of consumers refusing to provide profile information, on a producer level or insurer level.</u></p>

**N. Supplemental Checklist for Marketing and Sales Standard #17**

<u>Yes</u>	<u>No</u>	<u>Requirement</u>
<b><u>Ensure the insurer’s and applicable producer’s system of annuity suitability supervision include from Model #275:</u></b>		
		<u>The producer has disclosed to the consumer, on a form substantially similar to Appendix A, a description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction.</u>
		<p><u>The producer has provided an affirmative statement on whether the producer is licensed and authorized to sell the following products:</u></p> <ul style="list-style-type: none"> <li>• <u>Fixed annuities;</u></li> <li>• <u>Fixed indexed annuities;</u></li> <li>• <u>Variable annuities;</u></li> <li>• <u>Life insurance;</u></li> <li>• <u>Mutual funds;</u></li> <li>• <u>Stocks and bonds; and</u></li> <li>• <u>Certificates of deposit.</u></li> </ul>
		<p><u>The producer has provided an affirmative statement describing the insurers the producer is authorized, contracted (or appointed), or otherwise able to sell insurance products for, using the following descriptions:</u></p> <ul style="list-style-type: none"> <li>• <u>One insurer;</u></li> <li>• <u>From two or more insurers; or</u></li> <li>• <u>From two or more insurers although primarily contracted with one insurer.</u></li> </ul>
		<u>The producer has provided a description of the sources and types of cash</u>

		<u>compensation and non-cash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of the premium or other remuneration received from the insurer, intermediary or other producer or by a fee as a result of a contract for advice or consulting services.</u>
		<u>A notice of the consumer’s right to request additional information regarding cash compensation is described in subparagraph (b) of the following checklist provision.</u>
		<u>Upon request of the consumer or the consumer’s designated representative, the producer shall disclose:</u> <ul style="list-style-type: none"> <li>• <u>A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and</u></li> <li>• <u>Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages.</u></li> </ul>
		<u>Prior to or at the time of the recommendation or sale of an annuity, the producer shall have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in non-guaranteed elements of the annuity, insurance and investment components and market risk.</u>

**POLICY IN FORCE STANDARDIZED DATA REQUEST**  
**Travel Line of Business**

**Content:** This file should be downloaded from company system(s) and contain one record for each policy or contract that the company issued which provided coverage to [applicable state] residents at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the issuance of travel insurance policies or contracts in [applicable state] within the scope of the examination:

- Cross-reference with the claims data file to ensure completeness of exam data submitted; and
- Cross-reference to state(s) licensing information to ensure proper producer licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
CoName	6	64	A		Company name
CoAddr	70	100	A		Company street address
CoCity	170	20	A		Company city
CoSt	190	2	A		Company state
CoZip	192	5	A		Company ZIP code
InsFein	197	10	A		Insured/employer Federal Employer Identification Number
PolForm	207	10	A		Policy form number as filed with the insurance department
PolPre	217	3	A		Policy prefix ( <b>Blank if NONE</b> )
PolNo	220	20	A		Policy number
PolSuf	240	3	A		Policy suffix ( <b>Blank if NONE</b> )
SrfNo	243	15	A		SERFF filing reference (Repeat field as necessary)
SrfSt	258	2	A		State related to SERFF filing reference (Repeat field as necessary)
ProdNo	260	10	A		Product number that distinguishes different products
PlanCode	270	6	A		System plan code <b>Please provide a list of system plan codes and their descriptions</b>

Field Name	Start	Length	Type	Decimals	Description
PolTyp	276	25	A		Type of policy (i.e., life, medical, trip cancellation, evacuation, package, comprehensive, etc.) <b>Please provide a list to explain any codes used</b>
PolDes	301	25	A		Coverage description, repeat as necessary (i.e., Travel Gold, Travel Silver, Travel Bronze)
CovTyp	326	25	A		Type of coverage purchased (i.e., trip cancellation, baggage delay, rental car, etc.) <b>Please provide a list to explain any codes used</b> (Repeat field as necessary)
CovLmt	351	10	N	2	Limit of coverage associated with each coverage type identified above (Repeat field as necessary)
PXWaiv	361	1	A		Is there a pre-existing conditions waiver on the policy? (Y/N)
PolPuDt	362	10	D		Purchase date of policy [MM/DD/YYYY]
PremPdDt	372	10	D		Date premium was actually paid if different from purchase date [MM/DD/YYYY]
StdAln	382	1	A		Stand-alone travel insurance or part of travel protection plan [I=Insurance only, C=Travel Protection Plan]
IndGrp	383	1	A		Individual or group coverage [I=Individual, G=Group]
PremTot	384	10	N	2	Total insurance policy premium collected
AmtChrg	394	10	N	2	Total amount charged to insured per proof of payment (i.e., credit card receipt, check, money order, wire transfer, etc.) The total amount includes but is not limited to insurance premium, fees, concierge/non-insurance services, commission, etc. combined per proof of payment (i.e., credit card, check, money order, etc.)
TxFee	404	10	N	2	Any monies charged in addition to the normal premium computed from the rate filing that the travel administrator charges to administer the travel insurance policy (list as separate fields, repeat field as necessary and include a revised file layout) at each POS (point of sale)
TxFeeDes	414	25	A		Description of monies charged in addition to the normal premium computed from the rate filing. Include any other charges to the insured associated with the purchase of travel insurance (list as separate fields, repeat field as necessary and include a revised file layout)



Field Name	Start	Length	Type	Decimals	Description
DedAmt	439	10	N	2	Amount of deductible (dollar amount or percentage amount) (repeat field for any deductibles per coverage)
PremRpt	449	2	A		State where premium is reported
PremSur	451	10	N	2	Premium surcharge amount
ReasSur	461	25	A		Reason for the surcharge <b>Please provide a list to explain any codes used</b>
PremTax	486	10	N	2	State premium tax paid
TxStPd	496	2	A		State to which the premium tax was paid
OptOut	498	1	A		Was this policy sold under an opt-out approach (Y/N)
OtrSvc	499	1	A		Did this policy include other services, such as assistance services, concierge, or non-insurance services (Y/N)
OtrChg	500	10	N	2	Amount charged for other services (i.e., assistance services, concierge, or non-insurance services)
EndorLst	510	25	A		List endorsements attached to the policy <b>Please provide a list to explain any codes used</b>
EndFrmNo	535	10	A		Endorsement form number
EndSrfNo	545	15	A		Endorsement SERFF filing reference, if applicable
EndTyp	560	25	A		Endorsement type (i.e., life, medical, trip cancellation, evacuation, package, comprehensive, etc.)
EndLmt	585	10	N	2	Policy endorsement limits
PremEnd	595	10	N	2	Endorsement premium amount
InsIDNo	605	10	A		Insured ID number, if different from policy number or certificate number
InsFirst	615	15	A		Insured first name
InsMid	630	15	A		Insured middle name
InsLast	645	20	A		Insured last name
InsAddr	665	100	A		Insured street address
InsCity	765	20	A		Insured city
InsSt	785	2	A		Insured state
InsZip	787	5	A		Insured ZIP code

Field Name	Start	Length	Type	Decimals	Description
DtEff	792	10	D		Date the coverage begins [MM/DD/YYYY]
PolEpDt	802	10	D		Date the coverage ends [MM/DD/YYYY]
CertNo	812	10	A		Certificate number assigned to applicant or insured
CertFirst	822	15	A		Certificate holder first name
CertMid	837	15	A		Certificate holder middle name
CertLast	852	20	A		Certificate holder last name
CertAddr	872	100	A		Certificate holder street address
CertCity	972	20	A		Certificate holder city
CertSt	992	2	A		Certificate holder state
CertZip	994	5	A		Certificate holder ZIP code
CertPuDt	999	10	D		Purchase date of certificate [MM/DD/YYYY]
CertEpDt	1009	10	D		Date certificate will expire [MM/DD/YYYY]
TermStat	1019	2	A		Termination status [ <b>C=Cancellation, NR=Nonrenewed, D=Declined, R=Rescinded, RW=Rewritten, IR=Insured's Request, NP=Premium Nonpayment, O=Other</b> ] Please provide a description if designated as 'Other'. Please provide a description in a separate field, if designated as 'Other'
CanTerRs	1021	64	A		Reason for cancellation/termination of coverage (i.e., lapse, insured request, company cancellation) <b>If codes are used, please provide a list of cancellation codes and their meanings</b>
CanTerDt	1085	10	D		Date policy cancelled/terminated [MM/DD/YYYY]
CanTerNt	1095	10	D		Date the cancellation/termination notice was mailed [MM/DD/YYYY]
PremRef	1105	10	N	2	Amount of travel insurance premium refunded to the insured
RateFact	1115	10	N	5	Pro rate or short rate factor applied to premium refund
AdvTyp	1125	15	A		Type of advertisement (i.e., radio script, TV script, website, leaflet, etc.)
DistMthd	1140	15	A		Distribution method (i.e., wholesale, group, retail) <b>Please provide a list to explain any codes used</b>
AgFlag	1155	1	A		Aggregator involved in sale (Y/N)
AgNPN	1156	6	A		Aggregator NPN

