INSTRUCTIONS FOR FORM 5

OVERVIEW

For long-term care insurance reported in the Long-Term Care Insurance Experience Reporting Form 1, Form 2 and Form 3, these lines are the state's portion of the earned premium, incurred claims and number of in force count of lives at end of the year. A schedule must be prepared for each jurisdiction in which the company has long-term care direct earned premiums and/or has direct incurred claims. In addition, a schedule must be prepared that contains the grand total (GT) for the company.

DEFINITIONS AND FORMULAS

Policy forms should be grouped by individual and group and reported on Lines 1 and 2, respectively. The subtotals for these two classes (i.e., individual and group) must be provided. Line 3 is the sum of Lines 1 and 2.

Column 1 – Earned Premiums

Earned premiums reported should be the state amount that is included in the current year of Form 2, Part C, Column 4.

Grand Total Page:

Line 1 should equal the amount in Form 2, Part C, Column 4, Line 1.

Line 2 should equal the amount in Form 2, Part C, Column 4, Line 4.

Line 3 should equal the amount in Form 2, Part C, Column 4, Line 7.

For Line 4 "Actual total reported experience through prior year", the amount will be Line 5 from the previous year's report.

For Line 5 "Actual total reported experience through statement year": should be the state's allocated earned premium for the current year (as reported on Line 3) added to the state's cumulative experience through prior year (as reported on Line 4).

Column 2 – Incurred Claims

Incurred claims reported should be the state amount that is included in the current year of Form 2, Part C, Column 5. Incurred claims should be paid claims in the state plus a reasonable allocation of claim reserves less the reported allocated portion of the prior year's claim reserve. The allocation method should be consistent from year-to-year when estimating reserves for each state.

Grand Total Page:

Line 1 should equal the amount in Form 2, Part C, Column 5, Line 1.

Line 2 should equal the amount in Form 2, Part C, Column 5, Line 4.

Line 3 should equal the amount in Form 2, Part C, Column 5, Line 7.

For Line 4 "Actual total reported experience through prior year", the amount will be Line 5 from the previous year's form.

For Line 5 "Actual total reported experience through statement year": This should be the state's allocated incurred claims for the current year (as reported on Line 3) added to the state's cumulative experience through prior year (as reported on Line 4).

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Column 3 – In Force Count End of Year

The In Force Count End of Year should be the state total used in calculating the In Force Count End of Year in Form 2, Part C, Column 11.

Grand Total Page:

Line 1 should equal the amount in Form 2, Part C, Column 11, Line 1.

Line 2 should equal the amount in Form 2, Part C, Column 11, Line 4.

Line 3 should equal the amount in Form 2, Part C, Column 11, Line 7.

Column 4 – Lives In force End of Year

Actual number of lives in force at the end of the year. Joint policies should be counted by number of lives. Once the state forms are completed, the Lives In force End of Year for all states (Grand Total State Page) LTC Form 5, Column 4, Line 01 should equal LTC Form 1, Column 7, Line A01 + A09 + A17 and Form 5, Line 02 should equal Form 1, Line B01 + B09 + B17. The number of lives for each state for individual policies should be based on the policies that were issued in that state. The number of lives for each state in group policies should be based on the certificates that were issued in that state.

Not for Distribution

ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT

This exhibit is required to be filed no later than April 1.

1. The name of the company must be clearly shown at the top of each page or pages.

2. The Exhibit will show information concerning direct business written on policy forms approved for use in the United States with a final total for all policy forms (including non-U.S. policy forms) on the bottom line of the Exhibit.

   The Exhibit will show information for each listed product for Individual, Group, and Other business categories. Subtotals by product within the individual category are required for all columns.

3. A Summary Page shows a reconciliation with Schedule H for Individual, Group and Credit policies separately and in total for companies filing the Life, Accident and Health, Fraternal and Property/Casualty Annual Statement, and a reconciliation of these policies in total only with the specified exhibits of the Health Annual Statement for companies filing that statement.

4. This Exhibit should not include any data pertaining to double indemnity, waiver of premiums and other disability benefits embodied in life contracts.

5. Include membership charges, modal loadings, and policy fees, if any, with premiums earned (Column 1).

DEFINITIONS

Accident Only or AD&D

Policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents. Types of coverage include student accident, sports accident, travel accident, blanket accident, specific accident or accidental death and dismemberment (AD&D).

Administrative Services Only (ASO) and Administrative Services Contract (ASC)

An uninsured accident and health plan is where an administrator performs administrative services for a third party that is at risk, but has not issued an insurance policy. The health plan bears all of the insurance risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Under an ASO plan, claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the administrator, but only after receiving funds from the plan sponsor that are adequate to fully cover the claim payments. Under an ASC plan, the administrator pays claims from its own bank accounts, and only subsequently receives reimbursement from the plan sponsor.

Comprehensive/Major Medical

Policies that provide fully insured indemnity, HMO, PPO, or Fee for Service coverage for hospital, medical, and surgical expenses. This category excludes Short-Term Medical Insurance, the Federal Employees Health Benefit Program and non-comprehensive coverage such as basic hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as any other coverage described in the other categories of this exhibit.

Not for Distribution

Group business is further segmented under this category as follows (please note there is a separate category for Administrative Services Only/Administrative Services Contract business):

> <u>Single Employer</u>:
>
> > Group policies issued to one employer for the benefit of its employees. This would include affiliated companies that have common ownership.
> >
> > Small Employer: Group policies issued to single employers that are subject to the definition of Small Employer business, when so defined, in the group's state of situs.
> >
> > Other Employer: Group policies issued to single employers that are not defined as Small Employer business.
>
> <u>Multiple Employer Associations and Trusts</u>:
>
> > Group policies that are issued to an association or to a trust. This category also includes policies issued to one or more trustees of a fund established or adopted by two or more employers, or by one or more labor unions or similar employee organizations. The organizations include those that are exempt and also those that are non-exempt from statewide community rating. This category does not exclude policies providing coverage to employees of small employers, as defined in the employer's state of situs.
>
> <u>Other Associations and Discretionary Trusts</u>:
>
> > Group policies issued to associations and trusts that are not included in the Small Employer, Other Employer or Multiple Employer Associations and Trusts group categories. This category does not exclude insurance providing coverage to employees of small employers, as defined in the employer's state of situs. This category does include blanket and franchise accident and sickness insurance, and insurance for any group that includes members other than employees, such as an association that has both employees of participating employers and also individuals as members.
>
> <u>Other Comprehensive/Major Medical</u>:
>
> > Group policies providing comprehensive or major medical benefits that are not included in any of the categories listed above.

Contract Reserves

Reserves set up when, due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim and premium reserves.

Credit

Individual or group policies that provide benefits to a debtor for full or partial repayment of debt associated with a specific loan or other credit transaction upon disability or involuntary unemployment of debtor, except in connection with first mortgage loans. In some states, involuntary unemployment credit insurance is not included in health insurance. This category should not include that type of credit insurance in those states.

Dental

Policies providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw. If dental benefits are part of a comprehensive medical plan, then include data under comprehensive/major medical category.

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Disability Income – Long-Term

Policies that provide a weekly or monthly income benefit for more than five years for individual coverage and more than one year for group coverage for full or partial disability arising from accident and/or sickness. Include policies that provide Overhead Expense Benefits. Does not include credit disability.

Disability Income – Short-Term

Policies that provide a weekly or monthly income benefit for up to five years for individual coverage and up to one year for group coverage for full or partial disability arising from accident and/or sickness. Include policies that provide Overhead Expense Benefits. Does not include credit disability.

Federal Employees Health Benefits Program (FEHBP)

Coverage provided to Federal employees, retirees and their survivors and administered by the Office of Personnel Management.

Group Business

Health insurance where the policy issued to employers, associations, trusts, or other groups covering employees or members and/or their dependents, to whom a certificate of coverage may be provided.

Individual Business

Health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes conversions from group policies.

Limited Benefit

Policies that provide coverage for vision, prescription drug and/or any other single service plan or program. Also include short-term care policies that provide coverage for less than one year for medical and other services provided in a setting other than an acute care unit of the hospital.

Long-Term Care

Policies that provide coverage for not less than one year for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, including policies that provide benefits for cognitive impairment or loss of functional capacity. This includes policies providing only nursing home care, home health care, community based care, or any combination. Do not include coverage provided under comprehensive/major medical policies, Medicare Advantage, or for accelerated death benefit-type products.

Medicaid

Policies issued in association with the Federal/State entitlement program created by Title XIX of the Social Security Act of 1965 that pays for medical assistance for certain individuals and families with low incomes and resources.

Medicare

Policies issued as Medicare Advantage Plans providing Medicare benefits to Medicare eligible beneficiaries created by title XVIII of the Social Security Act of 1965. This includes Medicare Managed Care Plans (i.e., HMO and PPO) and Medicare Private Fee-for-Service Plans. This also includes all Medicare Part D Prescription Drug Coverage through a Medicare Advantage product and whether sold directly to an individual or through a group.

Medicare Part D – Stand-Alone

Stand-alone Part D coverage written through individual contracts; stand-alone Part D coverage written through group contracts and certificates; and Part D coverage written on employer groups where the reporting entity is responsible for reporting claims to the Centers for Medicare & Medicaid Services (CMS).

Not for Distribution

Medicare Supplement

Policies that qualify as Medicare Supplement policy forms as defined in the NAIC Medicare Supplement Insurance Minimum Standards Model Act. This includes standardized plans, pre-standardized plans and Medicare select.

Other Business

Any business that is not included in the Individual Business or Group Business listed above, including credit insurance, stop loss/excess loss, administrative services only and administrative services contract.

Other Group Business

Group policies providing health insurance benefits that are not included in any other group business category of this exhibit should be reported as other group business.

Other Individual Business

Individual policies providing health insurance benefits that are not included in any other individual business category of this exhibit should be reported as other individual business.

Other Medical (Non-Comprehensive)

Policies such as hospital only, hospital confinement, surgical, outpatient indemnity, intensive care, mental health/substance abuse, and organ and tissue transplant (including scheduled type policies), etc. Expense reimbursement and indemnity plans should be included. This category does not include TRICARE/CHAMPUS Supplement, Medicare Supplement, or Federal Employee Health Benefit Program coverage.

Short-Term Medical

Policies that provide major medical coverage for a short period of time, typically 30 to 180 days. These policies may be renewable for multiple periods.

Specified/Named Disease

Policies that provide benefits only for the diagnosis and/or treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem or as a principal sum.

State Children's Health Insurance Program

Policies issued in association with the Federal/State partnership created by title XXI of the Social Security Act.

Stop Loss/Excess Loss

Individual or group policies providing coverage to a health plan, a self-insured employer plan, or a medical provider providing coverage to insure against the risk that any one claim or an entire plan's losses will exceed a specified dollar amount.

Student

Policies that cover students for both accident and health benefits while they are enrolled and attending school or college. These can be either individual policies or group policies sponsored by the school or college.

TRICARE

Policies issued in association with the Department of Defense's health care program for active-duty military, active-duty service families, retirees and their families, and other beneficiaries.

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CROSS REFERENCES AND OTHER INSTRUCTIONS

The Exhibit

Column 1 – Premiums Earned

Fractional premium loadings and policy fees must be included in the Earned Premiums.

The Policy Experience Exhibit requires that the Premiums Earned should be on a direct basis.

Column 2 – Incurred Claims Amount

This column does not include the "Increase in Policy Reserves."

The Policy Experience Exhibit requires that the Incurred Claims should be on a direct basis.

Column 3 – Change in Contract Reserves

The Policy Experience Exhibit requires that the change in contract reserves should be on a direct basis.

Column 4 – Loss Ratio

This is the ratio of the Incurred Claims (Column 2) plus the Change in Contract Reserves (Column 3) to Earned Premiums (Column 1).

Column 5 – Number of Policies or Certificates as of Dec. 31

This is the number of individual policies or group certificates issued to individuals covered under a group policy in force as of December 31 of the reporting year. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Column 6 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of December 31 of the reporting year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Column 7 – Member Months

The sum of total number of lives insured on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

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SUMMARY

Part 1

Columns 1 and 2 should agree to Schedule H – Part 1, Column 1 minus the sum of Columns 3 and 5, Lines 2 and 3, respectively.

Part 2

Columns 1 and 2 should agree to Schedule H – Part 1, Column 3, Lines 2 and 3, respectively.

Part 3

Columns 1 and 2 should agree to Schedule H – Part 1, Column 5, Lines 2 and 3, respectively.

Part 4

Columns 1 and 2 should agree to Schedule H – Part 1, Column 1, Lines 2 and 3, respectively. Column 3 should agree to Schedule H – Part 1 Line 6 less the change in premium deficiency reserve Footnote (a) Schedule H Part 2 current year minus prior year.

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REINSURANCE ATTESTATION SUPPLEMENT

ATTESTATION OF CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER REGARDING REINSURANCE AGREEMENTS

Insurers are required to file a supplement to the annual statement titled "Reinsurance Attestation Supplement" by March 1 each year. All insurers are required to complete and file a signed attestation except for insurers that: (1) do not utilize reinsurance; or (2) in situations where the affiliated or lead company has filed this attestation supplement, only engage in a 100% quota share contract with an affiliate; or (3) in situations where the affiliated or lead company has filed this attestation supplement, have no external cessions and only participate in an intercompany pool.

The following terms or phrases are used within this attestation and are defined as follows to encourage consistent reporting.

All reinsurance contracts for which the reporting entity is taking credit - As discussed in *SSAP No. 62R—Property and Casualty Reinsurance*, Exhibit A question 10, a contract is not defined but is essentially a question of substance. For purposes of this attestation, the insurer should utilize this same guidance. This specifically excludes voluntary and involuntary pools as defined in *SSAP No. 63—Underwriting Pools* as well as residual market mechanisms including Fair Plans and the National Flood Insurance Program, that are included in the voluntary and mandatory pool section of Schedule F of the Annual Financial Statement.

Current financial statement - Represents the annual statement that this attestation applies to. However, even though the current financial statement is prepared on a comparative basis, the current financial statement is not meant to apply to the prior year and should ONLY apply to the current year.

Documentation available for review - *SSAP No. 62R—Property and Casualty Reinsurance*, Exhibit A, question 7 states that the determination of risk transfer is made at contract inception. This attestation requires that all contracts for which risk transfer is not reasonably self-evident, entered into, renewed, or amended on or after January 1, 1994 should have documentation concerning risk transfer and economic intent available for review. To the extent that risk transfer is not considered reasonably self-evident and documentation for the contract(s) is not available for review, a statement to this effect should be included in the exceptions section of this attestation.

Entered into, renewed, or amended on or after January 1, 1994 - This language is included because the risk transfer requirements as set forth in *SSAP No. 62R—Property and Casualty Reinsurance*, (and the Q&A Appendix) were actually adopted by the NAIC in 1994 with this language. Therefore, these requirements have been in place for some time. It applies for all contracts **entered into, renewed, or amended on or after January 1, 1994 and the company is taking credit on it's current financial statements.**

Economic intent - Means the risk that is intended to be transferred to the assuming reinsurer under the reinsurance contract.

Taking credit - As discussed in Appendix A-785 of the *Accounting Practices and Procedures Manual*, credit for reinsurance represents either the establishment of an asset or a reduction of a liability.

There are no separate written or oral agreements - A reinsurance agreement consists of the wording itself (including the reinsurers' individual Interest and Liability Agreements), any amendments, and any documents expressly incorporated by reference in the wording or amendments and considered in the transfer of risk analysis. All other documents will be considered separate written or oral agreements for the purpose of the attestation.

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The below provides a list of what is required within this filing.

The Chief Executive Officer and Chief Financial Officer shall attest, under penalties of perjury, with respect to all reinsurance contracts for which the reporting entity is taking credit on its current financial statement, that to the best of their knowledge and belief after diligent inquiry:

(I) Consistent with *SSAP No. 62R—Property and Casualty Reinsurance*, there are no separate written or oral agreements between the reporting entity (or its affiliates or companies it controls) and the assuming reinsurer that would under any circumstances, reduce, limit, mitigate or otherwise affect any actual or potential loss to the parties under the reinsurance contract, other than inuring contracts that are explicitly defined in the reinsurance contract except as disclosed herein;

(II) For each such reinsurance contract entered into, renewed, or amended on or after January 1, 1994, for which risk transfer is not reasonably considered to be self-evident, documentation concerning the economic intent of the transaction and the risk transfer analysis evidencing the proper accounting treatment, as required by *SSAP No. 62R—Property and Casualty Reinsurance*, is available for review;

(III) The reporting entity complies with all the requirements set forth in *SSAP No. 62R—Property and Casualty Reinsurance*; and

(IV) The reporting entity has appropriate controls in place to monitor the use of reinsurance and adhere to the provisions of *SSAP No. 62R—Property and Casualty Reinsurance*.

If there are any exception(s), that fact should be noted in the Reinsurance Attestation Supplement filed electronically with the NAIC and in hard copy with the domestic regulator (excluding the details of the exceptions). The details of the exceptions shall be filed in a separate hard copy supplement (Exceptions to the Reinsurance Attestation Supplement) with the domestic regulator.

For reporting period ended December 31, 20__

Signed:

______________________	__________	______________________	__________
Chief Executive Officer	Date	Chief Financial Officer	Date

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EXCEPTIONS TO THE REINSURANCE ATTESTATION SUPPLEMENT

All insurers are required to file a supplement to the annual statement titled "Reinsurance Attestation Supplement" by March 1 each year (Supplement 20-1). As stated in the instructions to that filing, if there are any exception(s), that fact should be noted in the attestation filed electronically with the NAIC and in hard copy with the domiciliary state (not the details of the exceptions); the details of the exceptions shall be filed in a separate hard copy supplement (Exceptions to the Reinsurance Attestation Supplement) with the domestic regulator (not with the NAIC).

The Exceptions to the Reinsurance Attestation Supplement should be filed by March 1 by all insurers that had exceptions to the Reinsurance Attestation Supplement 20-1. This supplement SHOULD NOT be filed with the NAIC, either electronically or in hard copy. For those companies completing this Supplement, the following represents an illustration of language that can be included in both Supplement 20-1 and Supplement 21-1 to clarify what is expected of companies that have exceptions to the attestation.

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ILLUSTRATION OF EXCEPTION LANGUAGE FOR THE REINSURANCE ATTESTATION SUPPLEMENT (20-1)

ATTESTATION OF CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER REGARDING REINSURANCE AGREEMENTS (IN PART)

The Company had exceptions to the items listed which are detailed within the Exceptions to the Reinsurance Attestation Supplement (21-1) which are incorporated into this document through reference.

ILLUSTRATION OF THE EXCEPTIONS TO THE REINSURANCE ATTESTATION SUPPLEMENT (21-1)

As noted on the Reinsurance Attestation Supplement (20-1), the Company had exceptions to the items listed on the attestation which are detailed below:

1) …
2) …
3) etc.

ACTUARIAL OPINION SUMMARY SUPPLEMENT

1. For all Companies that are required by their domiciliary state to submit a confidential document entitled Actuarial Opinion Summary (AOS), such document shall be filed with the domiciliary state by March 15 (or by a later date otherwise specified by the domiciliary state). This AOS shall be submitted to a non-domiciliary state within 15 days of request, but no earlier than March 15, provided that the requesting state can demonstrate, through the existence of law or some similar means, that it is able to preserve the confidentiality of the document.

2. The AOS should be consistent with the appropriate Actuarial Standards of Practice (ASOPs), including but not limited to ASOP No. 23, ASOP No. 41 and ASOP No. 43, as promulgated by the Actuarial Standards Board, and Statements of Principles adopted by the Casualty Actuarial Society.

3. Exemptions for filing the AOS are the same as those for filing the Statement of Actuarial Opinion.

4. The AOS contains significant proprietary information. It is expected that the AOS be held confidential; it is not intended for public inspection. The AOS should not be filed with the NAIC and should be kept separate from any copy of the Statement of Actuarial Opinion (Actuarial Opinion) in order to maintain confidentiality of the AOS. The AOS can contain a statement that refers to the Actuarial Opinion and the date of that opinion.

5. The AOS should be signed and dated by the Appointed Actuary who signed the Actuarial Opinion and shall include at least the following:

   A. The Appointed Actuary's range of reasonable estimates for loss and loss adjustment expense reserves, net and gross of reinsurance, when calculated;

   B. The Appointed Actuary's point estimates for loss and loss adjustment expense reserves, net and gross of reinsurance, when calculated;

   C. The Company's carried loss and loss adjustment expense reserves, net and gross of reinsurance;

   D. The difference between the Company's carried reserves and the Appointed Actuary's estimates calculated in A and B, net and gross of reinsurance; and

   E. Where there has been one-year adverse development in excess of 5% of the prior year-end's policyholders' surplus as measured by Schedule P, Part 2 Summary in three (3) or more of the past five (5) calendar years, an explicit description of the reserve elements or management decisions that were the major contributors.

6. The AOS for a pooled Company (as referenced in paragraph 1C of the instructions for the Actuarial Opinion) shall include a statement that the Company is a xx% pool participant. For a non-0% Company, the information provided for paragraph 5 should be numbers after the Company's share of the pool has been applied; specifically, the point or range comparison should be for each statutory Company and should not be for the pool in total. For any 0% pool participant, the information provided for paragraph 5 should be that of the lead company.

7. The net and gross reserve values reported by the Appointed Actuary in the AOS should reconcile to the corresponding values reported in the Insurer's Annual Statement, the Appointed Actuary's Actuarial Opinion and the Actuarial Report. If not, the Appointed Actuary shall provide an explanation of the difference.

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8. The Insurer required to furnish an AOS shall require its Appointed Actuary to notify its Board of Directors in writing within five (5) business days after any determination by the Appointed Actuary that the AOS submitted to the domiciliary commissioner was in error as a result of reliance on data or other information (other than assumptions) that, as of the balance sheet date, was factually incorrect. The AOS shall be considered to be in error if the AOS would have not been issued or would have been materially altered had the correct data or other information been used. The AOS shall not be considered to be in error if it would have been materially altered or not issued solely because of data or information concerning events subsequent to the balance sheet date or because actual results differ from those projected. Notification shall be required when discovery is made between the issuance of the AOS and Dec. 31 of that year. Notification should include a summary of such findings.

   If the Appointed Actuary learns that the data or other information relied upon was factually incorrect, but cannot immediately determine what, if any, changes are needed in the AOS, the Appointed Actuary and the Company should quickly undertake procedures necessary for the Appointed Actuary to make such determination. If the Insurer does not provide the necessary data corrections and other support (including financial support) within ten (10) business days, the Appointed Actuary should proceed with the notification to the Board of Directors and the domiciliary commissioner.

   An Insurer who is notified pursuant to the preceding paragraphs shall forward a copy of the amended AOS to the domiciliary commissioner within five (5) business days of receipt of such and shall provide the Appointed Actuary making the notification with a copy of the letter and amended AOS submitted to the domiciliary commissioner. If the Appointed Actuary fails to receive such copy within the five (5) business day period referred to in the previous sentence, the Appointed Actuary shall notify the domiciliary commissioner within the next five (5) business days that an amended AOS has been finalized.

9. No Appointed Actuary shall be liable in any manner to any person for any statement made in connection with the above paragraphs if such statement is made in a good faith effort to comply with the above paragraphs.

Not for Distribution

SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1, 2 AND 3

The purpose of this supplemental exhibit is to assist state and federal regulators in identifying and defining elements that make up the medical loss ratio as described in Section 2718(b) of the Public Health Service Act (PHSA) and for purposes of submitting a report to the HHS Secretary, as required by Section 2718(a) of the PHSA. The supplemental exhibit is also intended to track and compare financial results of health care business as reported in the annual financial statements. Thus, the numbers included in this supplemental exhibit are not the exact numbers that will be utilized for rebate purposes due to possible revisions for claim reserve run-off subsequent to year-end, statistical credibility concerns and other defined adjustments. (See Cautionary Statement at *www.naic.org/cmte_e_app_blanks.htm*.)

