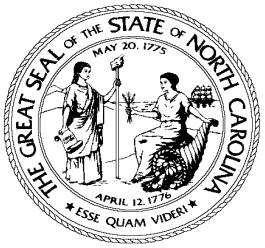

Report on

Market Conduct Examination

of

Gerber Life Insurance Company

White Plains, New York

by Representatives of the

North Carolina Department of Insurance

as of

July 12, 2019

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Raleigh, North Carolina
July 12, 2019

Honorable Michael Causey
Commissioner of Insurance
Department of Insurance
State of North Carolina
Albemarle Building
325 N. Salisbury Street
Raleigh, North Carolina 27603

Honorable Linda A. Lacewell
Superintendent of Financial Services
Department of Financial Services
State of New York
One State Street
New York, New York 10004

Honorable Commissioner and Superintendent:

In accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134, a target examination has been made of the market conduct activities of the following entity

Gerber Life Insurance Company (NAIC #70939)
NAIC Exam Tracking System Exam Number: NC-131-9
New York, New York 10004
(hereinafter generally referred to as the Company)

The examination was conducted at the Company's home office located at 1311 Mamaroneck Avenue, Suite 350, White Plains, New York and at the North Carolina Department of Insurance (Department) office located at 325 N. Salisbury Street, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The North Carolina Department of Insurance conducted a target examination of the Company. This examination commenced on December 6, 2016 and covered the period of January 1, 2014 through December 31, 2015, with analyses of certain operations of the Company being conducted through July 9, 2019. This action was taken due to market analysis on claims practices. Based on the findings of the initial examination, the Department instructed the Company to conduct a self-audit that extended the examination period to January 1, 2010 through December 31, 2013 and January 1, 2016 through December 31, 2016 to further inspect in detail the Company's claims practices and oversight of the Third Party Administrator (TPA). All comments made in this report reflect conditions observed during the periods of the examination.

This examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of this examination was not comprehensive but included a limited review of the Company's practices and procedures in third-party administration, claims and policy rescissions. The findings and conclusions contained within the report are based solely on the work performed and are referenced within the appropriate sections of the examination report.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/non-compliance that fall outside certain tolerance levels. The Department applied a 3 percent tolerance level for claims practices and a 5 percent tolerance level for policy rescissions. Sample sizes were generated using Audit Command Language (ACL) software. The Department utilized a 95% Confidence Level to determine the error tolerance level.

EXECUTIVE SUMMARY

This market conduct target examination revealed concerns with Company procedures and practices in the following areas:

Claims Practices –

- Failure to pay claims within 30 calendar days after receipt of claims and pay interest accordingly
- Misrepresenting pertinent facts or insurance policy provisions relating to coverages
- Failure to act reasonably and promptly regarding insurance claims and policies

- Failure to pay claims based on a reasonable investigation and all available information
- Failure to affirm or deny coverage of claims within reasonable time after proof-of-loss statements were submitted
- Failure to in good faith, effectuate prompt, fair and equitable claims payments
- Compelling the claimant to institute litigation to recover amounts due under an insurance policy and using delay tactics in the payment of claims.
- Attempting to settle claims for less than the amount to which a reasonable man would believe he was entitled
- Delaying the investigation or claims payment by requiring the claimant or physician to submit both a claim report and a proof-of-loss form, when both submissions contain the same information
- Failure to promptly settle claims where liability had become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage

Third-Party Administrators – Failure to verify licensure of a TPA prior to entering into a contractual agreement.

Specific violations are noted in the appropriate section of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site www.ncdoi.com.

This examination identified various statutory violations which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina per its insurance laws and regulations.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations.

COMPANY OVERVIEW

Third-Party Administrators

While reviewing Accidental Death and Dismemberment claims paid and denied, it was evident that the Company utilized the services of the Third-Party Administrator (TPA), A. C. Newman & Company located at 7060 N. Marks Avenue, Suite 108, Fresno, California 93711.