Field Name	Start	Length	Type	Decimals	Description
AgName	1162	64	A		Name of aggregator involved in sale
Repeat producer or limited lines producer fields (from field # to field # below), as necessary					
PrCode	1226	6	A		Company internal producer, CSR or business entity producer identification code <b>Please provide a list to explain any codes used</b>
PrFirst	1232	15	A		Producer first name
PrMid	1247	15	A		Producer middle name
PrLast	1262	20	A		Producer last name
PrStId	1282	6	A		Producer state licensing number
PrLcTyp	1288	1	A		Producer license type [F=Full, L=Limited]
PrNPN	1289	6	A		Producer NPN
PrAddr	1295	100	A		Producer street address
PrSt	1395	2	A		Producer state
PrCity	1397	20	A		Producer city
PrZip	1417	5	A		Producer ZIP code
PrComm	1422	10	N	2	Commission amount paid to the producer
Repeat retailer fields (from field # to field # below) as necessary					
RtTyp	1432	2	A		Retailer type [ <b>TR=Travel Retailer, WH=Wholesaler, TS=Travel Supplier, TA=Travel Agency, OT=Other</b> ]
RtFirst	1434	15	A		Retailer first name (Includes travel retailer, wholesaler, travel supplier, travel agency, etc.)
RtMid	1449	15	A		Retailer middle name
RtLast	1464	20	A		Retailer last name
RtAddr	1484	100	A		Retailer street address
RtStId	1584	2	A		Retailer state
RtCity	1586	50	A		Retailer city
RtZip	1636	5	A		Retailer ZIP code
RtComm	1641	10	N	2	Commission amount paid to the retailer
GrpName	1651	64	A		Eligible group name (Eligible groups, as defined by applicable state law)
GrpIntNo	1715	6	A		Eligible group internal agency number

Field Name	Start	Length	Type	Decimals	Description
GrpStID	1721	6	A		Eligible group state licensing number
GrpNPN	1727	6	A		Eligible group NPN
GrpID	1733	6	A		Eligible group ID number
GrpCnt	1739	64	A		Name of eligible group contact
GrpAddr	1803	100	A		Eligible group street address
GrpSt	1903	2	A		Eligible group state
GrpCity	1905	20	A		Eligible group city
GrpZip	1925	5	A		Eligible group ZIP code
GrpComm	1930	10	N	2	Commission amount paid to eligible group
Repeat travel administrator fields (from field # to field # below) as necessary (Travel administrator, as defined by applicable state law)					
TAName	1940	64	A		Name of travel administrator
TAIntNo	2004	6	A		Travel administrator internal agency number
TASTID	2010	6	A		Travel administrator state licensing number
TANPN	2016	6	A		Travel administrator NPN
TAFEIN	2022	10	A		Travel administrator FEIN
TAAddr	2032	100	A		Travel administrator street address
TACity	2132	20	A		Travel administrator city
TAST	2152	2	A		Travel administrator state
TAZip	2154	5	A		Travel administrator ZIP code
TAComm	2159	10	N	2	Commission amount paid to travel administrator
LPS	2169	64	A		Last point of sale - should match an entity in the sales chain (i.e., tour operator, MGA/TPA, Internet site, travel agent, group, company, etc.)
AppSrc	2233	25	A		Initial source of application (i.e., company direct, MGA/TPA, tour operator, travel agency, travel agent, travel supplier, other, etc.) <b>Please provide a list to explain any codes used</b>
AppDt	2258	10	D		Date application was signed [MM/DD/YYYY]
ProgTyp	2268	25	A		Program type or affinity/association (i.e., AARP, Rotary Club, etc.)
RateMthd	2293	25	A		Code for rating method <b>Please provide a description of each code/rating method (i.e., age-banded, aggregated, etc.)</b>

<b>Field Name</b>	<b>Start</b>	<b>Length</b>	<b>Type</b>	<b>Decimals</b>	<b>Description</b>
ReCoCode	2318	5	A		Reinsuring company NAIC code
RWCd	2323	5	A		Rewrite code designating coverage rewritten in another affiliate
InsDest	2328	64	A		Insured's destination [ <b>I=International, D=Domestic</b> ]
TrvlTyp	2392	2	A		Travel type description [ <b>I=Inbound, O=Outbound, RT=Round Trip</b> ]
TrvlSeg	2394	1	A		Single segment of travel or multiple [ <b>S=Single, M=Multiple</b> ]
TripCost	2395	10	N	2	Cost of trip if different from coverage amount
DtDepart	2405	10	D		Departure date of trip [MM/DD/YYYY]
DtReturn	2415	10	D		Return date of trip [MM/DD/YYYY]
EndRec	2425	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

## CLAIMS STANDARDIZED DATA REQUEST Travel Line of Business

**Content:** This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Do not include expense payments to vendors.

For any fields where there are multiple entries, please repeat field as necessary.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the handling of travel insurance claims within the scope of the examination:

- Cross-reference with the in-force data file to ensure completeness of exam data submitted; and
- Cross-reference to state(s) licensing information to ensure proper adjuster licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
GrpID	6	5	A		Group ID number
GrpName	11	64	A		Group name
PolPre	75	3	A		Policy prefix ( <b>Blank if NONE</b> )
PolNo	78	20	A		Policy number
PolSuf	98	3	A		Policy suffix ( <b>Blank if NONE</b> )
PolForm	101	10	A		Policy form number
PolTyp	111	25	A		Type of policy (i.e., life, medical, trip cancellation, evacuation, package, comprehensive, etc.) <b>Please provide a list to explain any codes used</b>
CovTyp	136	25	A		Type of coverage purchased (i.e., trip cancellation, baggage delay, rental car, etc.) <b>Please provide a list to explain any codes used</b> (Repeat field as necessary)
CovLmt	161	10	N		Limit of coverage associated with each coverage type identified above (Repeat field as necessary)
PXWaiv	171	1	A		Is there a pre-existing conditions waiver on the policy? (Y/N)

Field Name	Start	Length	Type	Decimals	Description
TSupp	172	64	A		Name of travel supplier (wholesaler, tour operator, cruise line, website, etc)
TAgency	236	64	A		Name of travel agency
InsFirst	301	15	A		First name of insured
InsMid	316	15	A		Middle name of insured
InsLast	331	20	A		Last name of insured
InsIDNo	351	10	A		Insured ID number, if different from policy number or certificate number
InsAddr	361	25	A		Insured street address
InsCity	386	20	A		Insured city
InsSt	406	2	A		Insured state
InsZip	408	5	A		Insured ZIP code
CertNo	413	10	A		Certificate number assigned to applicant or insured
CertFirst	423	15	A		Certificate holder first name
CertMid	438	15	A		Certificate holder middle name
CertLast	453	20	A		Certificate holder last name
CertAddr	473	100	A		Certificate holder street address
CertCity	573	20	A		Certificate holder city
CertSt	593	2	A		Certificate holder state
CertZip	595	5	A		Certificate holder ZIP code
CertPuDt	600	10	D		Purchase date of certificate [MM/DD/YYYY]
CertEpDt	610	10	D		Date certificate will expire [MM/DD/YYYY]
ClmNo	620	10	A		Claim number
ClmPre	630	3	A		Claim number prefix <b>(Blank if NONE)</b>
ClmSuf	633	3	A		Claim number suffix <b>(Blank if NONE)</b>
AmtSub	636	10	N	2	Amount of claim submitted