A schedule must be prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical health business, or has direct amounts paid, incurred or unpaid for provisions of health care services. In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company. However, insurers that have no business that would be included in Columns 1 through 9 or 12 of Part 1 for ANY of the states are not required to complete this supplement at all. If an insurer is required to file the supplement, then the insurer must complete Parts 1 and 2 for each state in which the insurer has any health business, even if a particular state will show $0 earned premiums reported in Columns 1 through 9 or 12 of Part 1. Also, Part 3 must be completed for any state in which there are non-zero amounts in Columns 1 through 9 of Part 1. Companies should contact their domiciliary regulator to obtain a waiver of the filing if the only reportable business in Columns 1 through 9 are comprised of closed blocks of small group, large group or individual business that, if totaled across all states, does not equal 1,000 lives in total.

Run-Off and Reinsurance Business

Similarly, insurers in run-off (major medical claims incurred with zero major medical earned premiums) or that only has assumed and no direct written major medical business in any of the states are not required to complete this supplement. However, 100% assumption reinsurance with novation (or 100% indemnity reinsurance for administration of a block of business entered into prior to March 23, 2010 – see HHS Reg. 158.130 (a)(3)) is treated as direct business for purposes of this supplement (included as direct business for the assuming reinsurer and excluded from direct business for the ceding insurer). Otherwise, the reinsurance data required in this supplement is only for use if an insurer writes direct major medical business and also assumes and/or cedes such insurance.

If an insurer has direct earned premiums to include in Columns 1 through 9 or 12 of Part 1, but also has some business in run-off (major medical claims incurred for 2018 policy year and prior, with zero major medical earned premiums or no coverage in place), the run-off claims and expenses results should be reported in Part 1, Columns 1 through 9 or 12. (If an insurer files the supplement and has a state in which the only Columns 1 through 9 or 12 business is run-off business as defined above, the insurer can report the run-off business for that state as if it was other health business; i.e., because the MLR is meaningless for that state, report zero for Columns 1 through 9 or 12 and include the run-off business along with any other health insurance reported in the Other Health Business columns of Parts 1 and 2.)

The allocation of premium and claims between jurisdictions should be based upon situs of the contract. For purpose of this exhibit, situs of the contract is defined as "the jurisdiction in which the contract is issued or delivered as stated in the contract." For individual business sold through an association, the allocation shall be based on the issue state of the certificate of coverage. When the association is made up of employers, it should be reported as large group or small group depending on the size of each employer. For employer business issued through a group trust, the allocation shall be based on the location of each employer. For employer business issued through a multiple employer welfare association the allocation should be based on the location of each employer.

Include only in this schedule the business issued by this reporting entity. Business that is written by an unaffiliated entity as part of a package provided to the consumer (e.g., inpatient written by this legal entity, outpatient written by unaffiliated separate entity) should not be included in this exhibit. Similarly, business written by an affiliated legal entity as part of a package provided as an option to the group employer (e.g., out of network coverage written by an affiliated entity and in-network coverage written via this legal entity) should not be included in this exhibit.

Not for Distribution

Comprehensive health coverage, Columns 1 through 3, includes business that provides for medical coverages including hospital, surgical and major medical. Include risk contracts and Federal Employees Health Benefit Plan (FEHBP), stand-alone plan and any other comprehensive plan addressed in PPACA and not excluded. Exclude mini-med plans, expatriate plans and student health plans, as these are reported in Columns 4 through 9. Stand-alone plans (e.g., stand-alone pharmacy) excluding Medicare Part D stand-alone addressed in PPACA and not excluded should be reported in the appropriate column that corresponds to the details of the plan.

Do not include business specifically identified in other columns (e.g., uninsured business, Medicare Title XVIII, Medicaid Title XIX, vision only, dental only business, Insurance Program (SCHIP), Medicaid Program Title XXI risk contracts and short-term limited duration insurance). Stop-loss coverage for self-insured groups should be reported in Part 1, Column 11 (Other Health Business).

Not for Distribution

COLUMN DEFINITIONS FOR SUPPLEMENTAL HEALTH CARE EXHIBIT – PARTS 1 AND 2

Where specifically stated, the reporting instructions and definitions contained in the supplement should be used. When not specifically stated, use the annual statement instructions and definitions. Amounts reported in the columns below are mutually exclusive to each other and should not be duplicated in another column.

Column 1 – Comprehensive Health Coverage – Individual

Include: Health insurance where the policy is issued to an individual covering the individual and/or their dependents in the individual market. This includes group conversion policies.

Column 2 – Comprehensive Health Coverage – Small Group Employer

All policies issued to small group employers.

Include small group health plans. "Small group health plan" means a health plan offered in the small group market as such term is defined in state law, consistent with the group's state of situs reporting, in accordance with the Public Health Service Act.

Column 3 – Comprehensive Health Coverage – Large Group Employer

All policies issued to large group employers (including Federal Employees Health Benefit Plan and similar insured state and local fully insured programs).

Include: TRICARE plans.

Column 4 – Mini-med plans – Individual
Column 5 – Mini-med plans – Small Group Employer
Column 6 – Mini-med plans – Large Group Employer

Include "mini-med" plans also referred to as "limited benefit indemnity health insurance plans" in Section 158.120(d)(3) of the MLR Interim Final Rule for policies that have a total annual limit of $250,000 or less.

The definition of individual, small group employer and large group employer is the same definition as used for Comprehensive Health Coverage (Columns 1 through 3) above.

Column 7 – Expatriate plans – Small Group
Column 8 – Expatriate plans – Large Group

Include expatriate plans referenced in Section 158.120(d)(4) of the MLR Interim Final Rule as policies that provide coverage for employees, substantially all of whom are: working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country.

These policies can be reported on a nationwide, aggregated basis, in the respective small group/large group columns. The amounts should be reported on the appropriate, domiciliary state page.

Column 9 – Student Health Plans

Include student health plans referenced in Section 147.145(a) of the MLR Interim Final Rule

These policies can be reported on a nationwide, aggregated basis. The amounts should be reported on the appropriate, domiciliary state page.

Not for Distribution

Column 10 – Government Business (Excluded by Statute)

Include government programs that are excluded by statute, such as Medicaid Title XIX, State Children's Health Insurance Program (SCHIP), Medicaid Program Title XXI risk contracts and other federal or state government-sponsored coverage. Exclude Medicare Advantage Part C and Medicare Part D stand-alone plans subject to the ACA reported in Column 12.

Column 11 – Other Health Business

Other Business (Excluded by Statute):

Health plan arrangements that do not provide comprehensive coverage as defined by statute.

Include short-term limited duration insurance and Medicare supplemental health coverage as defined under Section 1882(g)(1) of the Social Security Act, if offered as a separate policy, including student health plans meeting this criteria. Include coverage supplemental to the coverage provided under chapter 55 of title 10, United State Code, and similar supplemental coverage provided under a group health plan, hospital or other fixed indemnity coverage, specified disease or illness coverage and other limited benefit plans as specified by regulations promulgated by HHS in consultation with the NAIC.

All other health care business included in the Accident and Health Experience Exhibit that is not reported in Columns 1 through 10 or 12, including the stand-alone dental and vision coverages, long-term care, disability income, etc.

For insurers that assume health business via aggregate stop-loss reinsurance or other reinsurance that applied to a reinsured entity's or group of entities' entire business that would not be allocable to comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student plans in Columns 1 through 9 of Parts 1 and 2 of the supplement: report such assumed reinsurance on Line 1.1 (premiums) and Line 5.1 (claims) in Column 11 (Other Health Business) for the state page corresponding to the **ceding** insurer's state of domicile.

Column 12 – Medicare Advantage Part C and Medicare Part D Stand-Alone Plans Subject to ACA

Include Medicare Advantage Part C plans as referenced in Section 1103 of Title 1, Subpart B of the federal Reconciliation Act, and Medicare Part D plans as referenced in Section 1860D-12(b)(3)(D) of the federal Affordable Care Act.

These policies can be reported on an aggregated basis on the domiciliary state page.

Not for Distribution

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1

(To Be Filed By April 1 – Not for Rebate Purposes – See Cautionary Statement at *www.naic.org/cmte_e_app_blanks.htm*.)

Column 14 – Uninsured Plans

Refer to *SSAP No. 47—Uninsured Plans* for additional guidance.

Line 1.1 – Health Premiums Earned

Include: Direct written premium plus the change in unearned premium reserves.

Premiums earned on novated policies and on 100% assumption reinsurance where policyholders have consented (via opt-in or failure to opt-out) to the replacement of the original policy issuer (including cases where full servicing of premiums and claims have been transferred) by the assuming reinsurer.

Columns 1 through 13 should equal Part 2, Line 1.11, Columns 1 through 13, respectively.

Line 1.2 – Federal High-Risk Pools

Include: Subsidies received or (assessments paid) under federal high-risk pools as provided in PPACA of 2010 [HR. 3590 – cite sections for initial high-risk and future-risk adjustment mechanisms].

Line 1.3 – State High-Risk Pools

Include: Subsidies received or (assessments paid) under state high-risk pools.

Exclude: Items included on Line 2.4.

Line 1.5 – Federal Taxes and Federal Assessments

Refer to *SSAP No. 101—Income Taxes* for "current income taxes incurred."

Include: All federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the federal Public Health Service Act. Risk adjustment user fees shall be treated as government assessments.

Federal reinsurance contributions required under Section 1341 of the federal Affordable Care Act, including the assessments payable for administration expenses and U.S. Treasury assessments.

Exclude: Federal income taxes on investment income and capital gains.

Not for Distribution

Line 1.6 – State Insurance, Premium and Other Taxes and Assessments

Include: Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the state directly; premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the state; or market stabilization redistributions, or cost transfers for the purpose of rate subsidies, not directly tied to claims and that are authorized by state law.

Guaranty fund assessments.

Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states.

Advertising required by law, regulation or ruling, except advertising associated with investments.

State income, excise and business taxes other than premium taxes.

State premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes.

In lieu of reporting state premium taxes, the reporting entity may choose to report payment for community benefit expenditures** limited to the highest premium tax rate in the state for which the report is being submitted, **but not both**.

Exclude: State sales taxes, if company does not exercise the option of including such taxes with the cost of goods and services purchased.

Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes.

Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

Line 1.6a – Community Benefit Expenditures (informational only)

Include: Allowed Community Benefit Expenditures described below and included here and on Line 1.6, limited to premiums earned on comprehensive health policies (individual, small group and large group business), mini-med plans (individual, small group and large group business) and expatriate plans. (small group and large group business) multiplied by the highest state premium tax rate applicable to entities subject to premium tax.

EITHER*:

a. Payments to a state, by health plans, of premium tax exemption values in lieu of state premium taxes;

b. Payments by health plans for community benefit expenditures.** These payments must be state-based requirements to qualify for inclusion in this line item;

OR

Not for Distribution

c. Payments made by (federal income) tax-exempt health plans for community benefit expenditures.** (NOTE: If the instruction for Line 1.5 above is revised to exclude federal income taxes, then tax-exempt health plans may NOT include community benefit expenditures in this line.)

Exclude: Any community benefit expenses in excess of the tax rate limitation. Such excess expenses will be reported on line 10.4a (informational) and included in line 10.4.

* These expenditures may not be double-counted between this category; the federal or state assessments for similar purposes included in Lines 1.5 or 1.6; or the quality improvement expenses reported in Lines 6.1 through 6.4.

** Community benefit expenditures are for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relieve government burden. This includes activities that:

- Are available broadly to the public and serve low-income consumers;
- Reduce geographic, financial or cultural barriers to accessing health services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);
- Address federal, state or local public health priorities, such as advancing health care knowledge through education or research that benefits the public;
- Leverage or enhance public health department activities, such as childhood immunization efforts; or
- Otherwise would become the responsibility of government or another tax-exempt organization.

Line 1.7 – Regulatory Authority Licenses and Fees

Include: Statutory assessments to defray operating expenses of any state insurance department. Examination fees in lieu of premium taxes as specified by state law.

Exclude: Fines and penalties of regulatory authorities.

Fees for examinations by state departments other than as referenced above.

Line 1.9 – Net Assumed Less Ceded Reinsurance Premiums Earned

The amount to net against the assumed reinsurance premiums earned is the ceded reinsurance premiums written plus the change in unearned premium reserve that is transferred to the company assuming the risk plus the change in reserve credit taken other than for unearned premiums.

Should agree with Supplemental Health Care Exhibit, Part 2, Line 1.12 plus Line 1.13 less Line 1.14 for each column.

Line 1.10 – Other Adjustments Due to MLR Calculations – Premiums

Any amounts excluded from premiums in Part 2 for MLR calculation purposes. Should agree with Supplemental Health Care Exhibit, Part 2, Line 1.15.

Not for Distribution

Line 1.11 – Risk Revenue

Include: Amounts charged by the reporting entity as a provider or intermediary for specified medical services (e.g., full professional, dental, radiology, etc.) provided to the policyholders or members of another insurer or reporting entity.

Unlike premiums that are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payment, made by another insurer or reporting entity to the reporting entity in exchange for services to be provided or offered by such organization.

Health Statement:

Column 13 should equal Statement of Revenue and Expense, Line [illegible], Column 2.

Line 2 – Claims

Health Statement:

Column 13, Lines 2.2 minus 2.3 should equal Statement of Revenue and Expense, Line 13, Column 2.

Line 2.1 – Incurred Claims Excluding Prescription Drugs

Include: Direct Paid Claims during the Year

Report payments before ceded reinsurance, but net of risk-share amount collected.

Change in Unpaid Claims

Report the change between prior year and current year unpaid claims reserves including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation.

Change in Incurred but not Reported

Report the change in claims incurred but not reported from prior year to current year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure, claim frequency or severity.

Change in Contract & Other Claims Related Reserves (including the Change in Reserve for Rate Credits).

Exclude: MLR rebates paid during the year.

Prescription drugs reported in Line 2.2.

Pharmaceutical rebates received during the year, reported in Line 2.3.

Medical incentive pools and bonuses.

Not for Distribution

Line 2.2 – Prescription Drugs

Include: Expenses for prescription drugs and other pharmacy benefits covered by the reporting entity.

Exclude: Prescription drug charges that are included in a hospital billing that should be classified as Hospital/Medical Benefits on Line 2.1.

Line 2.3 – Pharmaceutical Rebates

Refer to *SSAP No. 84—Health Care and Government Insured Plan Receivables* for accounting guidance.

Line 2.4 – State Stop Loss, Market Stabilization and Claim/Census Based Assessments (Informational Only)

Any market stabilization payments or receipts by insurers that are directly tied to claims incurred and other claims based or census based assessments.

State subsidies based on a stop-loss payment methodology.

Unsubsidized state programs designed to address distribution of health risks across health insurers via charges to low risk-carriers that are distributed to high risk carriers.

Refer to *SSAP No. 35R—Guaranty Fund and Other Assessments* for accounting guidance.

Line 3 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk-sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers to promote quality improvements as defined in the PHSA (Section 2717).

Should agree to Supplemental Health Care Exhibit, Part 2, Line 2.11, for each column.

<u>Health Statement</u>:

Column 15 should equal Underwriting and Investment Exhibit, Part 2, Line 13, Column 1 minus 10.

Line 4 – Deductible Fraud and Abuse Detection/Recovery Expenses

This amount is the lesser of the expense reported in Part 3, Column 7, Lines 1.11, 2.11, 3.11, 4.11, 5.11, 6.11, 7.11, 8.11 and 9.11, and the fraud and abuse recoveries reported in Part 2, Line 3, Columns 1, 2, 3, 4, 5, 6, 7, 8 and 9, respectively.

Line 5.0 – Total Incurred Claims (Lines 2.1 + 2.2 – 2.3 + 3)

Should agree with Supplemental Health Care Exhibit, Part 2, Line 2.15.

Line 5.1 – Net Assumed Less Ceded Reinsurance Claims Incurred

Assumed reinsurance claims paid plus the change in the assumed reinsurance claims liability and aggregate assumed reinsurance claims reserve less the ceded reinsurance claims paid plus the change in the ceded reinsurance claims liability and aggregate ceded reinsurance claims reserve less the change in claims related reinsurance recoverables.

Should agree with Supplemental Health Care Exhibit, Part 2, Line 2.16 plus Line 2.17, less Line 2.18, for each column.

Not for Distribution

Line 5.2 – Other Adjustments Due to MLR Calculation – Claims

Any amounts excluded from claims in Part 2 for MLR calculation purposes.

Deduct: MLR rebated incurred included in Line 5.0

Line 5.3 – Rebates Paid

MLR Rebates paid during the year.

Columns 1 through 3 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(8), Columns 1 through 3, respectively.

Sum of Columns 4 through 9 plus 12 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(8), Column 4.

Line 5.4 – Estimated Rebates Unpaid at the End of the Prior Year

Should equal Line 5.5 from the prior year.

Columns 1 through 3 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(3), Columns 1 through 3, respectively.

Sum of Columns 4 through 9 plus 12 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(3), Column 4.

Line 5.5 – Estimated Rebates Unpaid at the End of the Current Year

MLR rebates estimated but unpaid as of reporting period.

Columns 1 through 3 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(9), Columns 1 through 3, respectively.

Sum of Columns 4 through 9 plus 12 should equal Note 24, Retrospectively Rated Contracts & Contracts Subject to Redetermination, Line 24D(9), Column 4.

This cross-check is for the year-end annual statement accrual for the Public Health Service Act rebates to Supplemental Health Care Exhibit, Part 1 April 1 filing. This amount may differ from the final payment made in accordance with the HHS filing.

Line 5.6 – Fee-for-Service and Co-Pay Revenue (net of expenses)

Include: Revenue recognized by the reporting entity for collection of co-payments from members and revenue derived from health services rendered by reporting entity providers that are not included in member policies.

Deduct: Medical expenses associated with fee-for-service business.

Not for Distribution

Line 6.1 – Improve Health Outcomes

Include expenses meeting the definition of Improve Health Outcomes in Part 3, Column 1 that are not health information technology expenses.

Part 1, Column 1, Line 6.1 should tie to Part 3, Column 1, Line 1.10

Part 1, Column 2, Line 6.1 should tie to Part 3, Column 1, Line 2.10

Part 1, Column 3, Line 6.1 should tie to Part 3, Column 1, Line 3.10

Part 1, Column 4, Line 6.1 should tie to Part 3, Column 1, Line 4.10

Part 1, Column 5, Line 6.1 should tie to Part 3, Column 1, Line 5.10

Part 1, Column 6, Line 6.1 should tie to Part 3, Column 1, Line 6.10

Part 1, Column 7, Line 6.1 should tie to Part 3, Column 1, Line 7.10

Part 1, Column 8, Line 6.1 should tie to Part 3, Column 1, Line 8.10

Part 1, Column 9, Line 6.1 should tie to Part 3, Column 1, Line 9.10

Line 6.2 – Activities to Prevent Hospital Readmissions

Include expenses meeting the definition of Improving Activities to Prevent Hospital Readmissions in Part 3, Column 2 that are not health information technology expenses.

Part 1, Column 1, Line 6.2 should tie to Part 3, Column 2, Line 1.10

Part 1, Column 2, Line 6.2 should tie to Part 3, Column 2, Line 2.10

Part 1, Column 3, Line 6.2 should tie to Part 3, Column 2, Line 3.10

Part 1, Column 4, Line 6.2 should tie to Part 3, Column 2, Line 4.10

Part 1, Column 5, Line 6.2 should tie to Part 3, Column 2, Line 5.10

Part 1, Column 6, Line 6.2 should tie to Part 3, Column 2, Line 6.10

Part 1, Column 7, Line 6.2 should tie to Part 3, Column 2, Line 7.10

Part 1, Column 8, Line 6.2 should tie to Part 3, Column 2, Line 8.10

Part 1, Column 9, Line 6.2 should tie to Part 3, Column 2, Line 9.10

Line 6.3 – Improve Patient Safety and Reduce Medical Errors

Include expenses meeting the definition of Improve Patient Safety and Reduce Medical Errors in Part 3, Column 3 that are not health information technology expenses.

Part 1, Column 1, Line 6.3 should tie to Part 3, Column 3, Line 1.10

Part 1, Column 2, Line 6.3 should tie to Part 3, Column 3, Line 2.10

Part 1, Column 3, Line 6.3 should tie to Part 3, Column 3, Line 3.10

Part 1, Column 4, Line 6.3 should tie to Part 3, Column 3, Line 4.10

Part 1, Column 5, Line 6.3 should tie to Part 3, Column 3, Line 5.10

Part 1, Column 6, Line 6.3 should tie to Part 3, Column 3, Line 6.10

Part 1, Column 7, Line 6.3 should tie to Part 3, Column 3, Line 7.10

Part 1, Column 8, Line 6.3 should tie to Part 3, Column 3, Line 8.10

Part 1, Column 9, Line 6.3 should tie to Part 3, Column 3, Line 9.10

Not for Distribution

Line 6.4 – Wellness and Health Promotion Activities

Include expenses meeting the definition of Wellness and Health Promotion Activities in Part 3, Column 4 that are not health information technology expenses.

Part 1, Column 1, Line 6.4 should tie to Part 3, Column 4, Line 1.10

Part 1, Column 2, Line 6.4 should tie to Part 3, Column 4, Line 2.10

Part 1, Column 3, Line 6.4 should tie to Part 3, Column 4, Line 3.10

Part 1, Column 4, Line 6.4 should tie to Part 3, Column 4, Line 4.10

Part 1, Column 5, Line 6.4 should tie to Part 3, Column 4, Line 5.10

Part 1, Column 6, Line 6.4 should tie to Part 3, Column 4, Line 6.10

Part 1, Column 7, Line 6.4 should tie to Part 3, Column 4, Line 7.10

Part 1, Column 8, Line 6.4 should tie to Part 3, Column 4, Line 8.10

Part 1, Column 9, Line 6.4 should tie to Part 3, Column 4, Line 9.10

Line 6.5 – Health Information Technology Expenses related to Health Improvement

Include expenses meeting the definition of HIT Expenses for Health Care Quality Improvements in Part 3, Column 5 that are health information technology expenses. Include ICD-10 conversion costs incurred up to .3% of earned premium related to quality improvement. (Refer to 45 CFR 158.150 of PPACA.) Exclude ICD-10 expenses related to claims adjudication or maintenance.

Part 1, Column 1, Line 6.5 should tie to Part 3, Column 5, Line 1.10

Part 1, Column 2, Line 6.5 should tie to Part 3, Column 5, Line 2.10

Part 1, Column 3, Line 6.5 should tie to Part 3, Column 5, Line 3.10

Part 1, Column 4, Line 6.5 should tie to Part 3, Column 5, Line 4.10

Part 1, Column 5, Line 6.5 should tie to Part 3, Column 5, Line 5.10

Part 1, Column 6, Line 6.5 should tie to Part 3, Column 5, Line 6.10

Part 1, Column 7, Line 6.5 should tie to Part 3, Column 5, Line 7.10

Part 1, Column 8, Line 6.5 should tie to Part 3, Column 5, Line 8.10

Part 1, Column 9, Line 6.5 should tie to Part 3, Column 5, Line 9.10

Not for Distribution

Line 8.1 – Cost Containment Expenses not Included in Quality of Care Expenses in Line 6.6

Include: Expenses that actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses that improve the quality of health care (reported in Line 6.6). The following are examples of items that shall be considered "cost containment expenses" only if they result in reduced levels of costs or services (see the instructions for Part 3 of this supplement for items that qualify for Quality Improvement instead of "cost containment"):

Post and concurrent claim case management activities associated with past or ongoing specific care;

Utilization review;

Detection and prevention of payment for fraudulent requests for reimbursement;

Expenses for internal and external appeals processes; and

Network access fees to preferred provider organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting.