The examiners researched the licensing of the TPA in the State of North Carolina during the examination period of January 1, 2010 through December 31, 2016 which included the initial examination period and the five-year look back period. The Company did not adhere to the

provisions of NCGS 58-56-51(a) as it was revealed that the TPA was not licensed in the State of North Carolina until September 6, 2013.

CLAIMS PRACTICES

Group Accidental Death & Dismemberment Claims Paid

The entire population of 46 accidental death & dismemberment claims paid files were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The Company did not adhere to the provisions of NCGS 58-63-15 (11)(a),(b),(d),(e),(f),(g),(h),(l) and (m) as 44 claim files contained either one or more violations of the enumerated acts of the Unfair Claim Settlement Practices as follows:

- Two claims exhibited misrepresentation of pertinent facts or insurance policy provisions relating to coverage at issue as the insurer attempted to deny coverage of natural born children. Biological parents were required to:
    - Prove that the natural born child was a dependent on an income tax return
    - Prove that the natural born child resided with the parent at the time of death in addition to furnishing receipts for clothing, tuition and other needs
    - Submit natural born child's marital status at the time of death
- Sixteen claim files contained evidence that the insurer did not acknowledge and act reasonably and promptly upon communications with respect to claims arising under insurance policies,
- Thirty-five claim files contained evidence that the insurer refused to pay claims without conducting a reasonable investigation based upon all available information,
- Forty-four claim files contained evidence that the insurer failed to affirm or deny coverage of claims within a reasonable time after proof-of-loss statements were completed,
- Forty-four claim files contained evidence that the insurer did not in attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear,
- Two claim files contained evidence that the insured was compelled to institute litigation to recover amounts due under an insurance policy,

- Twelve claim files contained evidence that the insurer attempted to settle claims for less than the amount to which a reasonable man would have believed he was entitled

- Forty-four claim files contained evidence that the insurer delayed the investigation or payment of claims by requiring the claimant or physician to submit preliminary claim report in addition to requiring the subsequent submission of formal proof-of-loss forms, both of which contain the same information,

- Forty-four claim files contained evidence that the insurer did not promptly settle claims where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

The Company did not adhere to the provisions of NCGS 58-3-225(b)(1) and (e) as 44 claim files contained evidence that the insurer did not pay interest on accidental death or loss of use benefits within 30 calendar days after receipt of the claim in accordance with the annual percentage rate of 18 percent.

At the request of the examiners, recoveries totaling $757,582.67 were issued by the Company to the designated claimants.

The average service time to process a claim payment was 233 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
22 - 30	1	2.2
Over 60	45	97.8
Total	**46**	**100.0**

Based on the Department's findings following the review of the entire population of paid group accidental death and dismemberment claim files, the Company was instructed to provide all claims paid from January 1, 2010 through December 31, 2013 and January 1, 2016 through December 31, 2016 to further examine the Company's claims practices. The Company was instructed to conduct a self-audit of the entire population of 94 claims paid identified for the five- year lookback examination period. The self-audit included a complete and thorough

review of policies effectuated in North Carolina for Accidental Death & Dismemberment claims

interest calculations

The Company did not adhere to the provisions of NCGS 58-63-15 (11)(b), (d),(e),(f),(h),(l) and (m) as 69 claim files contained either one or more violations of the enumerated acts of the Unfair Claim Settlement Practices as follows:

- Twelve claim files did not acknowledge and act reasonably and promptly upon communications with respect to claims arising under insurance policies
- Fifty-four claim files contained evidence that the insurer refused to pay claims without conducting a reasonable investigation based upon all available information
- Sixty-nine claim files contained evidence that the insurer failed to affirm or deny coverage of claims within a reasonable time after proof-of-loss statements were completed
- Sixty-nine claim files contained evidence that the insurer did not in attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear
- Thirty-three claim files contained evidence that the insurer attempted to settle claims for less than the amount to which a reasonable man would have believed he was entitled
- Sixty-nine claim files contained evidence that the insurer delayed the investigation or payment of claims by requiring the claimant or physician to submit preliminary claim report in addition to requiring the subsequent submission of formal proof-of-loss forms, both of which contain the same information
- Sixty-nine claim files contained evidence that the insurer did not promptly settle claims where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage

The Company did not adhere to the provisions of NCGS 58-3-225(b)(1) and (e) as 62 claim files contained evidence that the insurer did not pay interest on accidental death or loss of use benefits within 30 calendar days after receipt of the claim in accordance with the annual percentage rate of 18 percent.

At the request of the examiners, recoveries totaling $1,634,197.87 were issued by the Company to the designated claimants.

The average service time to process a claim payment was 184 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
22 - 30	3	3.2
31 - 60	9	9.6
Over 60	82	87.2
Total	**94**	**100.0**

Group Accidental Death and Dismemberment Claims Denied

The entire population of 50 accidental death & dismemberment claims denied files were reviewed to determine adherence to Company guidelines, compliance with applicable North Carolina statutes and rules, as well as its own policies and procedures. While no adverse trends or unfair trade practices were observed in this section of the examination based on the Department's error ratio threshold, one claim was improperly denied.

At the request of the examiners, a recovery totaling $141,884.44 was issued by the Company to the designated claimant.

The average service time to process a claim denial was 234 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
31 - 60	1	2.0
Over 60	49	98.0
Total	**50**	**100.0**

The North Carolina Department of Insurance conducted a target examination of the Company. Based on the Department's findings following the review of the entire population of denied group accidental death and dismemberment claim files, the Company was instructed to provide all claims denied from January 1, 2010 through December 31, 2013 and

January 1, 2016 through December 31, 2016 to further examine the Company's claims practices. The Company was instructed to conduct a self-audit of the entire population of 102 claims denied identified for the five-year lookback examination period. The self-audit was to include a complete and thorough review of policies effectuated in North Carolina for Accidental Death & Dismemberment claims interest calculations.

No adverse trends or unfair trade practices were observed in this section of the examination.

The average service time to process a claim denial was 237 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
8 - 14	1	1.0
31 - 60	2	2.0
Over 60	99	97.0
Total	**102**	**100.0**

POLICY RESCISSIONS

Individual Life Rescissions

The entire population of eight rescinded life policy files were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. No adverse trends or unfair trade practices were observed in this section of the examination.

The average service time to process a rescission was 263 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	12.5
15 - 21	1	12.5
31 - 60	1	12.5
Over 60	5	62.5
Total	**8**	**100.0**

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Company must implement corrective actions as a result of this target examination. These corrective actions must include but are not limited to compliance with statutory requirements regarding claims. The Company must pay interest on future claims not paid within 30 days of receiving satisfactory proof of loss.

Upon acceptance of the Report the Company shall provide the Department with a statement of corrective action plan to address the violations identified during the examination. The Department will conduct a future investigation, if warranted, to determine if the Company successfully implemented its statement of corrective action.

CONCLUSION

A target examination has been conducted on the market conduct affairs of Gerber Life Insurance Company for the period January 1, 2014, through December 31, 2015. The Five-year look back period dates are January 1, 2010 through December 31, 2013 and January 1, 2013 through December 31,2016 with analyses of certain operations of the Company being conducted through July 9, 2019**.**

This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of third-party administration, claims practices and policy rescissions.

In addition to the undersigned, Shane E. Jordan, MHS, MCM, North Carolina Market Conduct Senior Examiner and Marion A. Flemmings MCM, HIA, HIPAAP, HCSA, North Carolina Market Conduct Senior Examiner participated in this examination.

Respectfully submitted,

Vicki S. Royal, CPM, MCM, ACS, AIAA, AIRC
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Teresa Knowles, ACS
Deputy Commissioner
Market Regulation Division
State of North Carolina