Field Name	Start	Length	Type	Decimals	Description
ICPdAmt	646	10	N	2	Amount paid under interruption or cancellation of trip or event coverage
BPEPdAmt	656	10	N	2	Amount paid under loss of baggage or personal effects coverage
ARVPdAmt	666	10	N	2	Amount paid under damages to accommodations or rental vehicles coverage
SADPdAmt	676	10	N	2	Amount paid under sickness, accident, disability or death coverages occurring during travel
EvcPdAmt	686	10	N	2	Amount paid under emergency evacuation coverage
RoRPdAmt	696	10	N	2	Amount paid under repatriation of remains coverage
OthPdAmt	706	10	N	2	Amount paid under any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the insurance commissioner of the applicable state
ClmPdDt	716	10	D		Claim paid date [MM/DD/YYYY]
ChkNo	726	10	A		Claim payment check number(s)
ClmPay	736	50	A		Claim payee
CmtFirst	786	15	A		First name of claimant
CmtMid	801	15	A		Middle name of claimant
CmtLast	816	20	A		Last name of claimant
CmtAddr	836	25	A		Claimant street address
CmtCity	861	20	A		Claimant city
CmtSt	881	2	A		Claimant state
CmtZip	883	5	A		Claimant ZIP code
DedAmt	888	10	N	2	Amount of deductible (dollar amount or percentage amount) (repeat field for any deductibles per coverage)
OtrSvc	898	1	A		Did this policy include other services, such as assistance services, concierge, or non-insurance services? (Y/N)
EffDt	899	10	D		Policy effective date [MM/DD/YYYY]



Field Name	Start	Length	Type	Decimals	Description
MGU	909	64	A		Name of third-party administrator or managing general underwriter authorized to adjudicate claims
NPN	973	6	A		Adjuster NPN (National (adjuster) number)
LossDt	979	10	D		Date loss occurred [MM/DD/YYYY]
RevdDt	989	10	D		First notice of loss [MM/DD/YYYY]
ClmAckDt	999	10	D		Date company or its producer acknowledged claim to claimant [MM/DD/YYYY]
DtInvs	1009	10	D		Date claim investigation was completed [MM/DD/YYYY]
NtcInvDt	1019	10	D		Date of written notice to insured/claimant regarding incomplete investigation [MM/DD/YYYY]
DtClsd	1029	10	D		Date claim was closed [MM/DD/YYYY]
RsnClsd	1039	25	A		Reason claim was closed. Please provide a separate list with a description of the codes, i.e. paid, closed-no response, denied, partially denied, withdrawn (by insured), etc.
AmtDen	1064	10	N	2	Amount of claim ineligible or denied
ClmDnyDt	1074	10	D		Date claim was denied (blank if not denied) [MM/DD/YYYY]
ClmDenRsn	1084	25	A		Reason for claim denial <b>Please provide a list to explain any codes used</b>
EndRec	1109	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record This must be in the same character position for every record in this table.

Draft: 12/4/23

Market Analysis Procedures (D) Working Group  
Virtual Meeting (*in lieu of meeting at the 2023 Fall National Meeting*)  
November 20, 2023

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 20, 2023. The following Working Group members participated: Jo LeDuc, Chair (MO); John Haworth, Vice Chair (WA); Cheryl Hawley (AZ); Don McKinley (CA); Steve DeAngelis (CT); Scott Woods (FL); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Raymond Guzman (MD); Connie Mayette (ME); Jeff Hayden (MI); Troy Smith (MT); Maureen Belanger (NH); Ralph Boeckman (NJ); Larry Wertel (NY); Guy Self (OH); Landon Hubbart (OK); Karen Veronikis (PA); Brett Bache (RI); Glynda Daniels (SC); Tanji J. Northrup (UT); Melissa Gerachis (VA); Karla Nuisl (VT); Rebecca Rebholz and Darcy Paskey (WI); and Theresa Miller (WV). Also participating were: Teresa Kroll (MO); Tony Dorschner (SD); and Bryan Stevens (WY).

1. Adopted its Oct. 16 Minutes

LeDuc said the Working Group met Oct. 16 and took the following action: 1) discussed the premium reporting threshold for the Market Conduct Annual Statement (MCAS); 2) received an update on the interviews with market analysts about their jurisdictions' use of the Market Analysis Prioritization Tool (MAPT); and 3) received an update from the subject matter expert (SME) group drafting the set of standardized ratios for the pet insurance MCAS blank.

Haworth made a motion, seconded by Daniels, to adopt the Working Group's Oct. 16 minutes (Attachment Six-A). The motion passed unanimously.

2. Discussed Lunch and Learn Trainings

LeDuc said the Lunch and Learn sessions have been well-received, and a lot of positive feedback has been received during the interviews with states about MAPT. She said the two Lunch and Learns were recorded and will be posted soon to the tutorial section of i-Site+.

LeDuc said the next Lunch and Learn will be in January due to the Fall National Meeting and the holiday season. She said a topic has not been decided yet, but in speaking with different states, she learned there are a few different baseline methodologies and specially built prioritization tools. LeDuc said she may ask some states to present on their tools and baseline methodologies. Coker suggested a session on Tableau.

3. Discussed NAIC MIS Data

LeDuc said there were more than 25 interviews scheduled, and they are close to completion. A report will be created to provide an overview of the most common themes throughout the interviews. She said there were a lot of commonalities among all the states, such as: 1) combining the financial and market MAPT with the MCAS-MAPT; 2) beginning with a download of all state and national data but focusing on state data; and 3) a consistent use of \$50,000 as a premium threshold for baseline analysis to match with the MCAS reporting threshold.

LeDuc said there were also a lot of suggestions that were heard multiple times, including: 1) combining the financial and the MCAS MAPTs; 2) providing a glossary and embedded helps in the tools; and 3) having all the lines of business available across MCAS, MAPT, and the Market Analysis Review System (MARS).

4. Discussed the Draft of the Pet Insurance MCAS Ratios

Bache said the SME group comprises industry and state insurance regulators, including many involved in drafting the pet insurance MCAS blank. The group has met a couple of times and is almost through reviewing all the ratios to get initial opinions. He said that, so far, no ratios have been removed from the 23 ratios in the initial draft. He said a few definitional questions have come up, including a question about the definition of partial payment. He said he expects the group to be finished by early 2024.

5. Discussed the Premium Reporting Threshold for the MCAS

LeDuc said the Working Group is looking into whether the premium reporting threshold should be changed since it was originally set nearly 20 years ago. She said this may influence whether fraternal organizations are required to file an MCAS. The concern with fraternal organizations is that they are often quite small, and the MCAS could be both a burden for many of them and of minimal value for analysts. She said, however, that there are many quite large fraternal organizations that do not file an MCAS even though they are larger than non-fraternal life companies that are required to file an MCAS.

LeDuc said that after the last Working Group meeting, Randy Helder (NAIC) sent each state market analysis chief (MAC) the state-specific data underlying the national data shown in Attachment C in the materials. She said for smaller states, a larger premium threshold may not make sense and would eliminate a large percentage of their marketplace from reporting the MCAS. She did think not many resources would be devoted to looking deeper into an issue on a company with less than \$50,000 in premium.

LeDuc said she is torn on whether to increase the reporting threshold for the MCAS. She said she does not use the MCAS just to identify outliers but also to research companies that come up in inquiries. There is data for companies available in the MCAS and cannot be found elsewhere.

Daniels said she would not want to lose the data on smaller companies. Haworth said that during the last Working Group meeting, he suggested a threshold of \$2 million and was clear that many smaller states would not benefit from such a high threshold. Kroll said she and LeDuc discussed and thought \$100,000 may be more reasonable now, 20 years later. LeDuc said the financial-market MAPT has a \$100,000 threshold option that would match with a decision to increase the MCAS threshold. Gerachis said Virginia could agree with \$100,000.

Stevens said that, initially, he has no concerns with \$100,000, but he would want to look more closely at it before agreeing to increase the threshold. Dorschner agreed with Stevens. He said even companies with low premium in lines like short-term, limited-duration (STLD) health can cause issues. Haworth noted that smaller states may not see who is writing certain lines in their states with MCAS reporting.

LeDuc said Missouri recently passed legislation requiring companies to report on insurance to the Department of Motor Vehicles (DMV) if they write more than a stated threshold. She said having the MCAS allows her department to identify companies that would not have to report to the DMV and develop a different process for those companies.

Self said he saw no benefit to raising the threshold, as it would only result in losing data for some companies. LeDuc said it is only being discussed in relation to the fraternal organizations exemption since many of them are very small. Bache said having a lower threshold allows states to have data on companies not just for baseline analysis but also for market information. He said an analyst can apply their own threshold when doing analysis. He said leaving the threshold at \$50,000 is the best of both worlds—market information and analysis.