Line 8.2 – All Other Claims Adjustment Expenses

All Other Claims Adjustment Expenses not Included in Quality of Care Expenses in Line 6.6.

Include: Costs expected to be incurred in connection with the adjustment and recording of accident and health claims defined in *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*. Further, Claim Adjustment Expenses for Managed Care Reporting Entities are those costs expected to be incurred in connection with the adjustment and recording of managed care claims defined in *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*.

Examples of other claim adjustment expenses are:

Estimating the amounts of losses and disbursing loss payments;

Maintaining records, general clerical and secretarial;

Office maintenance, occupancy costs, utilities and computer maintenance;

Supervisory and executive duties; and

Supplies and postage.

Not for Distribution

Line 10 – General and Administrative Expenses

General and Administrative Expenses not Included in Line 6.6 or Line 8.3.

Line 10.1 – Direct Sales Salaries and Benefits

Compensation (including, but not limited, to salaries and benefits) to employees of the company engaged in the activity of soliciting and generating sales to policyholders for the company.

Line 10.2 – Agents and Brokers Fees and Commissions

All expenses incurred by the company payable to a licensed agent, broker or producer who is not an employee of the issuer in relation to the sale and solicitation of policies for the company.

Line 10.3 – Other Taxes (Excluding Taxes on Lines 1.5 through 1.7 above and Line 14 below)

Include: Taxes of Canada or of any other foreign country not specifically provided for elsewhere.

Sales taxes, other than state sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased.

Line 10.4a – Community Benefit Expenditures (informational only; already reported in line 10.4)

Community benefit expenditures excluded from line 1.6a due to tax rate limitation.

Line 16 – ICD-10 Implementation Expenses (Informational only; already included in Line 8.2 and Line 6.5)

Costs associated the implementation of ICD-10, including the total cost of conversion, claims adjudication, maintenance and quality improvement allowance.

Line 16a – ICD-10 Implementation Expenses (Informational only, already included in Line 6.5)

Include: Quality improvement ICD-10 conversion costs incurred up to .3% of earned premium in the relevant state market. (Refer to 45 CFR 158.150 of PPACA.)

Not for Distribution

OTHER INDICATORS

These should be allocated to jurisdictions in the same manner as premium.

Line 1 – Number of Certificates / Policies

This is the number of individual policies (for individual business) or certificates issued to individuals covered under a group policy in force as of end of the reporting period. It is not the number of persons covered under individual policies or group certificates. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Column 15 should equal Accident and Health Policy Experience Exhibit Column [illegible], Line D2 – D1.

Line 2 – Number of Covered Lives

This is the total number of lives insured, including dependents, under individual policies and group certificates as of the reporting period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Column 15 should equal Accident and Health Policy Experience Exhibit Column 6, Line D2 – D1.

Line 3 – Number of Groups

This is the total number of insurance groups issued as of the end of the reporting period.

Line 4 – Member Months

The sum of total number of lives insured on a pre-specified day of each month of the reported period. Reasonable approximations are allowed when exact information is not administratively available to the insurer.

Column 15 should equal Accident and Health Policy Experience Exhibit Column 7, Line D2 – D1.

Not for Distribution

ACA RECEIPTS, PAYMENTS, RECEIVABLES and PAYABLES TABLE

Permanent ACA Risk Adjustment Program

The amounts from the lines below for Column 1, Individual Plans and Column 2, Small Group Employer Plans, are included in the amount reported on Line 1.1 of Part 2:

Line 1.0	Premium adjustments receivable/(payable)
Line 4.0	Premium adjustments receipts/(payments)

Transitional ACA Reinsurance Program

The amounts from the lines below for Column 1, Individual Plans, are included in the amount reported on Line 2.17 and Line 2.18 of Part 2:

Line 2.0	Amounts recoverable for claims (paid & unpaid)
Line 5.0	Amounts received for claims

Temporary ACA Risk Corridors Program

The amounts from the lines below for Column 1, Individual Plans and Column 2, Small Group Employer Plans, are included in the amount reported on Line 1.6 of Part 2:

Line 3.1	Accrued retrospective premium
Line 3.2	Reserve for rate credits or policy experience refunds

The amounts from the lines below for Column 1, Individual Plans and Column 2, Small Group Employer Plans, are included in the amount reported on Line 1.5 of Part 2:

Line 6.1	Retrospective premium received
Line 6.2	Rate credits or policy experience refunds paid

Not for Distribution

Column 13 – Total

For Part 2, the GT (Grand Total) page:

- Column 13, Line 1.16 (Net Premiums Earned) should equal the Accident and Health Policy Experience Exhibit, Part 4, Column 1, Line 6 (Total) minus Line 2 (Other Forms Direct Business).
- Column 13, Line 1.11 (Total Direct Premiums Earned) minus Line 1.5 (Paid Rate Credits) minus Line 1.8 (Change in Reserve for Rate Credits) plus Line 1.15 (Other Adjustments Due to MLR Calculation – Premiums) should equal the Accident and Health Policy Experience Exhibit, Part 4, Column 1, Line 1 (U.S. Forms Direct Business).
- Column 13, Line 2.20 (Net Incurred Claims) minus Line 2.11 (Incurred Medical Incentive Pools and Bonuses) should equal the Accident and Health Policy Experience Exhibit, Part 4, Columns 2 plus 3, Line 6 (Total) minus Line 2 (Other Forms Direct Business).
- Column 13, Line 2.15 (Total Incurred Claims) minus Line 2.8 (Paid Rate Credits) minus Line 2.9 (Reserve for Rate Credits Current Year) plus Line 2.10 (Reserve for Rate Credits Prior Year) minus Line 2.11 (Incurred Medical Incentive Pools and Bonuses) plus Line 2.19 (Other Adjustments Due to MLR Calculation – Claims) should equal the Accident and Health Policy Experience Exhibit, Part 4, Columns 2 plus 3, Line 1 (U.S. Forms Direct Business).

NOTE: If the reporting entity has a Premium Deficiency Reserve, they will fail the crosschecks above due to the Accident and Health Policy Experience Exhibit excluding Premium Deficiency Reserve. The reporting entity should provide that explanation for the crosscheck failure.

Lines 1.1 – Direct Premiums Written

Include: Premium adjustments for contracts subject to redetermination where premium adjustments are based on the risk scores (health status) of covered enrollees, rather than the actual loss experience of the policy (e.g., Medicare Advantage risk adjustment and ACA risk adjustment). See *SSAP No. 54R—Individual and Group Accident and Health Contracts* and *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act* for accounting guidance.

Exclude: Amounts for rate credits paid. Premium adjustments related to retrospectively rated contracts are reported on Part 2 Line 1.5 through Line 1.8.

Line 1.5 – Paid Rate Credits

Report experience-rated premium refunds paid or received during the reporting year for retrospectively rated contracts.

Include: MLR rebates paid, risk corridor premiums paid or received, and all other premium refunds paid or received related to retrospectively rated contracts. See *SSAP No. 66—Retrospectively Rated Contracts* and *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act* for accounting guidance.

Not for Distribution

Line 1.6 – Reserve for Rate Credits Current Year

Report experience-rated refund liabilities less receivables under retrospectively rated contracts.

Include: MLR rebates accrued, premium stabilization reserves and risk corridor liabilities less receivables.

Line 1.9 – Premium Balances Written Off

Include: Agents' or premium balances determined to be uncollectible and written off as losses. Also include recoveries during the current year on balances previously written off. Include actual write offs, not reserves for bad debt or statutory nonadmitted amounts.

Line 1.10 – Group Conversion Charges

If Line 1.1 has been reduced or increased by the amount of any conversion charges associated with group conversion privileges between group and individual lines of business in the annual statement accounting, enter the reverse of these charges on this line in the appropriate columns.

Line 1.11 – Total Direct Health Premiums Earned

Include: Direct written premium plus the change in unearned premium reserves.

Line 1.12 – Assumed Premium Earned from Non-affiliates

Include: Premiums assumed from ceding entity per *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance.*

Line 1.13 – Net Assumed Less Ceded Premiums Earned from Affiliates

Include: Premiums received from ceding entity and ceded premium per *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance.*

Line 1.14 – Ceded Premium Earned to Non-affiliates

Include: Assessments payable for reinsurance for issuers of individual policies per *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act* and ceded premium per *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance.*

Line 1.15 – Other Adjustments Due to MLR Calculation – Premiums

Include: Any amounts excluded from premium for MLR calculation purposes that are normally included in premiums for financial statement purposes.

Do Not Include: MLR rebates or any other premium adjustment related to retrospectively rated contracts as those amounts are to be reported on Part 2 Line 1.5 through Line 1.8.

Not for Distribution

Line 2 – Direct Claims Incurred:

<u>Hospital/Medical Benefits</u>

Include:

Expenses for physician services provided under contractual arrangement to the reporting entity.

Salaries, including fringe benefits, paid to physicians for delivery of medical services. Capitation payments by the reporting entity to physicians for delivery of medical services to reporting entity subscribers.

Fees paid by the reporting entity to physicians on a fee-for-service basis for delivery of medical services to reporting entity subscribers. This includes capitated referrals.

Inpatient hospital costs of routine and ancillary services for reporting entity members while confined to an acute care hospital.

Charges for non-reporting entity physician services provided in a hospital are included in this line item only if included as an undefined portion of charges by a hospital to the reporting entity. (If separately itemized or billed, physician charges should be included in outside referrals, below.)

The cost of utilizing skilled nursing and intermediate care facilities.

Routine hospital service includes regular room and board (including intensive care units, coronary care units and other special inpatient hospital units), dietary and nursing services, medical-surgical supplies, medical social services and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.

Ancillary services may also include laboratory, radiology, drugs, delivery room, physical therapy services, other special items and services for which charges are customarily made in addition to a routine service charge.

Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation service.

Intermediate care facilities are for individuals who do not require the degree of care and treatment that a hospital or skilled nursing-care facility provides, but that do require care and services above the level of room and board.

<u>Other Professional Services</u>

Include:

Expenses for other professional providers under contractual arrangement to the reporting entity.

Salaries, as well as fringe benefits, paid by the reporting entity to non-physician providers licensed, accredited or certified to perform specified clinical health services, consistent with state law, engaged in the delivery of medical services to reporting entity enrollees. Capitation payments by the reporting entity to such clinical service

Compensation to personnel engaged in activities in direct support of the provision of medical services.

Not for Distribution

Exclude:	Professional services not meeting this definition. Report these services as administrative expenses. For example, exclude compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks.

Outside Referrals

Include:	Expenses for providers not under arrangement with the reporting entity to provide services, such as consultations or out-of-network providers.

Emergency Room and Out-of-Area

Include:	Expenses for other health delivery services, including emergency room costs incurred by members for which the reporting entity is responsible and out-of-area service costs for emergency physician and hospital. In the event a member is admitted to the health care facility immediately after seeking emergency room service, emergency service expenses are reported in this line, the expenses after admission are reported in the hospital/medical line, provided the member is seeking services in the service area. Out-of-area expenses incurred, whether emergency or hospital, are reported in this line.

Aggregate Write-ins for Other Hospital and Medical

Include:	Other hospital and medical expenses not covered in the other claims accounts.

Line 2.1 Paid Claims during the Year

Report payments net of risk share amount collected.

Line 2.2 – Direct Claim Liability Current Year

Report the outstanding liabilities for health care services related to claims in the process of adjustment, incurred but not reported, amounts withheld from paid claims and capitations.

Include: Unpaid Claims

Report the current year unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation.

Incurred but not Reported

Report the claims incurred but not reported in the current year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure, claim frequency or severity.

The direct claims related portion of lawsuit liability as reported on the Liabilities Page 3, Line 4.2 (Life Statement), Line 1, (Health Statement) and Line 1 (Property Statement).

Not for Distribution

Line 2.4 – Direct Claim Reserves Current Year

Report reserves related to health care services for present value of amounts not yet due on claims and the claims related portion for reserve for future contingent benefits.

Include: Amounts for the reserve for rate credits for the current year.

The direct claims related portion of lawsuit reserves as reported on the Liabilities Page 3, Line 2 (Life Statement), Line 7 (Health Statement) and Line 1 (Property Statement).

Line 2.6 – Direct Contract Reserve Current Year

Report the amount of reserves required when due to the gross premium structure the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves. Refer to *SSAP No. 54R—Individual and Group Accident and Health Contracts* for guidance.

Include: Contract reserves and other claims related reserves.

Exclude: Premium deficiency reserves.

Line 2.8 – Paid Rate Credits

Report experience-rated premium refunds paid or received during the reporting year for retrospectively rated contracts.

Include: MLR rebates paid, risk corridor premiums paid or received, and all other premium refunds paid or received related to retrospectively rated contracts.

Line 2.9 – Reserve for Rate Credits Current Year

Report experience-rated refund liabilities less receivables under retrospectively rated contracts.

Include: MLR rebates accrued, premium stabilization reserves, and risk corridor liabilities less receivables.

Line 2.11 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk-sharing arrangements whereby the reporting entity agrees to share savings with contracted providers.

Line 2.12 – Net Health Care Receivables

Report the change between prior year health care receivables and current year health care receivables. The amounts on this line are the gross health care receivable assets, not just the admitted portion. This amount should not include those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Line 2.13 – Group Conversion Charges

If Line 1.1 has been reduced or increased by the amount of any conversion charges associated with group conversion privileges between group and individual lines of business in the annual statement accounting, enter the reverse of these charges on this line. Otherwise, if group conversion charges were reported separately from premiums and claims on the annual statement, enter these charges on this line in the appropriate columns.

Not for Distribution

Line 2.14 – Multi-option Coverage Blended Rate Adjustment

If multi-option coverage is provided to a single employer at blended rates, which are defined as cross-subsidized rates charged for coverage provided by a single employer through two or more affiliates, the reporting entity may make an adjustment to bring each affiliate's ratio of incurred claims to earned premium to equal the ratio calculated for that employer group in aggregate for the MLR reporting year. If the reporting entity chooses to make this adjustment, it must be made for a minimum of three years. (This does NOT include dual contract amounts for in network and out of network coverage.)

Line 2.15 – Total Incurred Claims

Should agree to Supplemental Health Care Exhibit, Part 1, Line 5.0.

Line 2.19 – Other Adjustments Due to MLR Calculation – Claims

Include: Any amounts excluded from claims for MLR calculation purposes that are normally included in claims for financial statement purposes. For example, premium deficiency reserves are excluded from contract reserves for MLR purposes in Part 2; thus, premium deficiency reserves would be included on this Line. Include the adjustment for multi-option coverage amounts (if offsetting line 2.14, report as a negative amount).

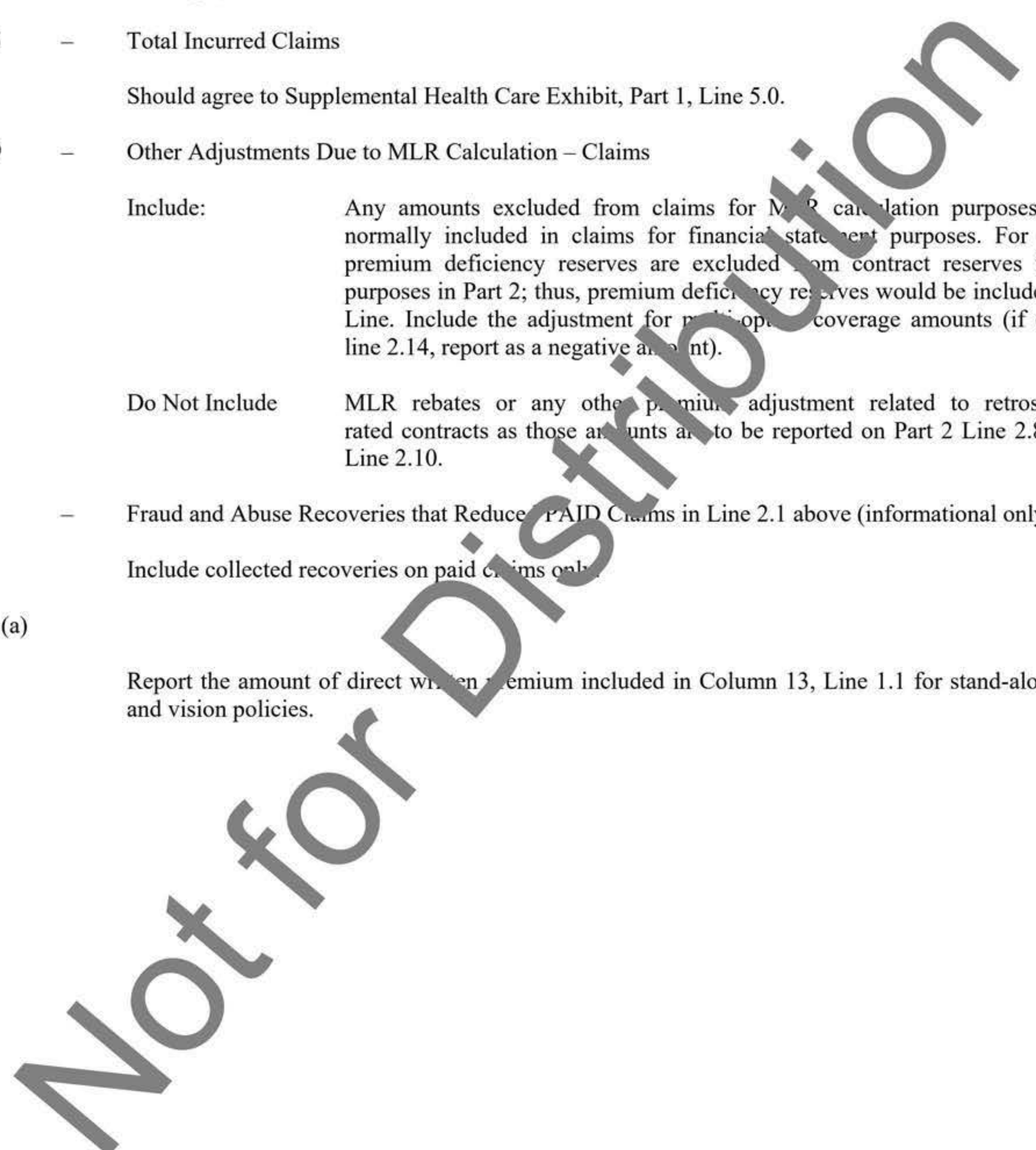
Do Not Include MLR rebates or any other premium adjustment related to retrospectively rated contracts as those amounts are to be reported on Part 2 Line 2.8 through Line 2.10.

Line 3 – Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)

Include collected recoveries on paid claims only.

Footnote (a)

Report the amount of direct written premium included in Column 13, Line 1.1 for stand-alone dental and vision policies.



SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

This exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student health plans.

This exhibit also shows the amount of qualifying HIT expenses, reported separately for the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student health plans, broken down into the four categories of Quality Improvement expenses (see below); similarly, the Other than HIT qualifying Quality Improvement expenses are disclosed for each of the four categories of Quality Improvement expenses.

The definitions of Individual, Small Group and Large Group are found in the instructions for Parts 1 and 2 of this supplement exhibit.

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage, as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans.

Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

They should not be designed primarily to control or contain cost, although they may have cost-reducing or cost-neutral benefits, as long as the primary focus is to improve quality.

Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency and outcomes.

NOTE: Expenses that otherwise meet the definitions for QI but were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

Not for Distribution

Column 1 – Improve Health Outcomes

Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, Web-based interactions or other means of communication) to improve health outcomes as defined above.

This category can include costs for associated activities such as:

- Effective case management, care coordination and chronic disease management, including:
  - Patient-centered intervention, such as:
    - Making/verifying appointments;
    - Medication and care compliance initiatives;
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center);
    - Programs to support shared decision-making with patients, their families and the patient's representatives; and
    - Reminding insured of physician appointments, lab tests or other appropriate contact with specific providers;
  - Incorporating feedback from the insured to effectively monitor compliance;
  - Providing coaching or other support to encourage compliance with evidence-based medicine;
  - Activities to identify and encourage evidence-based medicine;
  - Use of the medical homes model as defined for purposes of Section 3602 of PPACA;
  - Activities to prevent avoidable hospital admissions;
  - Education and participation in self-management programs; and
  - Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;
- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1 through 5;
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine;
- Quality reporting and documentation of care in non-electronic format; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.

Not for Distribution

Column 2 – Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions as defined above, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help ensure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Personalized post-discharge counseling by an appropriate health care professional;
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.

Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors (as defined above) through:

- The appropriate identification and use of best clinical practices to avoid harm;
- Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions), including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.

Column 4 – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or Web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition; and
- Public health education campaigns that are performed in conjunction with state or local health departments.

Not for Distribution

- Actual rewards/incentives/bonuses/reductions in co-pays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:
    - Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit;
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and
- Health information technology expenses to support these activities (Report in Column 5 – See instructions).

Column 5 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers or enrollees for the electronic creation, maintenance, access or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, in the following ways:

1. Monitoring, measuring or reporting clinical effectiveness, including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations, such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law;
2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient-centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic health records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history;
3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; or
5. Provision of electronic health records and patient portals.
6. ICD-10 conversion costs incurred up to .3% of earned premium related to quality improvement. (Refer to 45 CFR 158.150 of PPACA).

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the ICD-10 conversion costs not related to quality improvement and ICD-10 conversion costs incurred that are in excess of .3% of earned premium that are related to quality improvement.

Not for Distribution

NOTE:

a. Health Care Professional Hotlines: Expenses for health care professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.

b. Prospective Utilization Review: Expenses for prospective utilization review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

The following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent utilization review;
- Fraud prevention activities (all are reported as cost containment, but Part 1, Line [illegible] includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider credentialing;
- Marketing expenses;
- Any accreditation fees that are not directly related to activities included in Columns 1 through 5;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.

NOTE: The NAIC will review requests to include expenses for broadly excluded activities and activities not described under Columns 1 through 5 above. Upon an adequate showing that the activity's costs support the definitions and purposes therein, or otherwise support monitoring, measuring, or reporting health care quality improvement, the NAIC may recommend that the HHS Secretary certify those expenses as Quality Improvement.

The sections for comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business) and expatriate plans (small group and large group business) are defined as per the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), expatriate plans (small group and large group business) and student health plans columns in Parts 1 and 2 of this supplement.

For questions on definitions, refer to the instructions for the Annual Statement Expenses Schedule (i.e., the Underwriting and Investment Exhibit, Part 3 for P/C and Health, and Exhibit 2 for Life and Fraternal), for the line references provided below. **DIFFERENT FROM A/S EXPENSE REPORTING**: For non-affiliated management agreements/outsourced services, report all amounts in the supplement's Line 1.2, 2.2, 3.2, 4.2, 5.2, 6.2, 7.2 , 8.2 or 9.2 for Outsourced Services (not just those amounts less than 10% of total expenses). Continue to allocate all affiliated management agreements/outsourced services to the appropriate expense lines as if the costs had been borne directly by the insurer.