Weyhenmeyer said that as a larger state, Illinois would be opposed to increasing the threshold. It uses MCAS data to monitor companies as they increase their business in the state.

Allison Koppel (American Fraternal Alliance—AFA) said that the AFA believes that there are some companies that are possibly being considered as fraternal organizations but are not. She asked for more time to research this. LeDuc said no decision will be made until 2024.

Rikki Pelta (American Council of Life Insurers—ACLI) asked if an MCAS reporting threshold change would apply to all of the travel and long-term care (LTC) lines of business. LeDuc said those lines have no threshold for specific reasons, and no threshold would be introduced for them. Haworth said a lot of LTC is written on riders, and it is difficult to know the premium amount written for riders in the financial annual statement. He said many companies use annuity funds for LTC administration and claims.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

Sharepoint/Member Meetings/D CMTE/2023 Fall National Meeting/MAPWG/1120/11 MAP T.docx

Draft: 11/8/23

Market Analysis Procedures (D) Working Group  
Virtual Meeting  
October 16, 2023

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 16, 2023. The following Working Group members participated: Jo LeDuc, Chair (MO); John Haworth, Vice Chair (WA); Steve Matlock and Jake Windley (AR); Cheryl Hawley and Tolanda Coker (AZ); Don McKinley and Pam O'Connell (CA); Tracy Garceau (CO); Steve Deangelis and Nick Gill (CT); Susan Jennette (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Shannon Lloyd (KS); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond Guzman (MD); Connie Mayette (ME); Jeff Hayden (MI); Troy Smith and David Dachs (MT); Robert McCullough and Martin Swanson (NE); Maureen Belanger and Doug Rees (NH); Ralph Boeckman and Erin Porter (NJ); Larry Wertel (NY); Guy Self (OH); Landon Hubbard (OK); Karen Veronikis (PA); Brett Bache (RI); Glynda Daniels (SC); Tracy Klausmeier (UT); Melissa Gerachis (VA); Karla Nuisl (VT); Mary Kay Rodriguez and Darcy Paskey (WI); and Theresa Miller (WV). Also participating was: Tony Dorschner (SD).

1. Adopted its Sept. 18 Minutes

LeDuc said the Working Group met Sept. 18 and took the following action: 1) discussed the exemption of fraternal from Market Conduct Annual Statement (MCAS) reporting; 2) discussed upcoming interviews with market analysts about their jurisdictions' use of the Market Analysis Prioritization Tool (MAPT); and 3) formed a subject matter expert (SME) group to draft a set of standardized ratios for the pet insurance MCAS blank.

Haworth made a motion, seconded by Veronikis, to adopt the Working Group's Sept. 18 minutes (Attachment Six-A1). The motion passed unanimously.

2. Discussed Lunch and Learn Trainings

LeDuc said the first Lunch and Learn was Sept. 25, with nearly 150 attendees. She said the session was about MAPT. She said she was encouraged by the amount of discussion and the contributions of experienced analysts and those newer to the process.

LeDuc said one of the concerns brought up was the difference between the financial MAPT and the MCAS-MAPT and how to incorporate both into a baseline analysis. To address this, she said the next Lunch and Learn will be about the MCAS-MAPT and is scheduled for Oct. 26.

She said while the Lunch and Learns will primarily be for new analysts to learn how to do market analysis and use all the analysis tools available to them, there will not be lectures. She said they are most successful if they are interactive and conversational, and she would like to have experienced analysts at the Lunch and Learns who can also contribute and share their knowledge and experience with the new analysts.

Rodriguez asked if the data specifications for MAPT could be distributed. LeDuc said she had an older version, and NAIC staff were trying to locate a more current version. She said it still needs to be decided if the proper location for the documentation and the Lunch and Learn recording is i-Site or StateNet.

### 3. Discussed NAIC MIS Data

LeDuc said the Working Group invited jurisdictions to submit responses to a series of questions about how they use the MAPT tool in their baseline analysis. Jurisdictions were also asked for some time to have interviews for more in-depth discussions on how MAPT is used, its effectiveness, and how it can be improved. She said 18 states responded, and interviews began the week of Oct. 9.

LeDuc said most jurisdictions conduct a baseline analysis once a year and usually wait for the MCAS data to become available. Many jurisdictions use MAPT in conjunction with MCAS-MAPT, and many suggested combining the two Market Information Systems (MIS) tools. She said typically, all the data is downloaded along with the scores and then filtered and sorted to meet the jurisdiction's needs. All agree that baseline analysis using MAPT is a labor-intensive process.

LeDuc said the discussions will continue into November, and there is still time to submit responses to the questions and set up some time for discussion. She said a written high-level summary will be made publicly available.

### 4. Discussed the Draft of the Pet Insurance MCAS Ratios

Bache said the SME group is composed of industry and state insurance regulators, including many involved in drafting the pet insurance MCAS blank. The group met for the first time Oct. 4 and is scheduled to meet about every two weeks until the work is complete. The group is beginning its work by reviewing all the ratios to see the initial opinions. The process will be transparent, and each new version of the ratios will continue to be posted on the Working Group web page so others can follow the progress and provide comments to the SME group.

LeDuc said that if any issues arise with the MCAS blank or definitions, they will be raised to the Working Group for discussion, while the SME group will concentrate only on developing ratios.

### 5. Discussed the Premium Reporting Threshold for MCAS

LeDuc said that in the Working Group discussion concerning the MCAS reporting exemption for fraternal organizations, there were concerns expressed about the burden on the typically small fraternal organization to have to file MCAS. She noted, however, that there are more than a few fraternal insurers that are significantly larger than some life insurance companies that are required to file MCAS. LeDuc said this led to consideration of a higher premium threshold for fraternal organizations, but rather than just considering revising the threshold for fraternal organizations or life companies, it is probably time to consider the MCAS premium thresholds for all lines of business. She said the Working Group is putting on hold its discussion of lifting the exemption for fraternal organizations and, first, will decide whether the MCAS premium reporting thresholds should be adjusted.

LeDuc said the current premium threshold is \$50,000 for all lines except long-term care (LTC) and travel. LTC and travel do not have a threshold. Any company writing any amount of LTC or travel insurance must report MCAS. This threshold was set in the early 2000s and has never been reviewed.

LeDuc said that the attachment in the materials summarizes the percentage of companies that would have to submit MCAS filings if the threshold was raised or reduced in each line of business. She said, as an example, for the life MCAS, with the current \$50,000 threshold, almost 99% of all life companies are reporting MCAS. Raising the threshold to \$100,000 would reduce the percentage of companies reporting to about 89%. Eliminating the threshold would capture 100% of the companies. She said the spreadsheet also shows the average number of life filings received per state in 2023 for the 2022 data year. She said the data is available for each participating jurisdiction and will be up to each state's market analysis chiefs (MACs).

Cynthia Maleski (FCSLA Life) asked if the premium threshold would be revised per company, per state, or in aggregate. Randy Helder (NAIC) said the threshold would be applied per state.

Lisa Brown (American Property Casualty Insurance Association—APCIA) asked if the cumulative percentage of the marketplace indicated on the spreadsheet was of companies or premium. LeDuc said she suspects the percentage of premium would also go down as the threshold is raised.

Haworth said the state of Washington will typically only look at companies that write at least \$2 million in premium. A company with only \$100,000 in premium and one complaint does not generate the same need for a Level 1 review as a company with a larger market share. He suggested a higher threshold may result in a more practical use of resources. LeDuc noted this was the original intent when a threshold was initially chosen for MCAS reporting. LeDuc asked if \$2 million is too high. Haworth said typically, analysts will be looking at larger writers, but there may be value to analyzing smaller companies also, though there is a resource issue to consider. Some of the companies reporting smaller premiums are reporting on closed blocks, or they are not really marketing.

Stevens said that for smaller states like Wyoming, Alaska, and Montana, a \$2 million threshold would eliminate a lot of companies. He said \$2 million is too high of a threshold. He said \$250,000 is more practical for smaller states. Dachs agreed with Stevens that a higher threshold would eliminate too many companies from reporting. He said Montana looks at data surrounding non-renewals and cancellations, which would not necessarily be driven by premium. Dorschner said South Dakota also has the same concerns as the other smaller states. Moran said Massachusetts does not go by market share but also looks at the smaller companies reporting in their jurisdiction. She said \$2 million would be too high and leave too many companies out. O'Connell said California has the same concerns as Massachusetts. She said MCAS data is important information they use when looking at large and small companies. It would be costlier to obtain the data in ways other than MCAS. Self said the threshold is not a one-size-fits-all matter. He said Ohio has different premium filters for different lines of business. He said the threshold should not be changed, and states should be able to apply whichever premium size filters they need to.

Moran noted that Massachusetts will look at the data for smaller companies if an issue arises with the company. LeDuc said that is done in Missouri also.

LeDuc asked why the LTC and travel MCAS do not have a premium threshold. Helder said the state insurance regulators wanted information on all companies with any LTC business in their states. Teresa Cooper (NAIC) said the travel blank has no threshold because state insurance regulators are unable to obtain premium information for travel insurance in the financial annual statement.

LeDuc asked the Working Group to review the threshold figures for their states, and the Working Group will continue the discussion at the next meeting.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 10/9/23

Market Analysis Procedures (D) Working Group  
Virtual Meeting  
September 18, 2023

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Sept. 18, 2023. The following Working Group members participated: Jo LeDuc, Chair (MO); John Haworth, Vice Chair (WA); Jake Windley (AR); Maria Ailor and Tolanda Coker (AZ); Don McKinley (CA); Tracy Garceau (CO); Steve DeAngelis and Nick Gill (CT); Pratima Lele (DC); Scott Woods (FL); Erica Weyhenmeyer (IL); Shannon Lloyd (KS); Lori Cunningham (KY); Raymond Guzman (MD); Connie Mayette (ME); Jeff Hayden (MI); Robert McCullough (NE); Maureen Belanger (NH); Ralph Boeckman and Erin Porter (NJ); Larry Wertel (NY); Guy Self (OH); Landon Hubbart (OK); Karen Veronikis (PA); Brett Bache (RI); Rachel Moore (SC); Shelley Wiseman (UT); Melissa Gerachis (VA); Isabelle Turpin Keiser (VT); Rebecca Rebholz and Darcy Paskey (WI); and Theresa Miller (WV).

1. Adopted its July 17 Minutes

LeDuc said the Working Group met July 17 and took the following action: 1) adopted the standardized ratios for the Other Health Market Conduct Annual Statement (MCAS); and 2) discussed the exemption of fraternal from MCAS reporting.

Haworth made a motion, seconded by Keiser, to adopt the Working Group's July 17 minutes (*see NAIC Proceedings – Summer 2023, Market Regulation and Consumer Affairs (D) Committee, Attachment Five*). The motion passed unanimously.

2. Discussed Lunch and Learn Trainings

LeDuc said the Lunch and Learn sessions will be launched on Monday, Sept. 25; the session will be on the Market Analysis Prioritization Tool (MAPT). She said she was starting with baseline analysis because it is the first step in market analysis, and the MAPT found on iSite+ is accessible to everyone and used by most states for all or a portion of their baseline analysis. She said while the Lunch and Learns will primarily be for new analysts to learn how to do market analysis and use all the analysis tools available to them, the sessions will not be lectures. She said they will be most successful if they are interactive and conversational. She said she would like to have plenty of experienced analysts at the Lunch and Learns who can also contribute and share their knowledge and experience with the new analysts. She said the sessions will be recorded, and because they will use real data, the sessions will be regulator-only.

3. Discussed the Inclusion of Fraternal Insurance Companies in the MCAS

LeDuc said the Working Group has been discussing whether fraternal insurance companies should be required to file an MCAS. She noted that the Working Group seems split on the matter, with some firmly supportive and others just as firmly opposed. She also said there are a few states that may not be able to require filings from fraternal.

Allison Koppel (American Fraternal Alliance—AFA) said the exemption of fraternal from reporting an MCAS should remain. She said there were no compelling reasons for removing the exemption. She said the AFA has spoken with its members, and they agree there will be additional resources required to comply with reporting an MCAS. She said most fraternal are small and may need to train personnel or hire consultants. She said if the exemption is removed, the AFA requests six or more months' notice in advance of the first calendar year reporting.



Lloyd said the Kansas Insurance Department does not support removing the exemptions for fraternal at this time.

LeDuc said while most fraternal are small, there are some very large fraternal that state insurance market conduct regulators have been blind to. She suggested that the Working Group may need to reconsider the premium threshold requirement either across all lines of business or specific to fraternal. Ailor agreed that the threshold should be re-evaluated, and she said it should be re-evaluated across all lines of business. Haworth said in Washington, there are fraternal that write property/casualty (P/C) and long-term care insurance (LTCI). LeDuc said the Working Group should step back from considering the exemption of fraternal until it has considered revising the premium threshold for the MCAS. Ailor suggested gathering data on the number of companies required to file by different premium ranges in each line of business. LeDuc said NAIC staff will gather the data on the number of companies by premium by line of business.

#### 4. Discussed NAIC MIS Data

LeDuc said she drafted a set of questions to guide her, several state insurance regulators, and NAIC staff in interviews with NAIC member jurisdictions concerning the use and effectiveness of the MAPT. She said the series of questions will cover whether the jurisdiction uses the MAPT, how it uses the MAPT, and whether it uses other data to complement its use of the MAPT. It concludes with a request for ways to improve the MAPT. LeDuc said she would like to begin these interviews as soon as possible because it may take some time to complete interviews of all the NAIC members. The interviews to go through the questions and discussion will be either with multiple jurisdictions at a time or individually depending on the preference of the jurisdiction.

Gerachis said she likes the flowchart of questions, and she said it would be helpful for states to complete the questions prior to the interviews. Guzman agreed and said completing the questions in writing would make the meetings more efficient. LeDuc agreed and said she is sensitive to how busy everyone is. Haworth said this will also help identify training needs.

#### 5. Discussed the Draft of the Pet Insurance MCAS Ratios

LeDuc said the Working Group will begin the process of developing the standardized ratios for the Pet Insurance MCAS Blank. She said a draft containing 23 potential ratios is posted on the Working Group web page under exposure drafts. She said the next step is to form a subject matter expert (SME) group to develop and finalize the list of ratios to be presented to the Working Group to consider and adopt. She said since Rhode Island led the development of the Pet Insurance blank, she asked Matt Gendron (RI) and Bache if they would lead the SME group, and they generously volunteered their time to do so.

LeDuc called for volunteers to be a part of the SME group. She said the Working Group is looking for both interested state insurance regulators and interested parties to participate in the drafting of the final version of ratios. She asked volunteers to contact Randy Helder (NAIC). Cari Lee (North American Pet Health Insurance Association—NAPHIA) volunteered.

Bache said the SME group will begin meeting right away and will post the drafting work of each meeting to the Working Group web page so everyone can follow the progress and provide comments to the SME group.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 11/29/2023

Market Conduct Annual Statement Blanks (D) Working Group  
Virtual Meeting  
October 10, 2023

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 10, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Tolanda Coker (AZ); Jake Windley (AR); Scott Woods (FL); Shannon Lloyd (KS); Ron Kreiter (KY); Danielle Torres (MI); Jennifer Hopper and Jo LeDuc (MO); Martin Swanson and Robert McCullough (NE); Guy Self (OH); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Shelley Wiseman (UT); Melissa Gerachis (VA); John Kelcher (WA); and Letha Tate (WV). Also participating was: Brett Bache (RI).

1. Adopted its Sept. 18 and Aug. 24 Minutes

The Working Group conducted an e-vote that concluded Sept. 18 to adopt two motions to eliminate duplicate data elements in the other health Market Conduct Annual Statement (MCAS) blank. These motions were to: 1) remove element 54, which is a duplicate of data element 61; and 2) remove data element 58, which is a duplicate of data element 62.

The Working Group also met Aug. 24 and took the following action: 1) adopted its July 19 minutes; 2) discussed the report of closed claims for a private passenger auto (PPA) and homeowners lines of business; 3) discussed possible edits to the MCAS data element revision process timeline; and 4) adopted a motion for a May 31 MCAS filing deadline for all health and short-term, limited-duration (STLD) submissions.

Veronikis made a motion, seconded by Hopper, to adopt the Working Group's Sept. 18 (Attachment Seven-A) and Aug. 24 (Attachment Seven-B) minutes. The motion passed unanimously.

2. Adopted the Report of Closed Claims for P/CMCAS Lines of Business

Weyhenmeyer stated that the proposed data element will read, "The number of claims closed in your system with the date and final payment of X days, and, quote, number of claims closed in your system without payment in X days."