Not for Distribution

Lines 1.1, 2.1,
3.1, 4.1, 5.1,
6.1, 7.1, 8.1
& 9.1 – Salaries

Life/Fraternal Statement:

Exhibit 2, Line 2 Salaries and wages

Exhibit 2, Line 3.11 Contributions for benefit plans for employees

Exhibit 2, Line 3.12 Contributions for benefit plans for agents

Exhibit 2, Line 3.21 Payments to employees under non-funded benefit plans

Exhibit 2, Line 3.22 Payments to agents under non-funded benefit plans

Exhibit 2, Line 3.31 Other employee welfare

Exhibit 2, Line 3.32 Other agent welfare

Health Statement:

U&I Part 3, Line 2 Salaries, wages and other benefits

P/C Statement:

U&I Part 3, Line 8.1 Salaries

U&I Part 3, Line 9 Employee relations and welfare

U&I Part 3, Line 11 Directors' fees

Lines 1.2, 2.2,
3.2, 4.2, 5.2,
6.2, 7.2, 8.2
& 9.2 – Outsourced Services

Include: All non-affiliated expenses for administrative services, claim management services, EDP programming, membership services, and other similar services, regardless of amount. Thus, non-affiliated amounts greater than the 10% threshold that are reported in the various expense categories (e.g., salaries, rent) for A/S Expense Exhibit reporting will be backed out of the expense categories and reported in Outsourced Services in the Supplemental Health Care Exhibit, Part 3. In addition, the non-affiliated amounts less than the 10% threshold will be included in Outsourced Services (reported as follows in the A/S Expense Exhibit):

Life/Fraternal Statement:

Exhibit 2, Line 4.5 Expense of investigation and settlement of policy claims

Outsourced portion of Exhibit 2, Line 7.1 Agency expense allowance

Health Statement:

U&I Part 3, Line 14 Outsourced services including EDP, claims, and other services

P/C Statement:

Outsourced portion of U&I Part 3, Line 1.4 Net claim adjustment services

Outsourced portion of U&I Part 3, Line 2.8 Net commission/brokerage

Outsourced portion of U&I Part 3, Line 3 Allowances to manager and agents

Exclude: Services provided by affiliates under management agreements.

Not for Distribution

Lines 1.3, 2.3,
3.3, 4.3, 5.3,
6.3, 7.3, 8.3
& 9.3 – EDP Equipment and Software

Life/Fraternal Statement:

Exhibit 2, Line 5.7 Cost or depreciation of EDP equipment and software

Health Statement:

U&I Part 3, Line 13 Cost or depreciation of EDP equipment and software

P/C Statement:

U&I Part 3, Line 15 Cost or depreciation of EDP equipment and software

Lines 1.4, 2.4,
3.4, 4.4, 5.4,
6.4, 7.4, 8.4
& 9.4 – Other Equipment (excluding EDP)

Life/Fraternal Statement:

Exhibit 2, Line 5.6 Rental of equipment

Equipment amounts from Exhibit 2, Line 5.5 Cost or depreciation of furniture/equipment

Health Statement:

U&I Part 3, Line 12 Equipment

P/C Statement:

U&I Part 3, Line 14 Equipment

Lines 1.5, 2.5,
3.5, 4.5, 5.5,
6.5, 7.5, 8.5
& 9.5 – Accreditation and Certification

Include: Fees associated with the certification and accreditation of a health plan, including but not limited to: fees paid to Joint Commission on Accreditation of Health Care Organizations (JCAHO), National Committee on Quality Assurance (NCQA), and American Accreditation Health Care Commission (URAC).

Life/Fraternal Statement:

Applicable portion of Exhibit 2, Line 6.2 Bureau and association fees

Health Statement:

U&I Part 3, Line 5 Certification and Accreditation

P/C Statement:

Applicable portion of U&I Part 3, Line 5 Boards, bureaus and associations

Exclude: Rating agencies and other similar organizations.

Not for Distribution

Lines 1.6, 2.6,
3.6, 4.6, 5.6,
6.6, 7.6, 8.6
& 9.6 – Other Expenses

Include: Any additional expenses not included in another category.

<u>Life/Fraternal Statement</u>:

Exhibit 2, Line 1 Rent

Exhibit 2, Line 4.1 Legal fees and expenses

Exhibit 2, Line 4.2 Medical examination fees

Exhibit 2, Line 4.3 Inspection report fees

Exhibit 2, Line 4.4 Fees of public accountants and consulting actuaries

Exhibit 2, Line 5.1 Traveling expenses

Exhibit 2, Line 5.2 Advertising

Exhibit 2, Line 5.3 Postage, express, telegraph and telephone

Exhibit 2, Line 5.4 Printing and stationery

Furniture portion of Exhibit 2, Line 5.5 Cost or depreciation of furniture/equipment

Exhibit 2, Line 6.1 Books and periodicals

Non-accreditation portion of Exhibit 2, Line 6.2 Bureau and association fees

Exhibit 2, Line 6.3 Insurance, except on real estate

Exhibit 2, Line 6.4 Miscellaneous losses

Exhibit 2, Line 6.5 Collection and bank service charges

Exhibit 2, Line 6.6 Sundry general expenses

In house portion of Exhibit 2, Line 7.1 Agency expense allowance

Exhibit 2, Line 7.2 Agents' balances charged off (less $__ recovered)

Exhibit 2, Line 7.3 Agency conferences other than local meetings

Exhibit 2, Line 9.1 Real estate expenses

Exhibit 2, Line 9.2 Investment expenses not included elsewhere

Exhibit 2, Line 9.3 Aggregate write-ins for expenses

Not for Distribution

Health Statement:

U&I Part 3, Line 1 Rent

U&I Part 3, Line 3 Commissions

U&I Part 3, Line 4 Legal fees

U&I Part 3, Line 6 Auditing, actuarial and other consulting

U&I Part 3, Line 7 Traveling expenses

U&I Part 3, Line 8 Marketing and advertising

U&I Part 3, Line 9 Postage, express and telephone

U&I Part 3, Line 10 Printing and office supplies

U&I Part 3, Line 11 Occupancy, depreciation and amortization

U&I Part 3, Line 15 Boards, bureaus and association fees

U&I Part 3, Line 16 Insurance, except on real estate

U&I Part 3, Line 17 Collection and bank service charges

U&I Part 3, Line 18 Group service and administration fees

U&I Part 3, Line 21 Real estate expenses

U&I Part 3, Line 24 Investment expenses not included elsewhere

U&I Part 3, Line 25 Aggregate write-ins

P/C Statement:

In house portion of U&I Part 3, Line 1.4 Net claim adjustment services

In house portion of U&I Part 3, Line 2.8 Net commission/brokerage

In house portion of U&I Part 3, Line 3 Allowances to manager and agents

U&I Part 3, Line 4 Advertising

Non-accreditation portion of U&I Part 3, Line 5 Boards, bureaus and associations

U&I Part 3, Line 6 Surveys and underwriting reports

U&I Part 3, Line 7 Audit of assured's records

U&I Part 3, Line 10 Insurance

U&I Part 3, Line 12 Travel and travel items

U&I Part 3, Line 13 Rent and rent items

U&I Part 3, Line 16 Printing and stationery

U&I Part 3, Line 17 Postage, telephone and telegraph, exchange and express

U&I Part 3, Line 18 Legal and auditing

U&I Part 3, Line 21 Real estate expenses

U&I Part 3, Line 24 Aggregate write-ins

Not for Distribution

Lines 1.8, 2.8,
3.8, 4.8, 5.8,
6.8, 7.8, 8.8
& 9.8 – Reimbursement by uninsured plans and fiscal intermediaries

Life Statement:

Exhibit 2, Line 6.7 Group service and administration fees

Exhibit 2, Line 6.8 Reimbursements by uninsured plans

Health Statement:

U&I Part 3, Line 19 Reimbursements by uninsured plans

U&I Part 3, Line 20 Reimbursements from fiscal intermediaries (e.g., Medicare, CHAMPUS, other governmental)

P/C Statement:

U&I Part 3, Line 23 Reimbursements by uninsured plans

Lines 1.9, 2.9,
3.9, 4.9, 5.9,
6.9, 7.9, 8.9
& 9.9 – Taxes, Licenses and Fees

Life Statement:

Exhibit 3, Line 1 Real estate taxes

Exhibit 3, Line 2 State insurance department licenses and fees

Exhibit 3, Line 3 State taxes on premiums

Exhibit 3, Line 4 Other state taxes, incl $__ for employee benefits

Exhibit 3, Line 5 U.S. Social Security taxes

Exhibit 3, Line 6 All other taxes

Fraternal Statement:

Exhibit 3, Line 1 Real estate taxes

Exhibit 3, Line 2 State insurance department licenses and fees

Exhibit 3, Line 3 Other state taxes, incl $__ for employee benefits

Exhibit 3, Line 4 U.S. Social Security taxes

Exhibit 3, Line 5 All other taxes

Health Statement:

U&I Part 3, Line 22 Real Estate Taxes

U&I Part 3, Line 23.1 State and local insurance taxes

U&I Part 3, Line 23.2 State premium taxes

U&I Part 3, Line 23.3 Regulatory authority licenses and fees

U&I Part 3, Line 23.4 Payroll taxes

U&I Part 3, Line 23.5 Other (excluding federal income and real estate)

Not for Distribution

P/C Statement:

U&I Part 3, Line 8.2 Payroll taxes

U&I Part 3, Line 20.1 State and local insurance taxes, deducting guaranty association credits of $___

U&I Part 3, Line 20.2 Insurance department licenses and fees

U&I Part 3, Line 20.3 Gross guaranty association assessments

U&I Part 3, Line 20.4 All other taxes, licenses and fees (excluding federal and foreign income and real estate)

U&I Part 3, Line 22 Real estate taxes

Lines 1.11, 2.11, 3.11, 4.11, 5.11, 6.11, 7.11, 8.11 & 9.11 – Total Fraud and Abuse Detection/Recovery Expenses Included in Column 7 (Informational Only)

Include: Fraud and abuse detection and recovery expenses as well as prevention expenses.

Not for Distribution

EXPENSE ALLOCATION SUPPLEMENTAL FILING

A single (not state-by-state), separate, regulator-only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each state and to each line and column on Part 3.

Additionally, companies reporting QI expenses in Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above.

The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing, as well. For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an "X" in the "New" column of the supplement and include in the description the expected time frame for the activity to accomplish the objective, verifiable results.

Expenses for prospective utilization review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an "E" in the "New" column. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

Expense Type from Part 3	Line Number
Improve Health Outcomes	1.0001 – 1.9999
Activities to Prevent Hospital Readmission	2.0001 – 2.9999
Improve Patient Safety and Reduce Medical Errors	3.0001 – 3.9999
Wellness & Health Promotion Activities	4.0001 – 4.9999
HIT Expenses for Health Care Quality Improvements	5.0001 – 5.9999

Not for Distribution

CYBERSECURITY AND IDENTITY THEFT INSURANCE COVERAGE SUPPLEMENT
GENERAL INSTRUCTIONS

This supplement should be completed by those reporting entities including surplus line insurers and Risk Retention Groups that provide cybersecurity insurance and identity theft insurance in a stand-alone policy or as part of a package policy. If the reporting entity's answer to Questions 1, 2, 4 and 5 of Part 1 would be "no," the reporting entity should not complete the supplement. If the reporting entity answers "yes" to any of those questions, the supplement should be completed. The supplement should be reported on a direct basis (before assumed and ceded reinsurance).

Cybersecurity Insurance

For the purposes of this reporting form, cybersecurity insurance applies to commercial insurance through a single policy or multi-peril coverage part solely intended to assist in helping manage risks associated with exposures arising out of network intrusions and improper handling of electronic data, including data such as personally identifiable information and other sensitive information in electronic form. The risks covered may include one or more of the following:

- Identity theft as a result of privacy violations and security breaches where sensitive information is stolen by an unauthorized person or inadvertently disclosed and includes identity restoration costs.
- Business interruption and extra expense from an unauthorized person preventing access to the Internet, the policyholder's website or other parts of the policyholder's network.
- Costs associated with restoring data from electronic or paper records that have been damaged by an unauthorized person.
- Costs related to a data breach such as forensic investigations, legal advice, public relations, notification and regulatory expenses.
- Exposure arising out of theft or loss of client's or customer's digital assets.
- Introduction of malware, worms and other malicious computer code to third parties.
- Cyber extortion against the policyholder.
- Liability and damages resulting from network failures.

Identity Theft Insurance

For the purposes of this reporting form, identity theft insurance applies to personal lines insurance through a single policy or as part of another personal lines coverage that covers only identity theft and identity theft restoration

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CYBERSECURITY AND IDENTITY THEFT INSURANCE COVERAGE SUPPLEMENT
PART 2 – STAND-ALONE POLICIES
POLICY AND CLAIMS DATA

If the reporting entity answers "yes" to either Question 1 or Question 4 of Part 1, then Part 2 should be completed. Part 2 should be reported on a direct basis (before assumed and ceded reinsurance).

Column 1 – Cybersecurity Insurance

This column only applies to commercial lines.

Column 2 – Identity Theft Insurance

This column only applies to personal lines.

Line 7 – Number of Policies in Force – Claims-Made

For Column 1, Cybersecurity Insurance, provide the number of claims-made policies in force.

Line 8 – Number of Policies in Force – Occurrence

For Column 1, Cybersecurity Insurance, provide the number of occurrence policies in force.

Line 9 – Number of Policies in Force – Total

Line 9 should equal Line 7 plus Line 8 for Column 1, Cybersecurity Insurance.

Provide the total number of policies in force for Column 2, Identity Theft Insurance.

Line 10 – Number of Claims Reported – First-Party

For Column 1, Cybersecurity Insurance, provide the number of first-party claims reported by incident.

Line 11 – Number of Claims Reported – Third-Party

For Column 1, Cybersecurity Insurance, provide the number of third-party claims reported by incident.

Line 12 – Number of Claims Reported – Total

Line 12 should equal Line 10 plus Line 11 for Column 1, Cybersecurity Insurance.

Provide the total number of claims reported for Column 2, Identity Theft Insurance.

Line 13 – Number of Claims Open – First-Party

For Column 1, Cybersecurity Insurance, provide the number of first-party claims open by incident.

Line 14 – Number of Claims Open – Third-Party

For Column 1, Cybersecurity Insurance, provide the number of third-party claims open by incident.

Line 15 – Number of Claims Open – Total

Line 15 should equal Line 13 plus Line 14 for Column 1, Cybersecurity Insurance.

Provide the total number of claims open for Column 2, Identity Theft Insurance.

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Line 16 – Number of Claims Closed with Payment – First-Party

For Column 1, Cybersecurity Insurance, provide the number of first-party claims closed with payment by incident.

Line 17 – Number of Claims Closed with Payment – Third-Party

For Column 1, Cybersecurity Insurance, provide the number of third-party claims closed with payment by incident.

Line 18 – Number of Claims Closed with Payment – Total

Line 18 should equal Line 16 plus Line 17 for Column 1, Cybersecurity Insurance.

Provide the total number of claims closed with payment for Column 2, Identity Theft Insurance.

Line 19 – Number of Claims Closed Without Payment – First-Party

For Column 1, Cybersecurity Insurance, provide the number of first-party claims closed without payment by incident.

Line 20 – Number of Claims Closed Without Payment – Third-Party

For Column 1, Cybersecurity Insurance, provide the number of third-party claims closed without payment by incident.

Line 21 – Number of Claims Closed Without Payment – Total

Line 21 should equal Line 19 plus Line 20 for Column 1, Cybersecurity Insurance.

Provide the total number of claims closed without payment for Column 2, Identity Theft Insurance.

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CYBERSECURITY AND IDENTITY THEFT INSURANCE COVERAGE SUPPLEMENT
PART 3 – PART OF A PACKAGE POLICY
POLICY AND CLAIMS DATA

If the reporting entity answers "yes" to either Question 2 or Question 5 of Part 1, then Part 3 should be completed. Part 3 should be reported on a direct basis (before assumed and ceded reinsurance), including quantified and estimated premiums.

Column 1 – Cybersecurity Insurance

This column only applies to commercial lines.

Column 2 – Identity Theft Insurance

This column only applies to personal lines.

Line 9 – Number of Policies in Force – Claims-Made

For Column 1, Cybersecurity Insurance, provide the number of claims-made policies in force.

Line 10 – Number of Policies in Force – Occurrence

For Column 1, Cybersecurity Insurance, provide the number of occurrence policies in force.

Line 11 – Number of Policies in Force – Total

Line 11 should equal Line 9 plus Line 10 for Column 1, Cybersecurity Insurance.

Provide the total number of policies in force for Column 2, Identity Theft Insurance.

Line 12 – Number of Claims Reported – First-Party

For Column 1, Cybersecurity Insurance, provide the number of first-party claims reported by incident.

Line 13 – Number of Claims Reported – Third-Party

For Column 1, Cybersecurity Insurance, provide the number of third-party claims reported by incident.

Line 14 – Number of Claims Reported – Total

Line 14 should equal Line 12 plus Line 13 for Column 1, Cybersecurity Insurance.

Provide the total number of claims reported for Column 2, Identity Theft Insurance.

Line 15 – Number of Claims Open – First-Party

For Column 1, Cybersecurity Insurance, provide the number of first-party claims open by incident.

Line 16 – Number of Claims Open – Third-Party

For Column 1, Cybersecurity Insurance, provide the number of third-party claims open by incident.

Line 17 – Number of Claims Open – Total

Line 17 should equal Line 15 plus Line 16 for Column 1, Cybersecurity Insurance.

Provide the total number of claims open for Column 2, Identity Theft Insurance.

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Line 18 – Number of Claims Closed with Payment – First-Party

For Column 1, Cybersecurity Insurance, provide the number of first-party claims closed with payment by incident.

Line 19 – Number of Claims Closed with Payment – Third-Party

For Column 1, Cybersecurity Insurance, provide the number of third-party claims closed with payment by incident.

Line 20 – Number of Claims Closed with Payment – Total

Line 20 should equal Line 18 plus Line 19 for Column 1, Cybersecurity Insurance.

Provide the total number of claims closed with payment for Column 2, Identity Theft Insurance.

Line 21 – Number of Claims Closed Without Payment – First-Party

For Column 1, Cybersecurity Insurance, provide the number of first-party claims closed without payment by incident.

Line 22 – Number of Claims Closed Without Payment – Third-Party

For Column 1, Cybersecurity Insurance, provide the number of third-party claims closed without payment by incident.

Line 23 – Number of Claims Closed Without Payment – Total

Line 23 should equal Line 21 plus Line 22 for Column 1, Cybersecurity Insurance.

Provide the total number of claims closed without payment for Column 2, Identity Theft Insurance.

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LIFE, HEALTH AND ANNUITY GUARANTY ASSOCIATION MODEL ACT ASSESSMENT BASE RECONCILIATION EXHIBIT

The exhibit for any state, District of Columbia and Puerto Rico in which the company is licensed should be submitted to that jurisdiction. In addition, an exhibit should be prepared for any state, District of Columbia and Puerto Rico in which the company received any direct premiums or deposits. DO NOT SUBMIT exhibits for American Samoa, Guam, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions. A copy of each jurisdiction and a grand total page for the exhibits that are submitted should be sent to the state of domicile and the NAIC Support and Services Office.

Only companies that are members of the life, health and annuity guaranty associations should complete this exhibit. If a company is unsure if it is a member of a life, health and annuity guaranty association, it should contact the state life, health and annuity guaranty associations in its state of domicile or state(s) where it is licensed to write life, health and annuity business.

For the purpose of these instructions, references to Schedule T apply to the Life and Health blank and references to the Exhibit of Premiums and Losses apply to the Property blank.

The columnar headings correspond to the annual statement, Schedule T (Life or Health blank) or Exhibit of Premiums and Losses (Property blank) as follows:

Health Blank Schedule T Column Reference	Col. 6 Life & Annuity Premiums & Other Considerations (In part)	Col. 6 Life & Annuity Premiums & Other Considerations (In part)	Col. 2-5 Accident and Health Insurance Premiums	Col. 9 Deposit-type Contract Funds	Col. 6 Life & Annuity Premiums & Other Considerations (In part)
Base Exhibit	Col. 1 Life Insurance Premiums	Col. 2 Annuity Considerations	Col. 3 A & H Premiums	Col. 4 Deposit-Type Contract Funds	Col. 4 Other Considerations

Life Blank Schedule T Column Reference	Col. 2 Life Contracts – Life Insurance Premiums	Col. 3 Life Contracts – Annuity Considerations	Col. 4 Accident and Health Insurance Premiums	Col. 7 Deposit-Type Contract Funds	Col. 5 Other Considerations
Base Exhibit	Col. 1 Life Insurance Premiums	Col. 2 Annuity Considerations	Col. 3 A & H Premiums	Col. 4 Deposit-Type Contract Funds	Col. 4 Other Considerations

Property Blank Exhibit of Premiums and Losses (Statutory Page 14) Column and Lines Reference			Col. 1 Direct Premiums Written Lines 13-15.8 (Various Accident and Health Insurance Premiums)		
Base Exhibit	Col. 1 Life Insurance Premiums	Col. 2 Annuity Considerations	Col. 3 A & H Premiums	Col. 4 Deposit-Type Contract Funds	Col. 4 Other Considerations

In the event that this detailed information is not available in the reporting entity's accounting records, recognized allocation to estimation processes may be utilized if consistently applied.

Adjustments to the exhibit may be required by states that have not adopted the *Life and Health Insurance Guaranty Association Model Act* (#520).

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PURPOSE OF THE LIFE, HEALTH AND ANNUITY GUARANTY ASSOCIATION MODEL ACT ASSESSMENT BASE RECONCILIATION EXHIBIT

It is desirable to display on one page the various types of annuity considerations, deposit-type contract funds and other considerations received directly by the reporting entity, separated by state, as is currently reported in the applicable Schedule T or Exhibit of Premiums and Losses. However, it is not possible to use such data for state guaranty association assessments without further modification. This is because of: (a) the limits placed on certain considerations for assessment purposes; (b) the variations by states in designation of "funds" for assessments; and (c) other factors that are interpreted differently by the individual states.

As a result, the NAIC has developed a specific exhibit, the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit ("Base Reconciliation Exhibit) which uses the state figures in Schedule T or Exhibit of Premiums and Losses as the starting point for development of the guaranty association assessment base (as defined in the NAIC *Life and Health Insurance Guaranty Association Model Act* (#520)). States should not use Schedule T or Exhibit of Premiums and Losses as the basis for guaranty association assessments, but instead use the Base Reconciliation Exhibit as the starting point.

Introduction

These instructions are intended to assist companies in completing the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (Base Reconciliation Exhibit) and Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (Adjustments Exhibit).

The Base Reconciliation Exhibit starts with premiums, deposit-type contract funds and other considerations as reported in the applicable Schedule T or Exhibit of Premiums and Losses and then makes necessary adjustments (both positive and negative) to establish the premium assessment base as defined by the current Model #520. The Base Reconciliation Exhibit must be completed for each state (as well as the District of Columbia and Puerto Rico) in which the company is licensed or does business.

Should you have questions about how to fill out the Base Reconciliation Exhibit, and the answers are not provided in the instructions below, you may wish to consult the Model #520, particular State Guaranty Acts, the *Annual Statement Instructions* manual, your company attorney, particular State Insurance Departments or particular State Guaranty Association Administrators.

The Base Reconciliation Exhibit has four columns: Column 1 is for all individual and group life insurance premiums; Column 2 is for all individual and group allocated annuity amounts (whether called premiums, deposit-type contract funds or other considerations); Column 3 is for all individual and group accident and health premiums; and Column 4 is for all unallocated annuity amounts (whether called premiums, deposit-type contract funds or other considerations).