Bache expanded the proposal to include not just homeowners and PPA but also lender place order and home, private flood, and travel. The thought process was that the insurer has been responsible for reporting all their claims as they wrote, knowing if they have a third party, they are accurately reporting the claims and including those. The suggestion would be not to add any wording other than what is being proposed.

Weyhenmeyer asked if there were any comments or questions. There were none.

Rebholz made a motion, seconded by Wiseman, to adopt the reporting of closed claims for the property/casualty (P/C) and casualty annual statement lines of business. The motion passed unanimously.

3. Adopted the MCAS Data Element Revisions

Weyhenmeyer stated that the draft consideration lists are to provide submission times for the Working Group to review, discuss, and consider reporting data, which should be provided to the Working Group by April 1. The Working Group should provide all other MCAS edits and changes by May 1. These new drafts are provided later

than April 1, and the Working Group decides on a case-by-case basis if there is a consensus to adopt prior to June 1 for use in the following year or if additional time is needed prior to adoption. Draft best practices are a minimum of five working group jurisdictions should volunteer and participate in subject matter expert (SME) group meetings when creating/reporting for a new MCAS line of business or blank changes to an existing business. Weekly SME meetings from the beginning of work and for formal meeting after the conclusion of the new group meeting and prior to the voting deadline to present the draft document to the Working Group, interested state insurance regulators, and interested parties.

LeDuc made a motion, seconded by Kreiter, to adopt MCAS data element revisions. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/D CMTE/2023 Fall/MCAS Blanks WG/MCASBWG Oct. 10 Minutes.docx

Market Conduct Annual Statement Blanks (D) Working Group  
E-Vote  
September 18, 2023

The Market Conduct Annual Statement (MCAS) Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee conducted an e-vote that concluded Sept. 18, 2023. The following Working Group members participated: Teri Ann Mecca (AR); Scott Woods (FL); Paula Shamburger (GA); Shannon Lloyd (KS); Mary Lou Moran (MA); Raymond Guzman (MD); Jeff Hayden (MI); Paul Hanson (MN); Jo LeDuc (MO); Martin Swanson (NE); Guy Self (OH); Karen Veronikis (PA); Rachel Moore (SC); Shelli Isiminger (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); John Haworth (WA); and Letha Tate (WV).

1. Adopted a Motion to Remove Duplicate Data Elements from the MCAS Other Health Blank

The Working Group considered data elements #54 and #61. Both data elements ask for covered lives impacted by cancellations initiated by the policyholder/certificated holder during the period:

- **Data element #54:** the number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the period.
- **Data element #61:** the number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder.

A quorum of the Working Group members voted in favor of adopting the motion, which will allow for the removal of data element #54 from the MCAS other health blank. The motion passed.

2. Adopted a Motion to Remove Duplicate Data Elements from the MCAS Other Health Blank

The Working Group considered data elements #58 and #62. Both data elements ask for covered lives impacted by cancellations resulting from nonpayment:

- **Data element #58:** the number of covered lives on policies/certificates by the company due to non-payment of premium during the period.
- **Data element #62:** the number of covered lives impacted on terminations and cancellations due to nonpayment.

A quorum of the Working Group members voted in favor of adopting the motion, which will allow for the removal of data element #58 from the MCAS other health blank. The motion passed.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

SharePoint/Market Regulation – Home/D Working Groups/MCAS Blanks WG (TES)/2023 MCAS Blanks WG/WG Mtg 1010

Draft: 9/6/23

Market Conduct Annual Statement Blanks (D) Working Group  
Virtual Meeting  
August 24, 2023

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Aug. 24, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Scott Woods (FL); Paula Shamburger and Elizabeth Nunes (GA); Shannon Lloyd (KS); Lori Cunningham (KY); Salama Karim-Camara (MD); Jeff Hayden (MI); Jennifer Hopper and Jo LeDuc (MO); Robert McCullough (NE); Guy Self (OH); Karen Veronikis (PA); Tony Dorschner (SD); Shelli Isiminger (TN); William Stimpson (UT); Melissa Gerachis (VA); John Kelcher (WA); and Letha Tate (WV). Also participating were: Nick Gill (CT); and Brett Bache (RI).

1. Adopted its July 19 Minutes

The Working Group met July 19 to: 1) discuss the reporting of closed claims for private passenger auto (PPA) and homeowners lines of business; and 2) discuss the Market Conduct Annual Statement (MCAS) Data Element Revision Process Timeline.

Shamburger made a motion, seconded by Phelps, to adopt the Working Group's July 19 minutes (*see NAIC Proceedings – Summer 2023, Market Regulation and Consumer Affairs (D) Committee, Attachment Six*). The motion passed unanimously.

2. Considered the Reporting of Closed Claims for PPA and Homeowners Lines of Business

Weyhenmeyer stated that the purpose is to clarify the reporting of claims closed with payment by updating the data elements to quote the number of claims closed in a system with the date of final payment within X number of days. Pennsylvania submitted comments in agreement with the proposed clarification of the data element wording. Also received were comments from Jo LeDuc (MO) urging the Working Group to consider expanding the request beyond PPA and homeowners. Weyhenmeyer agreed that there are other lines of business with this same issue, specifically lender-placed home and auto, private flood travel, disability income, and life.

Maria Ailor (AZ) stated that many reporting companies rely on external entities to process claims and gather data from these entities. She posed the following questions: 1) whether this revision is going to be inclusive of these external entities; and 2) whether the data element change is included in the system.

Rebholz said she believes it makes sense to wait to adopt the new language and data elements until there is a clear definition. She suggested that this discussion be put on hold until the definition is exactly how the Working Group wants it.

Bache said as far as closed within the system, that wording is used in the clarification within the system. The homeowners and PPA data column definitions have the date of final payment, as well as a calculation clarification. It specifies reporting a claim as closed with payment or closed without payment. If it is closed in the company's claims system during the reporting period, that is when the converting claims system is being used.

Ailor said there have been challenges from certain companies in the reporting requirements because they rely on third parties.

LeDuc said to not run into unnecessary changes and confusion, the Working Group should do this all at once since it has time.

Bache said he will revise the proposal form, and this topic will move forward at the next Working Group meeting.

3. Considered Possible Edits to the MCAS Data Element Revision Process Timeline

LeDuc said she advocates for a firm deadline for the subject matter experts (SMEs) to get their work to the Working Group so there is adequate time to review the proposal, submit comments, and debate. She said she is still in favor of a hard deadline for new business or new lines of business, and she does not see a need for hard and fast deadlines for revisions.

Weyhenmeyer and Rebholz will be working on the language for the definition of “time revision” to the MCAS Data Element Revision Process Timeline.

4. Considered a May 31 MCAS Filing Deadline for Other Health and STLD

Veronikis said having one consistent deadline for all Health and Short-Term, Limited-Duration (STLD) MCAS submissions would make it easier for the companies to be tracked for market analysis.

Ailor made a motion, seconded by Gerachis, to make the adjustment to the MCAS filing deadline. The motion passed unanimously.

5. Discussed Other Items

Randy Helder (NAIC) asked the Working Group to take a look at duplicate data elements in the Health Blank. Data elements number 54 and 61 are essential, and numbers 58 and 62 ask the same question. Helder asked for the Working Group’s approval to remove the duplicates.

Hopper said she would like to look at the blank in its entirety.

Weyhenmeyer said an email will be sent out to the Working Group, state insurance regulators, and all interested parties regarding the duplicates. A vote will then be conducted via email before the Working Group’s next meeting.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

SharePoint/Market Regulation – Home/D Working Groups/MCAS Blanks WG (TES)/2023 MCAS Blanks WG/WG Mtg 0824

Draft: 11/20/23

Market Conduct Examination Guidelines (D) Working Group  
Virtual Meeting  
November 8, 2023

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 8, 2023. The following Working Group members participated: Matthew Tarpley, Chair, Thomas Morgan and Stacie Parker (TX); Erica Weyhenmeyer, Vice Chair (IL); Teri Ann Mecca and Jake Windley (AR); Catherine O'Neil (AZ); Nick Gill (CT); Tina Ching and Pratima Lele (DC); Paula Shamburger (GA); Ron Kreiter (KY); Mary Lou Moran and John Turchi (MA); Airic Boyce, Jeff Hayden, and Danielle Torres (MI); Brad Gerling, Julie Hesser, Jo LeDuc, and Win Nickens (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger (NH); Tia Hammond (NJ); Hermoliva Abejar (NV); Richard Ramos (NY); Rodney Beetch (OH); Landon Hubbart, Zach Palank, and Shelly Scott (OK); Colette Hittner; Ana K. Pace, and Tashia Sizemore (OR); Paul Towsen (PA); Brett Bache and Matt Gendron (RI); Andrea Baytop and Melissa Gerachis (VA); Karla Nuisl and Beth Sides (VT); Jeanette Plitt (WA); and Barbara Belling, Darcy Paskey, Rebecca Rebholz, and Mary Kay Rodriguez (WI).

1. Adopted the Oct. 4 Draft of Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook*

Tarpley said the revisions to the Chapter 23 exposure draft relate to revisions to the *Suitability in Annuity Transactions Model Regulation* (#275) that the NAIC adopted in early 2020.

Tarpley said revisions to Chapter 23 were first circulated April 19, 2022, and they were first presented during the Working Group's April 21, 2022, meeting. The subject matter experts (SMEs) who prepared that initial exposure draft of Chapter 23 reviewed comments received on the chapter in late May 2022 from Virginia, Missouri, and the Insured Retirement Institute (IRI). The SMEs created a revised draft, which was posted and distributed Aug. 22, 2022, and discussed during the Working Group's Sept. 8 meeting. The SMEs' Aug. 22 revisions to that draft were highlighted in yellow to differentiate them from the revisions occurring prior to their review.

In September 2022, the Working Group received comments on the Aug. 22 draft from the IRI; the Center for Economic Justice (CEJ); and jointly from the CEJ/Independent Insurance Agents & Brokers of America (IIABA). Individuals who submitted those comments presented them at the Working Group's Oct. 20 meeting, which was the last Working Group meeting of 2022. In 2023, the SMEs reviewed the exposure draft from 2022 and made edits, which were distributed June 6 for a public comment period; the revisions were highlighted in blue to further differentiate them from the prior revisions.

Tarpley said the June 6 draft was discussed at the July 18 Working Group meeting, the comment deadline was extended to Sept. 5, and comments dated Sept. 6 were received from the CEJ Sept. 7. The SMEs met in September and made additional changes to the draft; the Oct. 4 revisions are highlighted in green. Tarpley asked Birny Birnbaum (CEJ) to present the CEJ's comments dated Sept. 6. Neither Birnbaum nor any other representative of CEJ were in attendance at the Working Group meeting.

Tarpley asked a member of the SMEs to present the edits made in the Oct. 4 exposure draft. Bache said that the SMEs revised marketing and sales examination standards 9 and 10 to show that the Annuity Suitability (A) Working Group is still discussing the issue of how the safe harbor provisions of Model #275 apply and that this Working Group may revisit both of these examination standards after the Annuity Suitability (A) Working Group's discussions are complete. For that reason, the annuity suitability SMEs decided to defer adding examiner guidance regarding safe harbor to the exposure draft (as the CEJ had suggested in its Sept. 6 comment letter) to such time

when the Annuity Suitability (A) Working Group has finalized its safe harbor frequently asked questions (FAQ) document.

Bache said the SMEs added the Model #275 definition of “financial professional” to both marketing and sales examination standards 9 and 10, as well as examiner guidance regarding whether a state had adopted “federal and state securities laws” or “state securities laws” in its state-specific safe harbor language.

Bache said that the SMEs added to marketing and sales examination standard 16 the four obligations outlined in Model #275 of care, disclosure, conflict of interest, and documentation in consideration of the CEJ’s comment that all four obligations be referenced in the exam standard. Prior to the SMEs’ Oct. 4 revisions, only the care obligation was referenced in standard 16.

Bache said that the SMEs revised the introductory language of marketing and sales Supplemental Checklist M for marketing and sales standard 16 to include “...with appropriate testing as needed (per Model #275)” to help alleviate the CEJ’s concern in its comment letter regarding disclosures signed by the consumer relating to the sale of an annuity without the required consumer profile information. Bache said that the SMEs also added language to the marketing and sales Supplemental Checklist M that examiners should be alert for trends of consumers, refusing to provide profile information on a producer level or an insurer level.

Tarpley said that he had received an inquiry prior to the meeting from Sarah Wood (IRI) about the Oct. 4 proposed revision to marketing and sales examination standard 16. He said Wood had indicated that she would speak on her concern about the language during the Nov. 8 Working Group meeting. Wood requested that the Working Group align the language of marketing and sales exam standard 16 more closely with Model #275. Tarpley asked Petra Wallace (NAIC) to show, via Webex screen share, new compromise language, as follows, to be incorporated into Standard 16 to replace the proposed language in the Oct. 4 exposure draft:

“The insurer issues annuities to consumers that are in the best interest of the consumer under the circumstances known to the producer at the time, the recommendation is made, without placing the producer’s or the insurer’s financial interests ahead of the consumer’s interest. The insurer shall establish and maintain reasonable procedures to ensure recommendations comply with the best interest obligations of care, disclosure, conflict of interest and documentation.”

Kim O’Brien (Federation of Americans for Consumer Choice—FACC) said that she agreed with Wood’s comments and expressed her appreciation and support for the proposed compromise language, indicating that the language addressed Wood’s issue.

Tarpley said that Missouri had submitted comments July 6 regarding the location of the new supplemental marketing and sales checklists K, L, M, and N in Chapter 23. Tarpley said that he had proposed at the July 18 Working Group meeting that the new supplemental checklists K, L, M, and N (which correspond, respectively, to marketing and sales exam standards 10, 12, 16, and 17) be moved to the end of Chapter 23 to occur in sequential order after the existing supplemental checklists A–J.

Tarpley suggested that in the review procedures and criteria sections of both marketing and sales examination standards 9 and 10, the language in the sentence “As of October 2023 the Annuity Suitability (A) Working Group is still discussing...” be changed to “As of November 2023 the Annuity Suitability (A) Working Group is still discussing ...” to account for the Market Conduct Exam Guidelines (D) Working Group’s review of the exposure draft in November.



Gendron made a motion, seconded by Weyhenmeyer, to adopt the Chapter 23 draft, as revised during the meeting, to include: 1) Tarpley's suggested compromise language edits to marketing and sales examination standard 16; 2) the revision in marketing and sales examination Standards 9 and 10 (changing "As of October 2023..." to "As of November 2023..."; and 3) to move the new supplemental marketing and sales checklists K, L, M, and N to the end of Chapter 23, to occur sequentially after supplemental checklist J. The motion passed unanimously.

Tarpley expressed his great appreciation to the annuity suitability SMEs for their time and efforts in the initial drafting, reviewing of comments, and revising language several times in the exposure draft of Chapter 23 since the spring of 2022. The SMEs are Bache, Gendron, Stephen DeAngelis (CT), and Frank Pyle (DE).

## 2. Adopted the Oct. 25 Exposure Drafts of the New Travel Insurance In-Force SDR and the New Travel Insurance Claims SDR

Tarpley said the travel insurance standardized data requests (SDRs) dated Aug. 17, 2022, were circulated on that date for the Working Group's initial review. The SDRs were discussed at the Working Group's Sept. 8, and Oct. 20, 2022 meetings. Comments were received on the SDRs from Missouri and the CEJ on Sept. 16, 2022, and from Virginia on Oct. 28, 2022. Considering those comments, the travel insurance SMEs met in 2023 to prepare revised SDRs for the Working Group's review.

Tarpley said the revisions the SMEs made to each of the SDRs were extensive; therefore, a track changes version and a clean version of each SDR were circulated to the Working Group, interested state insurance regulators, and interested parties Oct. 25, 2023. Tarpley asked Gendron, one of the travel insurance SMEs, to provide a high-level overview of the changes made to the SDRs.

Gendron said the SMEs reviewed the comments received from Missouri, Virginia, and the CEJ in several meetings in 2023; the SDRs showed track changes where the SMEs made revisions, and some field names are highlighted in the travel in-force SDR, which delineates where fields were moved from their original location to a new location so that they would better fit with the flow of the data requested in the SDR.

Gendron said a new field, "StndAln," regarding "standalone travel insurance or a part of a travel protection plan," was added to the in-force SDR and better defined. A number of the types of terms within the in-force SDR were removed, such as travel agency, tour operator, wholesaler, TPA, and travel supplier, as they were subsumed into an existing defined term(s) in the *Travel Insurance Model Act* (#632). In addition, the term "certificate" was added back into the travel in-force SDR since certificates were not addressed in the original exposure draft of that SDR.