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Base Reconciliation Exhibit

Premiums, Considerations and Deposits from Schedule T or the Exhibit of Premiums and Losses

Line 1 – **These amounts must exactly match the amounts reported by your company on Schedule T or the Exhibit of Premiums and Losses for all lines of business.**

Modifications to Premiums, Considerations and Deposits

Lines 2 through 10 are required to adjust amounts reported on your company's Annual Statement Schedule T to its Assessable Premium Base and are critical in transforming premium data prepared for Annual Statement purposes into data suitable for Guaranty Association purposes.

Line 2 – Enter any life, annuity or health premiums, deposit-type contract funds and other considerations received by your company that were not reported on Schedule T or the Exhibit of Premiums and Losses and, therefore, not included in Line 1 above. The total of Line 2 should equal Line 2.1 + Line 2.2. Such amounts should be reported in the appropriate column based on whether such amounts relate to life insurance, annuity, accident and health, or annuity and deposit-type business. Include all amounts received for insurance contracts. Guaranteed investment contract receipts, universal life insurance deposits and any other amounts received by the company for covered contracts that were not reported on the company's Schedule T or the Exhibit of Premiums and Losses (sometimes referred to as FASB 97 deposit reporting) must be reported on Line 2. Annuity amounts entered on Lines 1 and 2 must include, but are not limited to, amounts received for immediate or deferred annuity contracts, structured settlement agreements, lottery contracts, group annuity contracts, guaranteed interest or investment contracts, deposit administration contracts and allocated or unallocated funding obligations. In addition, allocate by state and include on Line 2 amounts reported on the applicable Schedule T as Company Contributions for Employee Benefit Plans (Line 60 (Health blank) or 90 (Life blank) of Schedule T), Dividends Applied to Purchase Paid-Up Additions and Annuities, Dividends Applied to Shorten Endowment or Premium-Paying Period, Premium or Annuity Considerations Waived Under Disability or Other Contract Provisions and Aggregate Other Amounts Not Allocable by State.

Line 2.1 – Enter fees and charges for investment management, administration and contract guarantees from the Separate Account associated with variable contracts reduced by any contractholder dividends representing a return of such fees and charges. Specifically, in the case of variable annuity products, those portions of fees and charges paid to the general account with respect to living and death benefit guarantees, M&E charges and annual contract charges. In the case of variable life products with guaranteed death benefits, the portion of fees/charges paid to the general account would include the cost of insurance in addition to M&E charges and annual contract charges. Because the fees and charges are reportable by state, a reporting entity may use either a seriatim, i.e., specific contract identification by state, or an allocation method. An appropriate allocation method would be to calculate a ratio of fee income to total variable premium for the product line and multiply the ratio by the state specific variable premium.

Line 2.2 – Enter any other life, annuity or health premiums, deposit-type contract funds and other considerations received by your company that were not reported on Schedule T or the Exhibit of Premiums and Losses.

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Lines 3.1 – 3.99 – The primary purpose of Lines 3.1 to 3.99 is to add back amounts that, as a result of statutory accounting practices, were deducted from the amounts reported on Line 1 or 2. For the most part, these deductions represent current year benefit payouts, transfers, surrenders or withdrawals.

Enter any amounts deducted prior to determining amounts included in Lines 1 and 2. Companies reporting net amounts on Lines 1 and 2 must complete Lines 3.1 through 3.99 in order to provide gross premiums and deposits. Amounts reported on these lines should include transfers to separate accounts, GIC rollovers to other companies, surrenders, excess interest, and any other amounts deducted from or not included in the company's gross premium figures. Amounts that were reported as "Deposit-Type Contract Funds and Other Considerations" (Column 4) in the year of receipt and transferred in the current year to "Annuity Considerations" (Column 2), as individuals are "annuitized," are to be included on Line 3.3 of Column 4 if these amounts were deducted from the amounts reported on Lines 1 or 2.

As an example, most pension plan unallocated annuities provide for the purchase of an annuity payout benefit ("annuitization") for an individual. In the year of the receipt of the consideration for the unallocated annuity, that consideration, subject to limitations, is to be included in the total assessment base reported in Line 11, Column 4. In the year of annuitization, the amounts transferred to fund the annuity payout benefits are to be included in the total assessment base reported in Line 11, Column 2. There should be no corresponding reduction to the total assessment base reported in Line 11, Column 4 for the amount transferred to fund the annuitization to the extent that such amounts would not have been included in an assessment base. When an annuity payout benefit is, pursuant to that contract, purchased for an individual from monies previously deposited with the Company, it is assumed that there is no new contract rather, it is an internal rollover of funds, i.e., no new funds have been received by the Company.

In order to correctly report amounts subject to assessment in Columns 2 and 4, companies should maintain transaction level detail for each deposit type contract. On a cumulative basis, the assessable premium can never be less than $0 on any given contract. For example, the following will illustrate the correct reporting of deposit type contracts that partially or fully annuitize in a model act state (i.e., assessable premium up to $5 million per unallocated annuity contract). The amount reported on Line 7.4 is a balancing amount such that the assessable premium for any unallocated contract never exceeds $5 million nor is less than $0 over the life of the contract. The same approach applies to any state that covers unallocated annuities, irrespective of the limits. In this example, there is a $50 million unallocated contract in Year 1 and the company reports $5 million in Column 4. If the contract is completely annuitized in year 2, the company must report $50 million in Column 2 as allocated premium and $50 million on Line 3.3 (as an add-back) in the unallocated premium column. The Company should report a deduction of $5 million on Line 7.4 in Column 4 in the second year, since it has reported the full $50 million received in Column 2 by the end of the second year. On a cumulative basis, $0 is reported in Column 4. The Company has not subjected to assessment more premium than it has received.

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(Millions of Dollars)

Example Contract		YEAR 1				YEAR 2	
		Col. 2	Col. 4			Col. 2	Col. 4
Deposit	50	X	X		0	X	X
Annuitize	0	X	X		50	X	X
Amt. Rep. Lines 1 & 2	X	0	50		X	50	-50
Amt. Rep. Line 3.3	X	X	0		X	0	50
Amt. Rep. Line 5	X	0	50		X	50	0
Amt. Rep. Line 7.4	X	X	45		X	0	5
Amt. Rep. Line 11	X	0	5		X	50	-5
Cumulative All Years Line 11	X	0	5		X	50	0

Four additional examples will further illustrate the correct reporting of deposit type contracts that partially or fully annuitize in a model act state. In these examples, it can be seen that at any point in time, the Company has never included more in the assessable premium base (Columns 2 and 4 combined) than what was received by the Company over that period of time. Also, the Company never included more than $5 million of assessable premium in Column 4 at any point in time.

(Millions of Dollars)

Contract #1		Yr 1			Yr 2			Yr 3			Yr 4			Yr 5			Cum	
		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4
Deposit	5	X	X	5	X	X	5	X	X	5	X	X	5	X	X	25	X	X
Annuitize	1	X	X	3	X	X	2	X	X	1	X	X	8	X	X	15	X	X
Amt. Rep. Lines 1 & 2	X	1	4	X	3	2	X	2	3	X	1	4	X	8	-3	X	15	10
Amt. Rep. Line 3.3	X	X	1	X	X	3	X	X	2	X	X	1	X	X	8	X	X	15
Amt. Rep. Line 5	X	1	[illegible]	X	3	5	X	2	5	X	1	5	X	8	5	X	15	25
Amt. Rep. Line 7.4	X	X	1	X	X	4	X	X	5	X	X	5	X	X	5	X	X	20
Amt. Rep. Line 11	X	1	4	X	3	1	X	2	0	X	1	0	X	8	0	X	15	5
Cumulative All Years Line 11	X	1	4	X	4	5	X	6	5	X	7	5	X	15	5	X	X	X

For Contract #1, the Company received $25 million of deposits and included $20 million in the assessable premium base ($15 million as annuity considerations and $5 million as deposit funds) over the five-year period.

(Millions of Dollars)

Contract #2		Yr 1			Yr 2			Yr 3			Yr 4			Yr 5			Cum	
		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4
Deposit	10	X	X	10	X	X	5	X	X	5	X	X	5	X	X	35	X	X
Annuitize	1	X	X	3	X	X	2	X	X	1	X	X	28	X	X	35	X	X
Amt. Rep. Lines 1 & 2	X	1	9	X	3	7	X	2	3	X	1	4	X	28	-23	X	35	0
Amt. Rep. Line 3.3	X	X	1	X	X	3	X	X	2	X	X	1	X	X	28	X	X	35
Amt. Rep. Line 5	X	1	10	X	3	10	X	2	5	X	1	5	X	28	[illegible]	X	35	35
Amt. Rep. Line 7.4	X	X	5	X	X	10	X	X	5	X	X	5	X	X	10	X	X	35
Amt. Rep. Line 11	X	1	5	X	3	0	X	2	0	X	1	0	X	28	-5	X	35	0
Cumulative All Years Line 11	X	1	5	X	4	5	X	6	5	X	7	5	X	35	0	X	X	X

For Contract #2, the Company received $35 million of deposits and included $35 million in the assessable premium base ($35 million as annuity considerations and $0 as deposit funds) over the five-year period.

(Millions of Dollars)

Contract #3		Yr 1			Yr 2			Yr 3			Yr 4			Yr 5			Cum	
		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4
Deposit	10	X	X	10	X	X	0	X	X	0	X	X	0	X	X	20	X	X
Annuitize	1	X	X	3	X	X	2	X	X	1	X	X	8	X	X	15	X	X
Amt. Rep. Lines 1 & 2	X	1	9	X	3	7	X	2	-2	X	1	-1	X	8	-8	X	15	5
Amt. Rep. Line 3.3	X	0	1	X	X	3	X	X	2	X	X	1	X	X	8	X	X	15
Amt. Rep. Line 5	X	1	10	X	3	10	X	2	0	X	1	0	X	8	0	X	15	20
Amt. Rep. Line 7.4	X	0	5	X	X	10	X	X	0	X	X	0	X	X	0	X	X	15
Amt. Rep. Line 11	X	1	5	X	3	0	X	2	0	X	1	0	X	8	0	X	15	5
Cumulative All Years Line 11	X	1	5	X	4	5	X	6	5	X	7	5	X	15	5	X	X	X

For Contract #3, the Company received $20 million of deposits and included $20 million in the assessable premium base ($15 million as annuity considerations and $5 million as deposit funds) over the five-year period.

(Millions of Dollars)

Contract #4		Yr 1			Yr 2			Yr 3			Yr 4			Yr 5			Cum	
		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4		Col 2	Col 4
Deposit	5	X	X	5	X	X	5	X	X	5	X	X	5	X	X	25	X	X
Annuitize	1	X	X	6	X	X	0	X	X	0	X	X	8	X	X	15	X	X
Amt. Rep. Lines 1 & 2	X	1	4	X	6	-1	X	0	5	X	0	5	X	8	-3	X	15	10
Amt. Rep. Line 3.3	X	X	1	X	X	6	X	X	0	X	X	0	X	X	8	X	X	15
Amt. Rep. Line 5	X	1	5	X	6	5	X	0	5	X	0	5	X	8	[illegible]	[illegible]	15	25
Amt. Rep. Line 7.4	X	X	1	X	X	6	X	X	3	X	X	5	X	X	5	X	X	20
Amt. Rep. Line 11	X	1	4	X	6	-1	X	0	2	X	0	0	X	8	0	X	15	5
Cumulative All Years Line 11	X	1	4	X	7	3	X	7	5	X	7	5	X	15	5	X	X	X

For Contract #4, the Company received $25 million of deposits and included $20 million in the assessable premium base ($15 million as annuity considerations and $5 million as deposit funds) over the five-year period. Contract #4 is different from Contract #1 in that after Year 2, only $3 million has been included in Column 4 since $7 million of the $10 million of deposits received has annuitized. For Year 3, $2 million is included in Column 4 bringing the cumulative total to $5 million, since a total of $15 million has been received, but only $7 million has annuitized.

You must provide a clear explanation of any amounts listed on Lines 3.501, 3.502, 3.503, etc. Line 3.99 (Total) should represent the difference between gross and net premiums for each column.

Line 4.1 – Transfer amounts received to fund annuity contracts qualified under Internal Revenue Code Section 403(b) (sometimes referred to as tax-sheltered annuities) from the Annuity Considerations column (Column 2) to the Deposit-Type Contract Funds and Other Considerations column (Column 4). This transfer line should be completed by companies that report 403(b) annuity amounts in the Life Contracts Annuity Considerations column 3 (Life blank) or Life & Annuity Premiums & Other Considerations Column 6 in part (Health blank) of Schedule T. All 403(b) amounts in that column should be transferred to Column 4 of the Base Reconciliation Exhibit, whether the 403(b) contract was issued to a governmental or non-governmental policyholder. The amount entered as a negative in the Annuity Considerations column must exactly match the amount entered as a positive in the Deposit-Type Contract Funds and Other Considerations column.

NOTE: In 1995, the NAIC adopted changes to Section 6.A(1)(b) and 6.A(1)(c) of the Model #520 which effectively reclassified contracts issued under a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code from the unallocated annuity to the allocated annuity account (Non-governmental 401 and 403(b) contracts funded by an unallocated annuity contract remain in the unallocated annuity account.) Although now inconsistent with the adopted change, Base Exhibit, Line 4.1 must continue to be completed in accordance with the instructions in the preceding paragraph since no state has yet adopted this change. Changes to future annual statement instructions, forms or formula charts will be considered at such future date if and when adopted by individual state(s).

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Line 4.2 – Transfer any allocated annuity amounts included in the Deposit-Type Contract Funds and Other Considerations column (Column 4) to the Annuity Considerations column (Column 2), except for amounts received to fund annuity contracts qualified under Internal Revenue Code Section 403(b) contracts. This includes all allocated annuity contracts, regardless of whether the annuity is in deferred or payout status, whether the annuity is group or individual, and whether the annuity is qualified or non-qualified for tax purposes.

According to Model #520, an "unallocated annuity contract means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by a reporting entity under such contract or certificate." An annuity is considered allocated unless it is unallocated. Examples of unallocated annuity contracts might be guaranteed investment contracts, deposit administration contracts, and unallocated funding agreements where no contract or agreement issued by the reporting entity, nor any certificate issued by the reporting entity thereunder, guarantees individual benefits to specifically identified individuals.

Group annuities may be allocated or unallocated. (The term "unallocated" is not synonymous with the term "group".) A group contract or certificate that guarantees annuity benefits to an individual (this is not the guarantee typically found in a guaranteed investment contract or deposit administration contract which allows the pension trustee or administrator to purchase an annuity for a plan participant at a guaranteed purchase rate) should be considered allocated. In addition to contracts under which periodic payments are being made to individuals, group annuity contracts should be considered allocated if the reporting entity is obligated under the contract upon the request of an individual (or his or her beneficiary) to make either partial or full cash withdrawal payments, which may be subject to plan or statutory restrictions, to the individual (or his or her beneficiary).

The reporting entity will be considered to be obligated upon the request of an individual to make either partial or full cash withdrawal payments if withdrawals or death benefit payments are made from that participant's account maintained (by the reporting entity or its designee) under the terms of the group annuity contract and regardless of whether such requests are submitted to the reporting entity directly by the individual (or his or her beneficiary) or indirectly through the plan trustee, administrator, sponsor or contract holder at the direction of the individual. As discussed in Line 4.1, the NAIC adopted a change to Model #520 that reclassifies governmental retirement plans established under Section 401, 403(b) and 457 of the Internal Revenue Code to the allocated annuity account. However, until adopted by a state legislature, 403(b) annuities should remain in the Deposit-Type Contract Funds and Other Considerations column (Column 4) to be consistent with existing statutes that require that these contracts be included with unallocated annuities for assessment purposes where applicable. Note that the amount entered as a negative in the Deposit-Type Contract Funds and Other Considerations column must exactly match the amount entered as a positive in the Annuity Considerations column.

Line 4.3 – Transfer any unallocated annuity amounts included in the Annuity Considerations column (Column 2) to the Deposit-Type Contract Funds and Other Considerations column (Column 4). The amount entered as a negative in the Annuity Considerations column must exactly match the amount entered as a positive in the Deposit-Type Contract Funds and Other Considerations column.

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Development of Amounts Included in Lines 1 Through 5 That Should Be Deducted in Determining the Base

Lines 6 through 9.99 are deductions from assessable premium based on the *Life and Health Insurance Guaranty Association Model Act* (#520) provisions. Companies must be careful not to deduct the same premium or deposits on more than one line. For example, amounts deducted on Line 6.1 as non-guaranteed separate account deposits should not be deducted a second time on Line 7.3 if those separate account deposits represent unallocated annuity deposits for a pension plan contract in excess of $5 million. Companies may only deduct amounts on Lines 6 through 9.99 (except for amounts on Line 8) to the extent those amounts have been included on Lines 1 through 5 of the Base Reconciliation Exhibit.

Lines 6.01 – 6.99 – Enter amounts received for any portion of a policy or contract not guaranteed by the reporting entity or under which the investment risk is borne entirely by the policy or contract holder. These amounts are those specified at the time of deposit as intended for deposit in separate accounts. Amounts entered on these lines are typically non-guaranteed separate account premiums. DO NOT INCLUDE on these lines amounts transferred to any guaranteed separate accounts. Two types of annuity contracts that should NOT be reported on Line 6 are: (i) modified guaranteed annuities, market adjusted annuities, or other contracts where the amounts payable on at least one future date do not (or may not) depend solely on the investment performance of assets in the separate accounts, and (ii) guaranteed investment contracts issued to fund pension plans even if there are not mortality guarantees or only incidental mortality guarantees. Such contracts are not properly includable on Line 6 since the reporting entity retains an investment risk.

Amounts entered on Line 6 should correspond to amounts reported on the Annual Statement of Separate Accounts to the extent amounts are included on Lines 1 through 5 of the Base Reconciliation Exhibit. Specify deductions and indicate where such amounts were reported in the Annual Statement. Lines 6.1 – 6.99 should not include transfers to a separate account except to the extent such transfers represent current year premiums included on Lines 1 through 5 of the Base Reconciliation Exhibit. Companies must specifically identify deductions on Lines 6.01 through 6.99 and indicate where such amounts are reported in the Annual Statement (blue book) and where they are reported on Lines 1 through 5 of the Base Reconciliation Exhibit.

Lines 7.1 – 7.4 – Enter unallocated amounts that meet the descriptions provided on Lines 7.1, 7.2 and 7.3.

Line 7.1 – Allows a deduction for any unallocated annuity contract that is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery. An example of an appropriate Line 7.1 deduction would be amounts received to fund a municipal guaranteed investment contract.

Line 7.2 – Allows a deduction for any unallocated annuity contract issued to an employee benefit plan protected under the Federal Pension Benefit Guaranty Corporation (PBGC). Employee benefit plans protected by the PBGC are defined benefit plans only and do not include defined contribution plans.

Line 7.3 – Allows a deduction for unallocated annuity premiums in excess of $5 million for unallocated government lotteries and for any unallocated employee, union or association of natural persons benefit plans that is not: (a) governmental retirement plan established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code or (b) protected under the Federal Pension Benefit Guaranty Corporation. Line 7.3 should only include those amounts in excess of $5 million. For example, for a $15 million guaranteed investment contract issued to an employee benefit plan, the company should report $10 million (i.e., amounts in excess of $5 million) on Line 7.3. Do not include on Lines 7.1, 7.2 or 7.3 amounts that have been reported as transfers or deductions on any other lines (e.g., Lines 4.2, 6, 7.1, 7.2 or 7.3).

Not for Distribution

Line 8 – Enter dividends and experience rating credits, but only if such amounts were not guaranteed in advance. Examples of items that might be reported on Line 8 include: (i) non-guaranteed amounts that constitute a return of premiums collected in the current year and paid out of divisible surplus; and (ii) non-guaranteed experience rating credits that were not already deducted in determining Lines 1 and 2. Excess interest should not be deducted as dividends.

Lines 9.01 – 9.99 – Enter any other deductible amounts with a clear explanation of the nature of such deduction on Lines 9.01, 9.02, 9.03, etc. An example of an appropriate deduction is the premiums received for the Federal Employee Health Benefits Plan contracts in the Accident and Health column (Column 3). Deductions are not permitted for premiums received for the Federal Employee Group Life Insurance. Line 9 should not be used as a substitute for deductions that are to be reported on any of the above lines. Deductions are not permitted in the first three columns for amounts received in excess of coverage limits specified in the Guaranty Laws (i.e., a reporting entity cannot deduct amounts received or contract values in excess of $100,000 related to allocated annuity contracts).

Model Act Base

Line 11 – Line 11 equals Line 5 minus Line 10.

Not for Distribution

ADJUSTMENTS TO THE
LIFE, HEALTH AND ANNUITY GUARANTY ASSOCIATION
MODEL ACT ASSESSMENT BASE RECONCILIATION EXHIBIT

To be filed on or before April 1.

Introduction

The purpose of the Adjustments to the Life, Health and Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (Adjustments Exhibit) is to collect premium information needed by State Guaranty Associations to make assessments. The Adjustments Exhibit must be prepared with the same care and accuracy that would be used in preparing the Annual Statement, since the information is being provided to the Guaranty Fund Associations.

These instructions are intended to assist companies in completing the Adjustments Exhibit. **COMPANIES MUST READ THESE INSTRUCTIONS CAREFULLY AND REFER TO THE RELEVANT GUARANTY ASSOCIATION ACTS, WHERE APPROPRIATE.**

Only companies that are members of the life, health and annuity guaranty associations should complete this exhibit. If a company is unsure if it is a member of a life, health and annuity guaranty association, it should contact the state life, health and annuity guaranty associations in its state of domicile or state(s) where it is licensed to write life, health and annuity business.

The Adjustments Exhibit has four columns: Column 1 is for all individual and group life insurance premiums; Column 2 is for all individual and group allocated annuity amounts (whether called premiums, deposits, or considerations); Column 3 is for all individual and group accident and health premiums; and Column 4 is for all unallocated annuity amounts (whether called premiums, deposits or considerations). However, the Adjustments Exhibit requires annuity information only for states that have not adopted the most recent *Life and Health Insurance Guaranty Association Model Act* (#520). Companies are required to complete each line of the Adjustments Exhibit for all states, District of Columbia and Puerto Rico in which they were licensed or had business during the reporting year, except for those states that use the Base Reconciliation Exhibit for their respective assessment premium base (these states may be identified by referring to the respective assessment premium base formulas). DO NOT SUBMIT the Adjustments Exhibit for American Samoa, Guam, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions. If your company writes only life and/or accident and health insurance, there is no need to submit the Adjustments Exhibit. (You may enter any miscellaneous adjustment your company may have to life and accident and health business on Line 9 of the Base Exhibit pursuant to the applicable instructions.)

Should you have questions about how to fill out the Adjustments Exhibit, and the answers are not provided in the instructions below, you may wish to consult the Model #520, particular State Guaranty Acts, the *Annual Statement Instructions*, your company attorney, particular State Insurance Departments, or particular State Guaranty Association Administrators.

Adjustments to the Base Reconciliation Exhibit

All Lines (except Lines 5.3, 6.4 and 9) of Column 4 (Unallocated Annuity Considerations and Other Unallocated Fund Deposits) and Line 2 of Column 2 (Allocated Annuity and Other Allocated Fund Deposits) must be completed for all states in which your company is licensed or did business during the survey year, except for those states that use the Base Reconciliation Exhibit for their respective assessment premium base. (These states may be identified by referring to the respective assessment premium base formulas.) DO NOT SUBMIT the Adjustments Exhibit for American Samoa, U.S. Virgin Islands, Canada, Northern Mariana Islands and other alien jurisdictions.

Deductions related to unallocated annuity contracts MUST be detailed on Lines 3 through 9, where appropriate. Deductions on Line 10 related to amounts received on unallocated annuity contracts WILL NOT be allowed.

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Line 1 – Model Act Base

The amount from Line 11 of the Base Reconciliation Exhibit should be transferred to Line 1 of the Adjustments Exhibit.

Line 2 – All 403(b) annuities are included in Column 4 (Unallocated Annuity and Other Unallocated Fund Deposits) on the Base Reconciliation Exhibit and must be transferred to Column 2 (Allocated Annuity and Other Allocated Fund Deposits) for certain states that have not adopted the most recent Model #520 in its entirety. The amount to be transferred from Column 4 to Column 2 represents the amount of 403(b) annuity premiums included in Line 1 of the Adjustments Exhibit, regardless of whether it was originally reported in Column 2 or Column 4 of the Base Reconciliation Exhibit. Those companies that originally reported 403(b) premiums in Column 4 of the Base Reconciliation Exhibit must transfer such amounts to Column 2 even though no original transfer was required on Line 4.1 of the Base Reconciliation Exhibit.

Lines 3.1 and 3.2 – Companies that have unallocated funding obligations that are not issued to or in connection with a specific employee, union or association of natural persons benefit plan or government lottery (Line 7.1 of the Base Reconciliation Exhibit) must report such amounts on Lines 3.1 and 3.2. Line 3.2 should include any amounts reported on Line 3.1.

Lines 4.1, 4.2 4.3 and 4.5 – Companies that have unallocated funding obligations issued to fund government lotteries or employee, union or association of natural persons benefit plans that are NOT: (a) governmental retirement plans established under Sections 401, 403(b) or 457 of the U.S. Internal Revenue Code, or (b) protected by the Federal Pension Benefit Guaranty Corporation must report such amounts on Lines 4.1, 4.2 and 4.3. Line 4.4 equals the sum of Lines 4.1, 4.2 and 4.3. Lines 4.1, 4.2 and 4.3 are mutually exclusive. Line 4.5 needs to be completed for Minnesota business only.

Lines 5.1, 5.2 5.3 and 5.4 – Companies that have unallocated funding obligations issued to fund governmental retirement plans established under Sections 401 and 457 of the U.S. Internal Revenue Code must report such amounts on Lines 5.1, 5.2 and 5.3. Line 5.2 should include the amounts reported on Line 5.1. Line 5.3 needs to be completed for New Jersey business only. Line 5.4 needs to be completed for Minnesota business only.

Lines 6.1, 6.2 6.4 and 6.5 – Companies that have unallocated funding obligations issued to fund governmental retirement plans established under Section 403(b) of the U.S. Internal Revenue Code must report such amounts on Lines 6.1 and 6.2. Line 6.3 equals the sum of Lines 6.1 and 6.2. Lines 6.1 and 6.2 are mutually exclusive. Line 6.4 needs to be completed for New Jersey business only. Line 6.5 needs to be completed for Minnesota business only.

Lines 7.1, 7.2 and 7.3 – Companies that have unallocated annuity contracts issued to an employee benefit plan protected by the Federal Pension Benefit Guaranty Corporation (Line 7.2 of the Base Reconciliation Exhibit) must report such amounts on Lines 7.1 and 7.2. Line 7.2 should include the amounts reported on Line 7.1. Line 7.3 needs to be completed for New Jersey business only.

Line 8 – Companies that have unallocated funding obligations issued to fund government lotteries must report such amounts up to $5 million per contract holder. This line should be completed for New Jersey business only.

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Line 9 – Companies that have unallocated funding obligations that fund employee or association of natural persons benefit plans in New Jersey in excess of $2 million need to report receipts up to $5 million per contract. This line should be completed for New Jersey business only.

Line 10 – Aggregate Write-ins for Other Deductions

Enter the total of the write-ins listed in schedule "Details of Write-ins Aggregated at Line 10 for Other Deductions."

Line 11 – Represents the preliminary assessment base calculation for those states that have not adopted the most recent Model #520.

Details of Write-ins Aggregated at Line 10 for Other Deductions

The company must provide a clear explanation of the amounts included on Line 10. Amounts deducted on any other lines on the Base Reconciliation Exhibit or Adjustments Exhibit should not be reported here, since to do so would amount to a duplicate deduction. Line 10 should not be used as a substitute for deductions that are to be reported on any of the above lines. In addition, deductions are not permitted in the first three columns for amounts received in excess of coverage limitations specified in the Guaranty Laws (e.g., a reporting entity cannot deduct amounts received or contract values in excess of $100,000 related to allocated annuity contracts).

NOTE: Cross check for Adjustments Exhibit Lines 3.2, 4.3 and 7.2, Column 4

The aggregate amounts on Adjustments Exhibit Lines 3.2, 4.3 and 7.2 should equal the aggregate of the amounts on Base Exhibit Lines 7.1, 7.2 and 7.3 less the amount reported on Base Exhibit Line 3.3.

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COMBINED ANNUAL STATEMENT FOR AFFILIATED PROPERTY/CASUALTY INSURERS

GENERAL

1. The primary purpose of the combined property/casualty annual statement is to provide the NAIC database with combined data for each group of affiliated insurers for use by the NAIC in statistical research and analysis. To accomplish this, the following instructions require affiliated companies having certain intercompany transactions to file a combined annual statement in order to eliminate intercompany transactions and avoid duplication of data. In no event should a company be included in more than one combined annual statement.

2. Wherever the word "company" appears in the blank, it should be construed to mean "company and its affiliates" or "companies and their affiliates" included in this combined annual statement. Wherever the word "combined" appears in the blank, it should be construed to mean consolidated or combined.

3. Every group of affiliated insurers, which includes more than one U.S. property/casualty insurer shall complete a combined annual statement and file it with the NAIC Support and Services Office if it meets the conditions described below.

   If a combined statement is required to be filed, it shall include the top-tiered U.S. property/casualty insurance company(ies) of the group (including U.S. branch (es) of an alien insurer) and those affiliated U.S. property/casualty insurers meeting the following criteria:

   A. Controlled stock insurers shall be included in the statement on a combined basis. A controlled stock insurer is one in which the parent company has the ability to exercise control over the insurer, unless the ability to control the insurer is temporary. Control is presumed to exist if there is direct or indirect ownership of more than 10% of voting shares, unless such assumption can be rebutted. In all cases, insurers in which a parent company owns (directly or indirectly) more than 50% of the insurer's voting securities are presumed to be controlled and shall be included in the statement on a combined basis.

      If control is present as described above, an affiliated group shall file a combined statement only if it meets one or more of the following conditions:

      1. Similar types of affiliated insurance companies in a holding company system that have direct or indirect ownership between them; or

      2. Those affiliated companies that have intercompany reinsurance between them; or

      3. Those affiliated companies that have intercompany pooling arrangements between them.

   Examples:

      1. Company A, a U.S. publicly-owned property/casualty stock company owns 100% of Company B, a U.S. property/casualty company. Company A is the top-tier company in the combined property/casualty annual statement. Company B is included in the combined statement on a consolidated basis.

      2. Company A, a U.S. life and health mutual company owns Company B, a U.S. holding company. Company B owns Companies C and D, U.S. property/casualty stock companies. Company D owns 100% of Company E, a U.S. property/casualty stock company. There are no intercompany transactions between Companies C and any of the other companies. Companies C and D do not meet one of the criteria for filing a combined annual statement. Companies D and E must file a combined property/casualty annual statement. Company D is the top-tier company.

      3. Common management controls Companies A and B, U.S. mutual property/casualty companies. There is no ownership between them, but they have an intercompany reinsurance agreement. Company A owns 100% of Company C, a stock property/casualty insurance company. Company C has a reinsurance agreement with Company B. Companies A, B, and C must file a combined property/casualty annual statement. Companies A and B are the top-tier companies.

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B. Non-controlled stock insurers (i.e., insurers in which a parent company has: (1) a financial interest represented by the direct or indirect ownership of less than 50% of voting shares, and (2) does not have the ability to exercise control over the insurer, e.g., through voting stock or management contract) shall be included in the blank on an equity basis.

C. Other controlled insurers (e.g., a mutual property/casualty insurer or Lloyds insurer that is controlled by common management, proxy, or contract by one or more other insurers) shall be included in the blank on a combined basis only if there is an intercompany reinsurance agreement or pooling arrangement between them.

Example:

> Companies A and B are U.S. property/casualty mutual companies. Common management controls them. Company A owns Companies C and D, U.S. property/casualty stock companies. There are no intercompany reinsurance agreements or pooling arrangements among them. Companies A, C, and D must file a combined property/casualty annual statement. Company A is the top-tier company. Company B is not included in the combined statement since it does not have reinsurance agreements or pooling arrangements with the other companies nor does Company B have any incidents of ownership, i.e., control, with the other companies.

Any affiliated U.S. property/casualty insurer whose assets are less than .5% of the largest U.S. property/casualty insurer of the group may be excluded from the blank if it is a subsidiary of any of the companies being included in the blank and, instead, included as an investment. However, if the affiliate's admitted assets are $100 million or more or its direct written premium is $10 million or more, it must be included in the blank. For purposes of this blank, all activities of a company acquired during the year shall be included and all activities of a company disposed of during the year shall be excluded. Prior years' data does not need to be restated to reflect the acquired or disposed company(ies) (or companies that do not meet the materiality threshold), but the beginning balances for the current year must be adjusted to reflect transactions. (Note: it is anticipated that companies will fail certain crosschecks if there are acquired or disposed of companies during the year or if companies are not included in the combined statement because they no longer meet the materiality threshold). In no event shall any company be included in more than one combined annual statement.

4. Date of filing: On or before May 1, following the calendar year reported, a copy of the combined annual statement should be filed with the NAIC. The filing shall be made via the Internet only.

5. Identify the blank as the Combined Annual Statement of the "top-tier" insurer "and its affiliated property/casualty insurers," identifying by name each of the affiliates included. If there are two or more "top-tier" insurers, identify the blank as the Combined Annual Statement of Company X and Company Y (the top-tier insurers) and their affiliated property/casualty insurers.

6. With the exception of Schedule Z, the format to be used is that of the NAIC Annual Statement blank for property/casualty insurers. The specific pages, exhibits, and schedules to be included are as follows:

   Title Page (in part)
   Assets
   Liabilities, Surplus and Other Funds
   Statement of Income
   Cash Flow
   Underwriting and Investment Exhibit, Parts 1 through 3
   Exhibit of Net Investment Income
   Exhibit of Capital Gains (Losses)
   Schedule D, Summary by Country
   Schedule D, Part 1A, Sections 1 and 2
   Schedule D, Parts 1 and 2, Totals (Line 8399999, 8999999 or 9899999) only
   Schedule F, Parts 1, 2, 3, 4 and 5, Subtotals and Totals only
   Schedule H, Parts 1 through 4 only
   Schedule P except interrogatories
   Schedule T
   Schedule Z
   Insurance Expense Exhibit (Supplemental Filing)

Not for Distribution

Pages should not be renumbered for the combined annual statement, as some pages are not required.

For all pages, exhibits, and schedules, Details of Write-in lines should be combined to a single entry.

7. Include only the following on the Title Page:

"This annual statement contains combined data for the Property/Casualty insurance companies listed above, compiled in accordance with the NAIC instructions for the completion of annual statements."

Bar Code	Produce the correct bar code for this group of insurers. The document code to use is 201.
Company Name	List the name(s) of the top-tier company(ies).
NAIC Group Code	Show the NAIC four-digit group code.
NAIC Company Code	Show the five-digit NAIC combined company code assigned to your combined group.
Mail Address	Provide the address where mail pertaining to this statement should be directed.
Contact Person, Email Address & Telephone number	Provide the name, email address and telephone number, including area code and extension, to whom calls regarding this statement should be directed.
Listing of Companies Included in this Statement	Provide a listing of the insurers included in this statement. Provide the five digit NAIC Company Code assigned to each individual insurer. Also provide the domiciliary state for each company.
Amending Filing	If there is an amendment, change, or modification of previously filed information, state the amendment number (each amendment made by an insurer should be sequentially numbered), the date this amendment is being filed, and the number of statement pages being changed by this amendment.

The title page for the property/casualty combined annual statement and combined Insurance Expense Exhibit does not require any signatures.

8. Combine the items reported in the annual statement of each of the companies being combined, making adjustments (discussed below) to eliminate intercompany items. The combined statutory net worth (surplus as regards policyholders) may not be the same as that of the top-tier property/casualty insurance company(ies) due to differences in reporting, inclusion of minority interests, and combining adjustments. Details of the adjusting or eliminating entries should be available to the NAIC upon request.

9. Combining Adjustments:

A. Equity investments in combined subsidiaries (Pages 2 through 6 and Schedule D):

Eliminate the carrying value (stock, surplus notes, partnership interests) and the capital and surplus account (capital, paid-in and contributed surplus, special surplus funds) from the balance sheet items of the subsidiaries being consolidated or combined. Eliminate capital dividend and other income (loss) transactions between related companies as well as realized and unrealized capital gains and losses due to equity investments in combined subsidiaries.

Intervening non-insurance or uncombined subsidiaries, if any, should continue to be carried as investments with their carrying value adjusted to exclude the carrying value of any other subsidiaries being combined.

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B. Reinsurance (Pages 2 through 12 and Schedules F, H, and P):

Eliminate from the balance sheet and supporting exhibits and schedules, reinsurance payables, recoverables, and reserves (unearned premium reserve, reserves on ceded or assumed business, etc.) between related companies. Eliminate in the Summary of Operations, Cash Flow Statement and supporting exhibits and schedules, reinsurance premiums, benefits, losses, dividends, experience rating refunds, commissions, and expenses between related companies.

To calculate the liability for unauthorized or overdue reinsurance, combine the liability from each company included in the combined annual statement and then eliminate the liability, if any, for unauthorized or overdue reinsurance between related companies. Make the offsetting entry to unassigned surplus and a corresponding adjustment to the Surplus Account (Page 4). This type of adjustment will increase reported capital and surplus funds in the combined annual statement.

C. Inter-company debt or other financing (Pages 2 through 6 and Schedule D):

Eliminate inter-company debt or other financing and the investment income and interest expense transactions on such inter-company financing.

D. Capital and Surplus Funds (Page 3):

Capital stock, gross paid-in and contributed surplus, and treasury stock at cost should be the same as the top-tier property/casualty company(ies).

E. Any other items; e.g., intercompany receivables and payables (Pages 2 and 3).

F. Underwriting and Investment Exhibit, Part 3 (Expenses):

Expenses which have been incurred due to transactions between related companies are to be eliminated against the income or expense recorded by the associated company. The elimination entry should be against the specific category of expense to which it relates. Alternatively, the elimination entry may be recorded as a reduction of general expenses at the bottom of the exhibit, e.g., write-in expense entry. Types of common intercompany expenses, which should be eliminated, are:

- Management Fees
- Insurance premium expense or income recognized on policies or contracts written between related companies
- Investment portfolio fees

Expenses incurred from transactions with affiliates that are not combined or consolidated should not be eliminated.

Not for Distribution

SCHEDULE Z

Part 1

List the top-tier company (ies) first, followed by the subsidiaries. The "Ownership Interest" for the top-tier company is not applicable and should be reported as a number 0.

The percent of ownership of the subsidiary by the parent should be reported for the current and prior year.

Indicate the basis for inclusion as consolidated or combined.

Companies acquired during the current year should be included in the combined statement for the current year. Companies disposed of during the current year should be excluded from the combined statement for the current year.

Part 2

List all companies included in this filing but excluded from the prior year. Explain the reason why the company is included; e.g., increase in ownership interest, acquisition.

Part 3

List all companies excluded from this filing but included in the prior year. Explain the reason why the company is excluded; e.g., decrease in ownership interest, sale.

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SCHEDULE Z

Part 1 – COMPANIES INCLUDED IN THE CURRENT YEAR THAT ARE CONSOLIDATED OR COMBINED

Name of Company	NAIC Code	FEIN	Ownership Interest Current	Ownership Interest Prior	Basis for Inclusion
Solvent Insurance Group	05427	00-0000000	0%	0%	Consolidation
ABC Company	75871	39-1234568	75%	60%	Consolidation
XYZ	82247	39-1234569	50%	15%	Consolidation

Part 2 – COMPANIES INCLUDED IN CURRENT YEAR AND EXCLUDED IN THE PRIOR YEAR

Name of Company	NAIC Code	FIT	Ownership Interest Current	Ownership Interest Prior	Reason for Inclusion
XYZ Company	82247	39-1234569	50%	15%	Increased Ownership

Part 3 – COMPANIES EXCLUDED IN CURRENT YEAR AND INCLUDED IN PRIOR YEAR

Name of Company	NAIC Code	FIT	Ownership Interest Current	Ownership Interest Prior	Reason for Exclusion
RST Company	45555	39-1234570	0%	65%	Company Sold

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Not for Distribution

Protected Cell Statement

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INSTRUCTIONS

For Completing Protected Cell Annual Statement Blank

INDEX

The annual statement shall contain an alphabetized index on the last page of the hard copy statement which references the title and page number of all of the pages that are required to be included in that filing. The NAIC shall maintain, and place on its Website at *www.naic.org/cmte_e_app_blanks.htm*, the alphabetized index for all statement types that is required to be included in the hard copy of the statement. The above is only required on the March 1 filing, and specifically excludes any supplements.

GENERAL

The instructions for completing the general account are to be followed to the extent applicable. This supplement provides additional instructions that are unique to the Protected Cell Blank as well as some that differ from those for the Property and Casualty Blank. Where there is a conflict with the Property and Casualty Blank's instructions, use these instructions. The reporting date must be plainly written or stamped at the top of all pages, exhibits and schedules (and duplicate schedules) and also upon all inserted schedules and loose sheets.

The protected cell statement reports only the operations of the protected cell itself. It assumes that the administration of the contracts is reflected in the general account statement – hence, administrative expense does not appear in the Protected Cell Statement. The insurance bond issued should be reported in the protected cell only. The impact of this transaction is reported in the host insurer's annual statement as a component of the assets and liabilities of the protected cell.

The format of the annual statement has been designed to facilitate data capture. Therefore, do not change the captions for pre-printed items, lines, or columns and do not insert write-ins between pre-printed items, lines, or columns. An entry for which there is no specific pre-printed line title must be reported with an identifying title (for example, Deferred option income) in the appropriate schedule for each applicable page or section thereof entitled DETAILS OF WRITE-INS AGGREGATED AT ITEM (or ON LINE) ______ FOR __________. These write-in lines should be reported in descending order. The statement provides a limited number of lines for write-ins in each applicable section. These pre-printed write-in detail schedules should not be modified.

If there is not sufficient room in a write-in detail schedule to accommodate all write-ins to be reported therein, companies shall report the write-in detail overflow on pages sequentially numbered beginning with Page 9, followed by 9.1, 9.2, etc. In such instances, companies shall carry the summary of write-in overflow lines from this page to the prescribed line in the original write-in detail section.

Not for Distribution

Each overflow write-in section should adhere to the following example:

Page 2

ASSETS
DETAILS OF WRITE-INS AGGREGATED AT LINE 11 FOR INVESTED ASSETS

1101.	Write-in caption aaaa	$	500,000
1102.	Write-in caption bbbb		350,000
1103.	Write-in caption cccc		250,000
1198.	Summary of remaining write-ins for Line 11 from Overflow page		300,000
1199.	TOTAL (Lines 1101 through 1103 plus 1198) (Page 2, Line 11)	$	1,400,000

Overflow Page
Page 2 – Continuation
Assets
Remainder of Write-ins Aggregated in Line 11

1104.	Write-in caption dddd	$	100,000
1105.	Write-in caption eeee		75,000
1106.	Write-in caption ffff		50,000
1107.	Write-in caption gggg		50,000
1108.	Write-in caption hhhh		20,000
1109.	Write-in caption iiii		5,000
1197.	Summary of remaining write-ins for Line 11 (Lines 1104 through 1196) (Page 2, Line 1198)	$	300,000

More than one detail section overflow may be entered on one page. However, the items should remain in page number order.

Whenever a reporting entity amends, changes, or otherwise modifies any previously filed information, the reporting entity should submit such changes with a new Jurat page, completed in all respects, along with new annual statement pages for all pages of the annual statement that contain information different from the most recently filed pages. The amendment, change, or modification should be filed with the NAIC, as well.

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JURAT PAGE

Enter all information completely as indicated by the format of the page.

NAIC Group Code

Current Period

Enter the NAIC Group Code for the current filing.

Prior Period

Enter the NAIC Group Code for the prior quarter.

State of Domicile or Port of Entry

Alien companies doing business in the United States through a port of entry should complete this line with the appropriate state. U.S. insurance entities should enter the state of domicile.

Country of Domicile

U. S. branches of alien insurers should enter the three-character identifier for the reporting entity's country of domicile from the Appendix of Abbreviations. Domestic insurers should enter "US" in this field.

Commenced Business

Enter the date when the reporting entity first became obligated for any insurance risk via the issuance of policies and/or entering into a reinsurance agreement.

Statutory Home Office

As identified with the Certificate of Authority in domiciled state.

Main Administrative Office

Location of the reporting entity's main administrative office.

Mail Address

Reporting entity's mailing address, if other than the main administrative office address. May be a P.O. Box and the associated ZIP code.

Primary Location of Books and Records

Location where examiners may review records during an examination.

Internet Website Address

Include the Internet Website address of the reporting entity. If none, and information relating to the reporting entity is contained in a related entity's Website, include that Website.

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Statutory Statement Contact

Name & Email

Name and email address of the person responsible for preparing and filing all statutory filings with the reporting entity's regulators and the NAIC. The person should be able to respond to questions and concerns for annual and quarterly statements.

Telephone Number & Fax Number

Telephone and fax number should include area code and extension.

Officers, Directors, Trustees

The state of domicile regulatory authority may dictate the required officers, directors, trustees and any other positions to be listed on the Jurat Page. Show full name (initials not acceptable) and title (indicate by number sign (#) those officers and directors who did not occupy the indicated position in the prior annual statement). Additional lines may be required to identify officers, directors, trustees and any other positions in primary policy making or managerial roles. Examples of titles are 1) President, Chief Executive Officer or Chief Operating Officer; 2) Secretary, or Corporate Secretary; 3) Treasurer or Chief Financial Officer, and, 4) Actuary.

When identifying officers, if the Treasurer does not have charge of the accounts of the reporting entity, enter the name of the individual who does and indicate the appropriate title.

Statement of Deposition

Those states that have adopted the NAIC blank require that the blank be completed in accordance with the NAIC *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law may differ. If the reporting entity deviates from any of these rules, disclose deviations in Note 1 of the Notes to Financial Statements, to the extent that there is an impact to the financial information contained in the annual statement.

Signatures

Complete the Jurat signature requirements in accordance with the requirements of the domiciliary state. Direct any questions concerning signature requirements to that state. At least one statement filed with each individual domiciliary state must have original signatures and must be manually signed by the appropriate corporate officers, have the corporate seal affixed thereon where appropriate, and be properly notarized. For statements filed in non-domestic states, facsimile signatures or reproductions of original signatures may be used except where otherwise mandated. If the appropriate corporate officers are incapacitated or otherwise not available due to a personal emergency, the reporting entity should contact the domiciliary state for direction as to who may sign the statement.

NOTE: If the United States Manager of a U.S. branch or the Attorney-in-Fact of a Reciprocal Exchange or Lloyds Underwriters is a corporation, the affidavit should be signed by two (or three) principal officers of the corporation; or, if a partnership, by two (or three) of the principal members of the partnership.

If this is an amendment, change, or modification of previously filed information, state the amendment number (each amendment made by a reporting entity should be sequentially numbered), the date this amendment is being filed, and the number of annual statement pages being changed by this amendment.