Shamburger made a motion, seconded by Gendron, to adopt the new travel insurance in-force and claims SDRs. The motion passed unanimously.

Tarpley expressed his gratitude to the travel insurance SMEs who worked on numerous Webex calls during 2023 to develop the revised SDRs discussed at the Working Group's meeting. The travel insurance SMEs are Lori Cunningham (KY), Teresa Kroll (MO), and Gendron.

## 3. Discussed Other Matters

Tarpley said it has come to his attention that the Handbook may need updating with regard to *Actuarial Guideline 49-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After December 14, 2020* (AG 49-A). Tarpley said he still needs to have some discussions on that issue with the leadership of the Life Actuarial (A) Task Force with regard to next steps.

Tarpley said that a few of the examination standards in the Conducting the Travel Examination chapter in the Handbook have missing review procedures and criteria. Tarpley asked if anyone at the meeting worked on the development of the chapter and could shed some light on that issue. Tarpley said that the chapter could be updated, if that is the will of the Working Group, in 2024.

Tarpley asked that Working Group members email him any updated material that should be placed in the Handbook or regarding any additional subject areas that need to be incorporated into the Handbook in 2024 (i.e., a new chapter “Conducting the Pet Insurance Examination”).

Tarpley said now that the annuity suitability and the travel insurance SDR exposure drafts are adopted, he would like to begin focusing, as time allows, on the Working Group’s charge to “Discuss the development of uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.”

Tarpley said that it is unlikely that the Working Group will meet before 2024 considering the timing of the Fall National Meeting and the upcoming holidays. Tarpley said a notice of the next Market Conduct Examination Guidelines (D) Working Group meeting will be sent once a meeting date and time has been determined. Tarpley said that in the meantime, he will reach out to Working Group members to request volunteers to begin to work on the aforementioned template charge in 2024.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/D CMTE/2023 Fall/MCEG/11-08.docx

Draft: 12/4/23

Speed to Market (D) Working Group  
*Virtual Meeting (in lieu of meeting at the 2023 Fall National Meeting)*  
November 17, 2023

The Speed to Market (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 17, 2023. The following Working Group members participated: Rebecca Nichols, Chair (VA); Maureen Motter, Vice Chair (OH); Erick Wright (AL); Shannon Hohl (ID); Julie Rachford (IL); Camille Anderson-Weddle (MO); Tammy Lohmann (MN); Cuc Nguyen (OK); Mark Worman (TX); Tanji J. Northrup (UT); and Lichiou Lee (WA).

1. Considered Adoption of its Summer National Meeting Minutes

Minutes were not taken to a vote as there was not a quorum.

2. Received a Report on the SERFF Modernization Project and SERFF PSC

Bridget Kieras (NAIC) stated that the key driver for the modernization of the System for Electronic Rates & Forms Filing (SERFF) is operational efficiency. Because industry and state insurance regulators are continually constrained, there is a need to move from data entry to analysis. With this, processes will extend beyond technology to improve rate and form filing efficiency as well as improve product speed to market. The next driver is product complexity and innovation, as our consumers' needs are changing, and the products to meet these needs are becoming more innovative and complex. A few elements putting increasing pressure on SERFF are InsureTech, smart contracts, and predictive models. The last driving element is technological advancement. State insurance regulators and industry users require better system integration capabilities with SERFF. These capabilities include improved workflow, reporting and data extraction capabilities, and analytics.

The goal of phases one and two of the SERFF modernization project is to address pain points in the existing system while building the fundamental components of a new platform. Those are to improve search capabilities and the introduction of Tableau. Data searches are now 15-20 times faster, six new search fields have been added, and the data search is combined with the document search. Document searches will now give faster and better results, including scanned PDFs, phrase search support, and the elimination of stop words. Document search results now load in about half of a second. Increased usage makes this available to all users with no adverse performance impact. The fundamental components of the search improvements are OpenSearch Index taking the load off operational data stores, Search API integrating with the application and public portal, and monitoring to ensure stability and responsiveness.

Tableau dashboards are in production and are providing more than just data. Tableau is a visual analytics platform that is transforming the way we use data to solve problems. For state insurance regulators, this can be used for filing and form metrics, objection metrics, filing company metrics, reviewer analytics, and company rates analytics. For industry users, Tableau can be used for filing and form metrics and productivity analytics.

There will be a new platform update with continuing development for Interstate Insurance Product Regulation Commission (Compact) filings, which is pushing for a release in the first or second quarter of 2024. Feature highlights of this new platform include the following: machine learning (M/L), a new and modern "find filing" feature, a new "browse filing" feature for easy navigation, the streamlined filing amendment process, integration with company licensing data, state business role support, and self-service user management.

There are some SERFF modernization features that the Working Group would particularly be interested in, including: 1) expanding to three business types (Property & Casualty (P/C); Life, Annuity and Credit and Health; Long-Term Care and Medicare Supplement); 2) Adding a type of insurance (TOI) group feature to improve search

and reports; 3) assessing “non-product coding matrix (PCM)” filings, and 4) assessing state checklists and the Product Requirements Locator (PRL).

Another feature in the SERFF modernization is ML. The system will learn to recognize patterns and help with document classification and data extraction, as well as filing and reviewing checklists. This feature will also have a help chatbot and correspondence assistance.

The remaining timeline for the SERFF modernization over 2024–2026 is as follows: During the second quarter of 2024, the focus is on the Compact and user management; The fourth quarter of 2024 is focused on life/annuity/credit; The third quarter of 2025 is focused on P/C; The fourth quarter of 2025 the is focused on health; The third quarter of 2026 is focused on plan management.

The Working Group then received updates from the SERFF Product Steering Committee (PSC). The PSC continues to meet monthly and receives updates on the current system as well as on modernization. It also provides input on new features. November’s PSC meeting featured an overview of the SERFF Tableau dashboards.

PSC meeting summaries are posted to the PSC’s web page, available at the following link: [https://www.serff.com/serff\\_product\\_steering\\_committee.htm](https://www.serff.com/serff_product_steering_committee.htm).

### 3. Received a Report from the Compact

Susan Ezalarab (Compact) said that as of today, there are 47 members (45 states and two territories) in the Compact. The newest member is North Dakota.. The Compact also collects state filing fees. There is a monthly newsletter available on the Compact’s website, and it sponsors a webinar in the spring and fall with sessions that are regulatory- and industry-focused. Recordings of these sessions are also on the website.

The Compact’s highlight for the year was the launch of its redesigned website in February 2023. Enhancements include a committee page and a uniform standards page. Currently, the Product Standards Committee is working on standards for index-linked variable annuities (ILVAs). The Compact is also working on group whole life insurance for employer groups, wLastly, the Compact is working on group term life for non-employer groups and considering comments that were received in an October public call. It is also working on how those implement the non-employer framework, as the Compact only approves the product and not the groups that would be involved.

### 4. Discussed Revisions to the *Product Filing Review Handbook*

Nichols stated the revisions to the *Product Filing Review Handbook* have been completed. Four attachments were added to the meeting documents labeled B1-B4. B1 is the completed Handbook as of November 2023. B2 is the table of contents for the 2023 Handbook. B3 is an overview of the renumbering of the chapters. It shows where the renamed and re-ordered chapters can be located in the Handbook’s 2016 and 2023 versions. B4 is the 2016 version of the Handbook, so the two versions can be compared. A date has not been set to vote to adopt the 2023 version of the Handbook, but the Working Group would like to consider adopting the changes in time for the Market Regulation and Consumer Affairs (D) Committee to adopt them in time for the Spring National Meeting. With the Working Group’s next meeting scheduled for February 2024, the plan is that it should be ready to adopt the Handbook’s 2023 version at that time. In the interim, notes will be taken of any comments and suggestions received. The Working Group would like everyone to have time to review the Handbook prior to suggesting any changes. It was suggested that any questions, comments, or recommended edits to the 2023 Handbook be sent to Petra Wallace (NAIC) and would be appreciated by Jan. 12, 2024.

Motter stated that what the Working Group is really looking for are any notes of errors and/or omissions, so this version of the Handbook can replace the prior one. Moving forward, the Working Group will be asking for Handbook revisions on an annual basis.

Having no further business, the Speed to Market (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/D CMTE/2023 Fall/S2M WG