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To be filed in electronic format only:

Policyowner Relations Contact

Name

List person able to respond to calls regarding policies, premium payments, etc., on individual policies.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the policyowner relations contact person as described above.

Government Relations Contact

Name

The government relations contact represents the person the company designates to receive information from state insurance departments regarding new bulletins, company and producer licensing information, changes in departmental procedures and other general communication regarding non-financial information.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the government contact person as described above.

Not for Distribution

Market Conduct Contact

Name

The market conduct contact represents the person the reporting entity designates to receive information from state insurance departments regarding market conduct activities. Such information would include (but not be limited to) data call letters, filing instructions, report cards, and inquires/questions about the reporting entity's market conduct.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the market conduct contact person as described above.

Cybersecurity Contact

Name

The cybersecurity contact represents the person the reporting entity designates to receive information from regulatory agencies on active, developing and potential cybersecurity threats.

Address

May be a P.O. Box and the associated ZIP code.

Telephone Number

Telephone number should include area code and extension.

Email Address

Email address of the cybersecurity contact person as described above.

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ASSETS

Receivables from the General Account Statement must be excluded from the assets of the Protected Cell Statement to eliminate the need for consolidating adjustments in the General Account Statement. Such receivables must be reported as a negative liability and netted against payables to the General Account Statement (see instructions for Page 3, Line 6, Due to/from general account (net)).

All protected cell assets shall be reported at fair value in accordance with the guidance set forth in *SSAP No. 74—Insurance-Linked Securities Issued Through a Protected Cell*.

There are two possible components for each line on the Assets page. They are:

Column 1 – Current Year – Fair Value Basis

Record the amount by category, from the company's financial records.

Column 2 – Prior Year – Fair Value Basis

Amounts contained in Column 1 of the prior year statement.

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LIABILITIES, SURPLUS AND OTHER FUNDS

Line 1 – Funds Held Under Securitization Agreement

Include: At issuance, the proceeds from the insurance-linked security should be reported. During the duration of the insurance-linked security the amount reported shall equal the contractual or discounted value of the security.

NOTE: The Investors in the insurance-linked securities assume all investment risk of the protected cell. Therefore, the Funds Held balance is adjusted downward when the assets in protected cell are less than the face value of the insurance-linked security.

Line 4 – Fees Payable

Include: Incurred but unpaid expenses related to the issuance and support of the insurance-linked security. This includes costs associated with the issuance of the security such as actuarial, accounting, investment banking, and legal. Costs related to the ongoing support of the insurance-linked security should also be reported on this line. This includes investment expenses and back office support.

Line 6 – Due To/From General Account (net)

Include: Premiums attributed to the protected cell from the general account.

Payable to the general account for the covered exposures after a triggering event occurs.

NOTE: The net due to/from general account must not exceed the protected cell assets that are carried at fair value.

Line 9 – Derivatives

Include: Derivative liability amounts shown as credit balances on Schedule DB, Parts A and B, if any.

Line 10 – Payable for Securities

Include: Amounts that are due to brokers when a security has been purchased, but have not yet been paid.

Line 11 – Payable for Securities Lending

Include: Liability for securities lending collateral received by the reporting entity that can be reinvested or repledged.

Line 14 – Unrealized Capital Gain (Loss)

Include: Change in fair value of protected cell assets.

Line 15 – Contractual Adjustment

Include: Offset for fair value adjustment of the protected cell assets as well as contractual (or discount) adjustment for “Funds Held Under Securitization Agreement”.

Line 16 – Aggregate Write-ins for Surplus Funds

Include: Seed monies contributed to the protected cell.

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SUMMARY OF OPERATIONS

Line 6 – Change in Unpaid Losses

Include: Losses incurred on attributed losses from the general account.

Line 7 – Change in Unpaid Losses (Securitized)

Include: Recovery for unpaid losses from the insurance-linked security.

Line 16 – Surplus

Include: Additional funds contributed by the general account at the inception of the protected cell (seed money).

Exclude: Premium attributed to the protected cell by the general account.

Line 18 – Surplus, December 31, Current Year

Should agree with the amount reported on Page 3, Line 17.

EXHIBIT OF CAPITAL GAINS (LOSSES)

Capital gains and losses, realized and unrealized, are to be calculated on the basis of original cost adjusted, as appropriate, for accrual of discount or amortization of premium and for depreciation.

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SCHEDULE DA –VERIFICATION BETWEEN YEARS

SHORT-TERM INVESTMENTS

Report the aggregate amounts required by type of short-term invested asset. The categories of assets to be reported are: bonds, mortgage loans, other short-term invested assets and investments in parent, subsidiaries and affiliates. A grand total of all activity is also required.

Line 1 – Book/Adjusted Carrying Value, December 31 of Prior Year

Report the market value per Page 2, Line 6, Column 1 of the prior year's Protected Cell Statement.

Line 2 – Cost of Short-term Investments Acquired

Report the aggregate cost of short-term investments acquired during the year. A reporting entity may summarize all "overnight" transactions and report the net amount as an increase in short-term investments on this line; all other transactions shall be recorded gross.

Line 6 – Deduct Consideration Received on Disposal of Short-term Investments

Report the proceeds received on disposal of short-term investments. A reporting entity may summarize all "overnight" transactions and report the net amount as a decrease in short-term investments on this line; all other transactions shall be recorded gross.

Line 12 – Statement Value at End of Current Period

Enter the amount of Line 10 less Line 11. The amount reported on this line should agree with Page 2, Line 6, Column 1.

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GENERAL INSTRUCTIONS FOR SCHEDULE DB

Each derivative instrument should be reported in Parts A, B or C according to the nature of the instrument, as follows:

Part A: Positions in Options, Caps, Floors, Collars, Swaps and Forwards*

Part B: Positions in Futures Contracts

Part C: Positions in Replicated (Synthetic) Assets

* Forward commitments that are not derivative instruments (for example, the commitment to purchase a GNMA security two months after the commitment date, or a private placement six months after the commitment date) should not be on Schedule DB (see General account instructions).

Part D should be used to report the counterparty exposure, (i.e. the exposure to credit risk on derivative instruments) to each counterparty (or guarantor as appropriate).

If the reporting entity engages in derivative instruments, the following adjustments should be made to the Protected Cell Statement:

Include, if a debit balance, the statement values individually for Parts A and B in the Protected Cell Statement as follows:

Page 2, Line 7 – Derivatives

Include, if a credit balance, the statement values individually for Parts A and B in the Protected Cell Statement as follows:

Page 3, Line 9 – Derivatives

See the general account instructions for complete information on completing Schedule DB.

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APPENDIX

INSTRUCTIONS FOR USE OF BARCODES

It is the responsibility of the company to prepare and utilize barcodes correctly.

The upper right-hand corner of the jurat page, and other pages and forms as identified on the Document Identifier Codes listing, will be the location of a 17-digit barcode symbol. The barcode standard to be utilized is the 3 of 9 (or 39) methodology. The barcode should be printed using at least a 24-point font. In addition to the barcode symbols, the name of the reporting entity, the year, and the document code should be printed on the barcode label. When the barcode is printed as part of the page rather than an affixed label, the reporting entity's name need not be printed above the barcode.

The barcode consists of the entity identifier (5 digits), the year (YYYY-4 digits), the document identifier (3 digits), the state code (2 digits), if state specific page, the data indicator (1 digit) and a filing type identifier (1 digit).

This 17th digit should utilize the following codes:

- 0 to represent the annual filings
- 1 to represent the March quarterly filing
- 2 to represent the June quarterly filing
- 3 to represent the September quarterly filing
- 4 to represent the Health Maintenance Organization's fourth quarter filing
- 5 to represent amended annual filings
- 6 to represent amended March quarterly filing
- 7 to represent amended June quarterly filing
- 8 to represent amended September quarterly filing

For filings of a reporting entity, the entity identifier is the NAIC company code number.

The year is represented as the last four digits of the filing year. For the 2018 annual statement due March 1, 2019, the year would be 2018.

The document identifier represents what page, schedule, exhibit, etc., is being filed. The respective identifiers for those documents requiring a barcode are included on the document identifier listing.

The state code represents if the document identifier can be filed for each individual state (e.g., the state business pages). The two-digit code would be the same as used on Schedule T. If it is not a state-specific form, the state code is 00. The state code Other is 58, and the code for Grand Total is 59. If the reporting entity has nothing to report on any state-specific supplemental schedule or exhibit, the barcode included in the Supplemental Exhibits and Schedules Interrogatories should contain a state code of 59.

The data indicator represents if the document contains data. For filings containing data place a one (1) in this field. If the document is a NONE, place a zero (0) in this field.

The filing type identifier is used to indicate the filing of NAIC filing components or state mandated (state specific) filing requirements other than those required by the NAIC. For NAIC filing requirements, the type code is 0. For state filing requirements, the type code is 1.

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If forms which are required to have a separate barcode as identified on the Document Identifier Codes listing are bound in the statement, these forms <u>MUST</u> have the barcode affixed to them. If a reporting entity submits with the March 1 filing a page requiring a barcode and that page has <u>not</u> been completed due to a later filing date, the barcode should not be affixed for the March filing. If the filing includes a page listing none schedules (and the state in which you are filing permits such a filing) and any of these schedules fall within that listing that requires a barcode, the barcode must be placed to the right of the name of the page, exhibit or schedule. On those forms which are completed on a by-state basis and are marked none because the company does not write that type of business or that particular state page is none, place the appropriate identifier with the data indicator of zero (0). State pages which have values reported must use the appropriate state barcode identifier from Schedule T. If any state requires the filing of a none "by-state basis" page, the name of the appropriate state must still be printed on the hard copy after "For the State of _______."

A listing of the Document Identifier Codes can be found at *www.naic.org/cmte_e_app_blanks.htm*.

The reporting entity is required to affix the appropriate barcode next to the respective Supplemental Interrogatory using the document identifier code provided. Note that it is only Supplemental Interrogatories to which the reporting entity has responded "NO" that it does not have to file a particular exhibit or form, and for which the physical page or form is marked none that the appropriate barcode be affixed. For supplements that are state specific, the only instance a barcode should be affixed is when that type of business is not written at all in any state.

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COUNTRY OF DOMICILE

APPENDIX OF ABBREVIATIONS

This is a comprehensive list of ISO Alpha 3 country abbreviations: Please note the following exception. Use NAT for Native American Tribes.

Code		Country
AFG	–	Afghanistan
ALA	–	Aland Islands
ALB	–	Albania
DZA	–	Algeria
ASM	–	American Samoa
AND	–	Andorra
AGO	–	Angola
AIA	–	Anguilla
ATA	–	Antarctica
ATG	–	Antigua and Barbuda
ARG	–	Argentina
ARM	–	Armenia
ABW	–	Aruba
AUS	–	Australia
AUT	–	Austria
AZE	–	Azerbaijan
BHS	–	Bahamas
BHR	–	Bahrain
BGD	–	Bangladesh
BRB	–	Barbados
BLR	–	Belarus
BEL	–	Belgium
BLZ	–	Belize
BEN	–	Benin
BMU	–	Bermuda
BTN	–	Bhutan
BOL	–	Bolivia
BES		Bonaire, Sint Eustatius and Saba
BIH	–	Bosnia and Herzegovina
BWA	–	Botswana
BVT	–	Bouvet Island
BRA	–	Brazil
VGB	–	British Virgin Islands
IOT	–	British Indian Ocean Territory
BRN	–	Brunei Darussalam
BGR	–	Bulgaria
BFA	–	Burkina Faso
BDI	–	Burundi
KHM	–	Cambodia
CMR	–	Cameroon
CAN	–	Canada
CPV	–	Cape Verde
CYM	–	Cayman Islands
CAF	–	Central African Republic
TCD	–	Chad
CHL	–	Chile
CHN	–	China
CUW		Curaçao
CXR	–	Christmas Island
CCK	–	Cocos (Keeling) Islands
COL	–	Colombia
COM	–	Comoros
COG	–	Congo (Brazzaville)
COD	–	Congo, Democratic Republic of the
COK	–	Cook Islands
CRI	–	Costa Rica
CIV	–	Côte d'Ivoire
HRV	–	Croatia
CUB	–	Cuba
CYP	–	Cyprus
CZE	–	Czech Republic
DNK	–	Denmark
DJI	–	Djibouti
DMA	–	Dominica
DOM	–	Dominican Republic
ECU	–	Ecuador
EGY	–	Egypt
SLV	–	El Salvador
GNQ	–	Equatorial Guinea
ERI	–	Eritrea
EST	–	Estonia
ETH	–	Ethiopia
FLK	–	Falkland Islands (Malvinas)
FRO	–	Faroe Islands
FJI	–	Fiji
FIN	–	Finland
FRA	–	France
GUF	–	French Guiana
PYF	–	French Polynesia
ATF	–	French Southern Territories
GAB	–	Gabon
GMB	–	Gambia
GEO	–	Georgia
DEU	–	Germany
GHA	–	Ghana
GIB	–	Gibraltar
GRC	–	Greece
GRL	–	Greenland
GRD	–	Grenada
GLP	–	Guadeloupe
GUM	–	Guam
GTM	–	Guatemala
GGY	–	Guernsey
GIN	–	Guinea
GNB	–	Guinea-Bissau
GUY	–	Guyana
HTI	–	Haiti
HMD	–	Heard Island and McDonald Islands
VAT	–	Holy See (Vatican City State)
HKG	–	Hong Kong, Special Administrative Region of China
HND	–	Honduras

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HUN – Hungary
ISL – Iceland
IND – India
IDN – Indonesia
IRN – Iran, Islamic Republic of
IRQ – Iraq
IRL – Ireland
IMN – Isle of Man
ISR – Israel
ITA – Italy
JAM – Jamaica
JPN – Japan
JEY – Jersey
JOR – Jordan
KAZ – Kazakhstan
KEN – Kenya
KIR – Kiribati
PRK – Korea, Democratic People's Republic of
KOR – Korea, Republic of
KWT – Kuwait
KGZ – Kyrgyzstan
LAO – Lao PDR
LVA – Latvia
LBN – Lebanon
LSO – Lesotho
LBR – Liberia
LBY – Libyan Arab Jamahiriya
LIE – Liechtenstein
LTU – Lithuania
LUX – Luxembourg
MAC – Macao, Special Administrative Region of China
MKD – Macedonia, Republic of
MDG – Madagascar
MWI – Malawi
MYS – Malaysia
MDV – Maldives
MLI – Mali
MLT – Malta
MHL – Marshall Islands
MTQ – Martinique
MRT – Mauritania
MUS – Mauritius
MYT – Mayotte
MEX – Mexico
FSM – Micronesia, Federated States of
MDA – Moldova
MCO – Monaco
MNG – Mongolia
MNE – Montenegro
MSR – Montserrat
MAR – Morocco
MOZ – Mozambique
MMR – Myanmar
NAM – Namibia
NRU – Nauru
NPL – Nepal
NLD – Netherlands
NCL – New Caledonia
NZL – New Zealand
NIC – Nicaragua
NER – Niger
NGA – Nigeria
NIU – Niue
NFK – Norfolk Island
MNP – Northern Mariana Islands
NOR – Norway
OMN – Oman
PAK – Pakistan
PLW – Palau
PSE – Palestinian Territory, Occupied
PAN – Panama
PNG – Papua New Guinea
PRY – Paraguay
PER – Peru
PHL – Philippines
PCN – Pitcairn
POL – Poland
PRT – Portugal
PRI – Puerto Rico
QAT – Qatar
REU – Réunion
ROU – Romania
RUS – Russian Federation
RWA – Rwanda
BLM – Saint-Barthélemy
SHN – Saint Helena
KNA – Saint Kitts and Nevis
LCA – Saint Lucia
MAF – Saint-Martin (French part)
SPM – Saint Pierre and Miquelon
VCT – Saint Vincent and Grenadines
WSM – Samoa
SMR – San Marino
STP – Sao Tome and Principe
SAU – Saudi Arabia
SEN – Senegal
SRB – Serbia
SYC – Seychelles
SLE – Sierra Leone
SGP – Singapore
SVK – Slovakia
SVN – Slovenia
SLB – Solomon Islands
SOM – Somalia
ZAF – South Africa
SGS – South Georgia and the South Sandwich Islands
SSD South Sudan
ESP – Spain
LKA – Sri Lanka
SDN – Sudan
SUR – Suriname *
SJM – Svalbard and Jan Mayen Islands
SWZ – Swaziland
SWE – Sweden
CHE – Switzerland

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SYR	–	Syrian Arab Republic
TWN	–	Taiwan, Republic of China
TJK	–	Tajikistan
TZA	–	Tanzania *, United Republic of
THA	–	Thailand
TLS	–	Timor-Leste
TGO	–	Togo
TKL	–	Tokelau
TON	–	Tonga
TTO	–	Trinidad and Tobago
TUN	–	Tunisia
TUR	–	Turkey
TKM	–	Turkmenistan
TCA	–	Turks and Caicos Islands
TUV	–	Tuvalu
UGA	–	Uganda
UKR	–	Ukraine
ARE	–	United Arab Emirates
GBR	–	United Kingdom
USA	–	United States of America
UMI	–	United States Minor Outlying Islands
URY	–	Uruguay
UZB	–	Uzbekistan
VUT	–	Vanuatu
VEN	–	Venezuela (Bolivarian Republic of)
VNM	–	Viet Nam
VIR	–	Virgin Islands, U.S.
WLF	–	Wallis and Futuna Islands
ESH	–	Western Sahara
YEM	–	Yemen
ZMB	–	Zambia
ZWE	–	Zimbabwe

Not for Distribution

APPENDIX

PROPERTY AND CASUALTY LINES OF BUSINESS

These definitions should be applied when reporting all applicable amounts for the following schedules: Underwriting and Investment Exhibit Parts 1, 1A, 1B, 2, and 2A; Exhibit of Premiums and Losses (Statutory Page 14); and the Insurance Expense Exhibit. Policy fees, service charges or membership charges are to be included with the line of business or in Other Income, as determined by *SSAP No. 53—Property Casualty Contracts – Premiums*.

Some lines of business (Lines 11, 17 and 18) are divided between "Occurrence" and "Claims Made."

Occurrence:

These policies cover insured events that occur within the effective dates of the policy, regardless of when they are reported to the reporting entity.

Claims Made:

These policies cover insured events that are reported (as defined in the policy) within the effective dates of the policy, subject to retroactive dates and extended reporting periods when applicable.

Force-Placed Business:

Include all types of business that are "force-placed" or "lender-placed" in the same pre-defined lines of business as business placed by borrower or creditor for the same coverage.

Force-placed (also known as lender-placed and creditor-placed insurance) is insurance that is placed by the lender subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to collateralized property as a result of fire, theft, collision or other risks of loss that would either impair a creditor's interest or adversely affect the value of collateral covered by limited dual-interest insurance. It is purchased by the lender according to the terms of the credit agreement as a result of the borrower's failure to provide required insurance, with the cost of the coverage being charged to the borrower. It may be either single-interest insurance or limited dual-interest insurance.

Riders/Endorsements/Floaters:

If a rider, endorsement or floater acts like a separate policy with separate premium, deductible and limit, then it is to be recorded on the same annual statement line as if it were a stand-alone policy regardless of whether it is referred to as a rider, endorsement or floater. If there is no additional premium, separate deductible or limit, the rider, endorsement or floater should be reported on the same annual statement line as the base policy.

State-specific deviations should be addressed on the Exhibit of Premiums and Losses (State Page).

Line 1 – Fire

Coverage protecting the insured against the loss to real or personal property from damage caused by the peril of fire or lightning, including business interruption, loss of rents, etc.

Line 2 – Allied Lines

Coverages that are generally written with property insurance; e.g., glass, tornado, windstorm and hail; sprinkler and water damage; explosion, riot and civil commotion; growing crops; flood; rain; and damage from aircraft and vehicle, etc.

Line 2.1 – Allied Lines

Include: Extended coverage; glass; tornado, windstorm and hail; sprinkler and water damage; explosion, riot and civil commotion; rain; and damage from aircraft and vehicle.

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Line 2.2 – Multiple Peril Crop

Include: Insurance protection that is subsidized or reinsured by the Federal Crop Insurance Corporation for protection against losses due to damage, decreases in revenues and/or gross margins from crop, livestock and other agricultural-related production from unfavorable weather conditions, drought, wind, frost, fire or lightning, flood, hail, insect infestation, disease or other yield-reducing conditions or perils.

Line 2.3 – Federal Flood

Include: Coverage provided by the Federal Insurance Administration (FIA) of the Federal Emergency Management Agency (FEMA) through insurers participating in the National Flood Insurance Program's (NFIP) Write Your Own (WYO) program. Coverage is subject to the terms and conditions provided in the Financial Assistance/Subsidy Arrangement between the reporting entity and the FIA.

Line 2.4 – Private Crop

Include: Private market coverage for crop insurance and agricultural-related protection such as hail and fire, and is not reinsured by the Federal Crop Insurance Corporation.

Line 2.5 – Private Flood

Include: Private market coverage (primary standalone, first dollar policies that cover the flood peril and excess flood) for flood insurance that is not offered through the National Flood Insurance Program.

Creditor-placed flood insurance.

Exclude: Sewer/water backup coverage issued as an endorsement to a homeowners or commercial policy.

Crop flood peril coverage appropriately reported on Lines 2.2 and 2.4.

Line 3 – Farmowners Multiple-Peril

A package policy for farming and ranching risks, similar to a homeowners policy, that has been adopted for farms and ranches and includes both property and liability coverages for personal and business losses. Coverages include farm dwellings and their contents, barns, stables, other farm structures and farm inland marine, such as mobile equipment and livestock.

<u>Commercial Farm and Ranch</u>

A commercial package policy for farming and ranching risks that includes both property and liability coverage. Coverage includes barns, stables, other farm structures and farm inland marine, such as mobile equipment and livestock.

Line 4 – Homeowners Multiple-Peril

A package policy combining broad property coverage for the personal property and/or structure with broad personal liability coverage. Coverage applicable to the dwelling, appurtenant structures, unscheduled personal property and additional living expense are typical. Includes mobile homes at a fixed location.

Not for Distribution

Line 5 – Commercial Multiple-Peril

A contract for a commercial enterprise that packages two or more insurance coverages protecting an enterprise from various property and liability risk exposures. Frequently includes fire, allied lines, various other coverages (e.g., difference in conditions) and liability coverage (such coverages would be included in other annual statement lines, if written individually). Include multi-peril policies (other than farmowners, homeowners and automobile policies) that include coverage for liability other than auto.

Builders' Risk Policies

Typically written on a reporting or completed value form, this coverage insures against loss to buildings in the course of construction. The coverage also includes machinery and equipment used in the course of construction and to materials incidental to construction.

Businessowners

The Businessowners policy (BOP) provides a broad package of property and liability coverages for small and medium-size apartment buildings, offices and retail stores.

Commercial Package Policy

The Commercial Package Policy (CPP) provides a broad package of property and liability coverages for commercial ventures other than those provided insurance through a businessowners policy. (The older Special Multiple-Peril program (SMP) also use this code.)

Manufacturers Output Policies

Provides broad form all risks coverage of personal property of an insured manufacturer that is located away from the premises of the manufacturer at the time of a claim.

E-Commerce

Coverage for all aspects of e-commerce business.

Difference in Conditions (DIC)

DIC is a special form of open-peril coverage written in conjunction with basic fire coverage and designed to provide protection against losses not reimbursed under the standard fire forms.

Line 5.1 – Commercial Multiple-Peril – Non-Liability Portion

Include: All business covering the fire and allied portion of Multiple-Peril policies.

Line 5.2 – Commercial Multiple-Peril – Liability Portion

Include: All business covering the liability portion of Multiple-Peril policies.

Line 6 – Mortgage Guaranty

Insurance that indemnifies a lender from loss if a borrower fails to meet required mortgage payments.

Mortgages – Fixed Rate Mortgages

The type of loan in which the interest rate will not change for the entire term of the loan.

Not for Distribution

Mortgages – Trust/Pools

Insure pools of loans secured by instruments constituting a first lien on real estate and evidenced by pass-through certificates or other instruments.

Mortgages – Variable Mortgages

The type of loan in which the interest rate may vary or float periodically throughout the term of the loan based on an interest rate index.

Line 8 – Ocean Marine

Coverage for ocean and inland water transportation exposures; goods or cargoes; ships or hulls; earnings; and liability.

Line 9 – Inland Marine

Coverage for property that may be in transit, held by a bailee, at a fixed location, a movable good that is often at different locations (e.g., off-road construction equipment) or scheduled property (e.g., Homeowners Personal Property Floater), including items such as live animals, property with antique or collector's value, etc. This line also includes instrumentalities of transportation and communication, such as bridges, tunnels, piers, wharves, docks, pipelines, power and phone lines, and radio and television towers.

Animal Mortality

Coverage that provides a death benefit to the owner of a policy in the event of the death of the insured livestock.

EDP Policies

Coverage to protect against losses arising out of damage to or destruction of electronic data processing equipment and its software.

Pet Insurance Plans

Veterinary care plan insurance policy providing care for a pet animal (e.g., dog or cat) of the insured owner in the event of its illness or accident.

Communication Equipment (Cellular Telephones)

Provides insured subscribers of Communications Equipment Service Provider replacement coverage for loss of and damage, theft or mechanical breakdown to communications equipment. Communications equipment means wireless telephones and pagers, and any other devices incorporating wireless phone and pager capabilities, including but not limited to personal digital assistants (PDA) and wireless aircards.

Event Cancellation

Coverage for financial loss because of the cancellation or postponement of a specific event due to weather or other unexpected cause beyond the control of the insured.

Travel Coverage

Covers financial loss due to trip cancellation/interruption; lost or damaged baggage; trip or baggage delays; missed connections and/or changes in itinerary; and casualty losses due to rental vehicle damage.

Vehicle Excess Waiver

Coverage of rental excess or personal excess due to the vehicle being involved in an accident while under the control of the insured or rental vehicle is damaged or stolen.

Not for Distribution

Boatowners/Personal Watercraft

Covers damage to pleasure boats, motors, trailers, boating equipment and personal watercraft, as well as bodily injury and property damage liability to others.

Other Commercial Inland Marine

All other inland marine coverage that is sold to commercial ventures, including coverage on property rented/leased by the named insured to others.

Other Personal Inland Marine

All other inland marine coverage that is sold for personal, family or household purposes.

Cash and Cash in Transit Insurance

Coverage of the transport, processing and storage of currency, securities, precious metals and diamonds. (Armored carriers, courier operations, check cashers and ATM servicers).

Line 10 – Financial Guaranty

A surety bond, insurance policy, or when issued by an insurer, an indemnity contract and any guaranty similar to the foregoing types, under which loss is payable upon proof of occurrence of financial loss to an insured claimant, obligee or indemnitee as a result of failure to perform a financial obligation (see *Financial Guaranty Insurance Guideline* (#1626)).

Line 11 – Medical Professional Liability

Insurance coverage protecting a licensed health care provider or health care facility against legal liability resulting from the death or injury of any person due to the insured's misconduct, negligence, or incompetence in rendering professional services. Medical Professional Liability is also known as Medical Malpractice.

Line 12 – Earthquake

Property coverages for losses resulting from a sudden trembling or shaking of the earth, including that caused by volcanic eruption. Excluded are losses resulting from fire, explosion, flood or tidal wave following the covered event.

Line 13 – Group Accident and Health

Coverage written on a group basis (e.g., employees of a single employer and their dependents) that pays scheduled benefits or medical expenses caused by disease, accidental injury or accidental death. Excludes amounts attributable to uninsured accidents and health plans and the uninsured portion of partially insured accident and health plans. Coverage is usually provided in the following manner:

A single policy called a "master contract" is issued to the group policyholder to cover a group of individuals who have a defined relationship (other than insurance) to the policyholder, such as:

- employee/employer
- member/union
- debtor/creditor

The contract provides specified types of insurance coverage for the individuals in a group. Policies generally provide benefits for one or more of the following coverages: short- or long-term disability income benefits, accidental death or dismemberment coverage, major medical expense benefits, and dental expense benefits.

Not for Distribution

Line 14 – Credit Accident and Health (Group and Individual)

Coverage provided to, or offered to, borrowers in connection with a consumer credit transaction where the proceeds are used to repay a debt or an installment loan in the event the consumer is disabled as the result of an accident, including business not exceeding 120 months duration.

Line 15 – Other Accident and Health

Accident and health coverages not otherwise properly classified as Group Accident and Health or Credit Accident and Health (e.g., collectively renewable and individual non-cancelable, guaranteed renewable, non-renewable for stated reasons only, etc.). Include all Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.

Line 15.1 – Collectively Renewable A&H

Include: Amounts pertaining to policies that are made available to groups of persons under a plan sponsored by an employer, or an association or a union or affiliated associations or unions or a group of individuals supplying materials to a central point of collection or handling a common product or commodity, under which the reporting entity has agreed with respect to such policies that renewal will not be refused, subject to any specified age limit, while the insured remains a member of the group specified in the agreement unless the reporting entity simultaneously refuses renewal to all other policies in the same group. A sponsored plan shall not include any arrangement where the reporting entity's customary individual policies are made available without special underwriting considerations and where the employer's participation is limited to arranging for salary allotment premium payments with or without contribution by the employer. Such plans are sometimes referred to as payroll budget or salary allotment plans. A sponsored plan may be administered by an agent or trustee.

Amounts pertaining to policies issued by a company or group of companies under a plan, other than a group insurance plan, authorized by special legislation for the exclusive benefit of the aged through mass enrollment.

Amounts pertaining to policies issued under mass enrollment procedures to older people, such as those age 65 and over, in some geographic region or regions under which the reporting entity has agreed with respect to such policies that renewal will not be refused unless the reporting entity simultaneously refuses renewal to all other policies specified in the agreement.

Line 15.2 – Non-Cancelable A&H

Include: Amounts pertaining to policies, which are guaranteed renewable for life or to a specified age, such as 60 or 65, at guaranteed premium rates.

Not for Distribution

Line 15.3 – Guaranteed Renewable A&H

Include: Amounts pertaining to policies that are guaranteed renewable for life or to a specified age, such as 60 or 65, but under which the reporting entity reserves the right to change the scale of premium rates.

Line 15.4 – Non-Renewable for Stated Reasons Only

Include: Amounts pertaining to policies in which the reporting entity has reserved the right to cancel or refuse renewal for one or more stated reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

Line 15.5 – Other Accident Only

Include: Policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents not included in Annual Statement lines 13, 14, 15.1 through 15.4, 15.6 and 15.8. Types of coverage include student accident, sports accident, travel accident, blanket accident, specific accident or accidental death and dismemberment (AD&D).

Line 15.6 – Medicare Title XVIII Exempt from State Taxes or Fees

Report Medicare Title XVIII premiums that are exempted from state taxes or other fees by Section 1854(g) of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This includes, but is not limited to, premiums written under a Medicare Advantage product, a Medicare PFFS product or a stand-alone Medicare Part D product.

Line 15.7 – All Other A&H

Include: Any other accident and health coverages not specifically required in Annual Statement lines 13, 14, 15.1 through 15.6 and 15.8.

Line 15.8 – Federal Employees Health Benefits Plan Premium

Include: Premiums, dividends and losses allocable to the Federal Employees Health Benefits Plan that are exempted from state taxes or other fees by Section 8909(f)(1) of Title 5 of the U.S. Code.

Not for Distribution

Line 16 – Workers' Compensation

Insurance that covers an employer's liability for injuries, disability or death to persons in their employment, without regard to fault, as prescribed by state or Federal workers' compensation laws and other statutes. Includes employer's liability coverage against the common law liability for injuries to employees (as distinguished from the liability imposed by Workers' Compensation Laws). Excludes excess workers' compensation.

Alternative Workers' Compensation

Other than standard workers' compensation coverage, employer's liability and excess workers' compensation (e.g., large deductible, managed care).

Employers' Liability

Employers' liability coverage for the legal liability of employers arising out of injuries to employees. This line of business should be used when coverage is issued as an endorsement or as part of a statutory workers' compensation policy. When coverage is issued as a stand-alone policy, or as an endorsement a package policy, the appropriate "Other Liability" line of business should be used.

Standard Workers' Compensation

Insurance that covers an employer's liability for injuries, disability or death to persons in their employment, without regard to fault, as prescribed by state or federal workers' compensation laws and included within the basic policy employers' liability coverage.

Line 17 – Other Liability

Insurance coverage protecting the insured against legal liability resulting from negligence, carelessness or a failure to act, causing property damage or personal injury to others. Typically, coverages include construction and alteration liability; contingent liability; contractual liability; elevators and escalators liability; errors and omissions liability, environmental pollution liability; excess stop loss, excess over insured or self-insured amounts and umbrella liability; liquor liability; personal injury liability; premises and operations liability; completed operations liability, nonmedical professional liability, etc. Also includes indemnification coverage provided to self-insured employers on an excess of loss basis (excess workers' compensation).

Completed Operations Liability

Premiums attributable to policies covering the liability of contractors, plumbers, electricians, repair shops and similar firms to persons who have incurred bodily injury or property damage from defective work or operations completed or abandoned by or for the insured, away from the insured's premises.

Construction and Alteration Liability

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from alterations involving demolition, new construction or change in size of a structure on the insured's premises.

Contingent Liability

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from work done by an independent contractor hired by the insured to perform work that was illegal, inherently dangerous, supervised too closely; or it was a situation that does not permit delegation of responsibility.

Not for Distribution

<u>Contractual Liability</u>

Premiums attributable to policies covering the liability of an insured that has assumed the legal liability of another party by written or oral contract. Includes coverage that names the lender/lessor as beneficiary and indemnifies the borrower/lessee for the liability of the balance due on the automobile loan/lease for an automobile that has been destroyed in an accident.

<u>Elevators and Escalators Liability</u>

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from use of elevators or escalators operated, maintained or controlled by the insured.

<u>Errors and Omissions Liability</u>
<u>Professional Liability Other Than Medical</u>

Premiums attributable to policies covering the liability of a professional or quasi-professional insured to persons who have incurred bodily injury or property damage, or who have sustained any loss from omissions arising from the performance of services for others, errors in judgment, breaches of duty, or negligent or wrongful acts in business conduct.

<u>Environmental Pollution Liability</u>

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from acids, fumes, smoke, toxic chemicals, waste materials or other pollutants.

<u>Excess and Umbrella Liability</u>

Premiums attributable to policies covering the liability of an insured above a specific amount set forth in a basic policy issued by the primary insurer; or a self-insurer for losses over a stated amount; or an insured or self-insurer for known or unknown gaps in basic coverages or self-insured retentions.

<u>Liquor Liability</u>

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage from an intoxicated person.

<u>Personal Injury Liability</u>

Premiums attributable to policies covering the liability of an insured to persons who have been discriminated against, falsely arrested, illegally detained, libeled, maliciously prosecuted, slandered, suffered mental anguish or alienation of affections, or have had their right of privacy violated. Includes identity theft.

<u>Premises and Operations Liability</u>

Premiums attributable to policies covering the liability of an insured to persons who have incurred bodily injury or property damage on an insured's premises during normal operations or routine maintenance, or from an insured's business operations either on or off of the insured's premises.

<u>Excess Workers' Compensation</u>

Either specific and/or aggregate excess workers' compensation insurance written above an attachment point or self-insured retention.

Not for Distribution

Commercial General Liability

Flexible and broad commercial liability coverage with two major sub-lines: premises/operations sub-line and products/completed operations sub-line.

Comprehensive Personal Liability

Comprehensive liability coverage for exposures arising out of the residence premises and activities of individuals and family members. (Non-business liability exposure protection for individuals.)

Day Care Centers

Liability coverage for day care centers.

Directors and Officers Liability

Liability coverage protecting directors or officers of a corporation from liability arising out of the performance of their professional duties on behalf of the corporation.

Employee Benefit Liability

Liability protection for an employer for claims arising from provisions in an employee benefit insurance plan provided for the economic and social welfare of employees. Examples of items covered are pension plans, group life insurance, group health insurance, group disability income insurance, and accidental death and dismemberment.

Employers' Liability

Employers' liability coverage for the legal liability of employers arising out of injuries to employees. This line of business should be used when coverage is issued as a stand-alone policy, or as an endorsement to a package policy. When this coverage is issued as an endorsement to a statutory workers' compensation policy, the "Workers' Compensation" line of business should be used.

Employment Practices Liability

Liability protection for an employer providing personal injury coverage arising out of employment-related practices, personnel policies, acts or omissions. Examples of claims such policies respond to are refusal to employ, termination, coercion, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation and discrimination.

Fire Legal Liability

Coverage for property loss liability as the result of separate negligent acts and/or omissions of the insured that allows a spreading fire to cause bodily injury or property damage of others. An example is a tenant who, while occupying another party's property, through negligence causes fire damage to the property.

Municipal Liability

Liability coverage for the acts of a municipality.

Nuclear Energy Liability

Coverage for bodily injury and property damage liability resulting from the nuclear energy material (whether or not radioactive) on the insured business's premises or in transit.

Not for Distribution

Veterinarian

Liability coverage for the acts of a veterinarian.

Internet Liability

Liability arising out of claims for wrongful acts related to the content posted on a website by the insured or the insured's failure to maintain the security of its computer systems.

Cyber Liability

Stand-alone comprehensive coverage for liability arising out of claims related to unauthorized access to or use of personally identifiable or sensitive information due to events including, but not limited to, viruses, malicious attacks, or system errors or omissions. This coverage could also include expense coverage for business interruption, breach management and/or mitigation services. When cyber liability is provided as an endorsement or as part of a multi-peril policy, as opposed to a stand-alone policy, use the appropriate annual statement line of business of the product to which the coverage will be attached.

Line 17.1 – Other Liability Occurrence

Exclude: Excess workers' compensation included in Line 17.3.

Line 17.2 – Other Liability Claims Made

Exclude: Excess workers' compensation included in Line 17.3.

Line 17.3 – Excess Workers' Compensation

Include: Indemnification coverage provided to self-insured employers on an excess of loss basis.

Line 18 – Product Liability

Insurance coverage protecting the manufacturer, distributor, seller or lessor of a product against legal liability resulting from a defective condition causing personal injury, or damage, to any individual or entity, associated with the use of the product.

Line 19 – Auto Liability

Coverage that protects the insured against financial loss because of legal liability for motor vehicle-related injuries (bodily injury and medical payments) or damage to the property of others caused by accidents arising out of ownership, maintenance or use of a motor vehicle (including recreational vehicles such as motor homes). "Commercial" is defined as all motor vehicle policies that include vehicles that are used primarily in connection with business, commercial establishments, activity, employment, or activities carried on for gain or profit. "No Fault" is defined by the state concerned.

Line 19.1 – Private Passenger Auto No-Fault (Personal Injury Protection)

"No Fault" is defined by the state concerned.

Line 19.2 – Other Private Passenger Auto Liability

Include: Bodily Injury, Property Damage, Uninsured Motorist and Underinsured Motorist Coverages.

Not for Distribution

Line 19.3 – Commercial Auto No-Fault (Personal Injury Protection)

"No Fault" is defined by the state concerned.

Line 19.4 – Other Commercial Auto Passenger Liability

Include: Bodily Injury, Property Damage, Uninsured Motorist and Underinsured Motorist Coverages.

Line 21 – Auto Physical Damage

Any motor vehicle insurance coverage (including collision, vandalism, fire and theft) that insures against material damage to the insured's vehicle. "Commercial" is defined as all motor vehicle policies that include vehicles that are used in connection with business, commercial establishments, activity, employment or activities carried on for gain or profit.

Line 21.1 – Private Passenger Auto Physical Damage

Include: Comprehensive and Collision Coverages.

Line 21.2 – Commercial Auto Physical Damage

Include: Comprehensive and Collision Coverages.

Line 22 – Aircraft

Coverage for aircraft (hull) and their contents; aircraft owners' and aircraft manufacturers' liability to passengers, airports and other third parties.

Line 23 – Fidelity

A bond covering an employer's loss resulting from an employee's dishonest act (e.g., loss of cash, securities, valuables, etc.).

Line 24 – Surety

A three–party agreement where the insurer agrees to pay a second party (the obligee) or make complete an obligation in response to the default, acts or omissions of a third party (the principal).

Line 25 – Glass
(1996 Annual Statement and previous)

Coverage for the costs of replacement and incidental costs of building glass due to breakage or application of chemicals to glass. NOTE: This coverage should be included in Allied Lines.

Line 26 – Burglary and Theft

Coverage for property taken or destroyed by breaking and entering the insured's premises, burglary or theft, forgery or counterfeiting, fraud, kidnap and ransom, and off-premises exposure.

Line 27 – Boiler and Machinery

Coverage for the failure of boilers, machinery and electrical equipment. Benefits include:

(i) property of the insured that has been directly damaged by the accident.
(ii) Costs of temporary repairs and expediting expenses.
(iii) Liability for damage to the property of others.

Not for Distribution

Line 28 – Credit

Coverage purchased by consumers, manufacturers, merchants, educational institutions or other providers of goods and services extending credit, for indemnification of losses or damages resulting from the nonpayment of debts owed to/from them for goods or services provided in the normal course of their business.

Credit insurance is generally issued in connection with the issuance of credit to an individual by a bank, retailer, finance company or other similar organization and protects the organization for the unpaid balance of the loan and frequently for durations of less than 120 months. (Taken from *SSAP No. 59—Credit Life and Accident and Health Contracts*.)

Personal GAP (Guaranteed Asset Protection) Insurance

Credit insurance that insures the excess of the outstanding indebtedness over the primary property insurance benefits in the event of a total loss to a collateral asset.

Credit Involuntary Unemployment

Credit insurance that provides a monthly or lump sum benefit during an unpaid leave of absence from employment resulting from specified causes, such as layoff, business closure, strike, illness of a close relative and adoption or birth of a child. This insurance is sometimes referred to as Credit Family Leave.

Line 29 – International

Includes all business transacted outside the U.S. and its territories and possessions where the appropriate line of business is not determinable.

Line 30 – Warranty

Coverage that protects against manufacturer's defects past the normal warranty period and for repair after breakdown to return a product to its originally intended use. Warranty insurance generally protects consumers from financial loss caused by the seller's failure to rectify or compensate for defective or incomplete work and cost of parts and labor necessary to restore a product's usefulness. Includes, but is not limited to, coverage for all obligations and liabilities incurred by a service contract provider, mechanical breakdown insurance and service contracts written by insurers.

Mechanical Breakdown Insurance

Premiums attributable to policies covering repair or replacement service, or indemnification for that service, for the operational or structural failure of property due to defects in materials or workmanship, or normal wear and tear. (May cover motor vehicles, mobile equipment, boats, appliances, electronics, residual structures, etc.)

Service Contracts

Premiums attributable to policies that undertake the obligation to provide repair or replacement service, or reimbursement for that service, for the operational or structural failure of covered property due to defect in materials or workmanship or normal wear and tear, but does not include mechanical breakdown insurance.

Not for Distribution

Reinsurance

Proportional assumed reinsurance is allocated to and reported in the appropriate lines of business and excluded from the reinsurance lines of business. For assumed reinsurance contracts that afford proportional and nonproportional reinsurance, the business is allocated to its component parts and reported in the appropriate lines of business.

Nonproportional assumed reinsurance means excess of a retention by the ceding company, and proportional reinsurance means fixed percentage of all losses.

Line 31 – Nonproportional Assumed Reinsurance – Property

Nonproportional Assumed Reinsurance – Property in the following lines: fire allied lines, ocean marine, inland marine, earthquake, group accident and health, credit accident and health, other accident and health, auto physical damage, boiler and machinery, glass, burglary and theft and international (of the forgoing).

Line 32 – Nonproportional Assumed Reinsurance – Liability

Nonproportional Assumed Reinsurance – Liability in the following lines: farmowners multiple-peril, homeowners multiple-peril, commercial multiple-peril, medical professional liability, workers' compensation, other liability, products liability, auto liability, aircraft (all perils) and international (of the foregoing).

Line 33 – Nonproportional assumed Reinsurance – Financial Lines

Nonproportional Assumed Reinsurance – Financial Lines in the following lines: mortgage guaranty, financial guaranty, fidelity, surety, credit and international (of the foregoing).

Line 34 – Details for Write-ins

Coverages not generally described above.

Involuntary Unemployment Insurance

Space

Coverage of satellites, shuttles, hull, drones and other non-standard aircraft.

Political and Natural Disaster Evacuation

Coverage of specified costs for an insured person to return to their country of residence or nearest place of safety and specified reasonable accommodation costs (if the insured person is unable to return to their country of residence), as a direct result of a covered evacuation or if a natural disaster has occurred in the country the insured person is currently in requiring their immediate evacuation to avoid the risk of bodily injury or sickness, while the insured person is on a journey covered by the policy.

War Risk Insurance/War Terrorism and Political Violence

Mortgage Interest Insurance

Money Insurance

Not for Distribution

APPENDIX

INSTRUCTIONS FOR UNIFORM CLASSIFICATIONS OF EXPENSES OF PROPERTY AND CASUALTY INSURERS

For the purpose of establishing uniformity in classifications of expenses of property and casualty insurers recorded in statements and reports filed with and statistics reported to Insurance Departments, all such insurers shall observe the instruction set forth below. Refer to *SSAP No. 63—Underwriting Pools* for accounting guidance.

LIST OF OPERATING EXPENSE CLASSIFICATIONS FOR ANNUAL STATEMENT PURPOSES

1. Claim Adjustment Services
    - 1.1 Direct
    - 1.2 Reinsurance Assumed
    - 1.3 Reinsurance Ceded
2. Commission and Brokerage
    - 2.1 Direct excluding contingent
    - 2.2 Reinsurance Assumed excluding contingent
    - 2.3 Reinsurance Ceded excluding contingent
    - 2.4 Contingent—Direct
    - 2.5 Contingent—reinsurance assumed
    - 2.6 Contingent—reinsurance ceded
    - 2.7 Policy and Membership Fees
3. Allowances to Managers and Agents
4. Advertising
5. Boards, Bureaus, and Associations
6. Surveys and Underwriting Reports
7. Audit of Assureds' Records
8. Salary and Related Items
    - 8.1 Salaries
    - 8.2 Payroll taxes
9. Employee Relations and Welfare
10. Insurance
11. Directors' Fees

Not for Distribution

12. Travel and Travel Items

13. Rent and Rent Items

14. Equipment

15. Cost or Depreciation of EDP Equipment and Software

16. Printing and Stationery

17. Postage, Telephone and Telegraph, Exchange and Express

18. Legal and Auditing

20. Taxes, Licenses and Fees

    20.1 State and Local Insurance Taxes deducting guaranty association credits

    20.2 Insurance Department Licenses and Fees

    20.3 Guaranty Association Assessments

    20.4 Other (excluding Federal Income and Real Estate)

21. Real Estate Expenses

22. Real Estate Taxes

24. Miscellaneous

Not for Distribution

Not for Distribution

RULES RELATING TO OPERATING EXPENSE CLASSIFICATIONS

1. CLAIM ADJUSTMENT SERVICES

1.1 Direct

Include: The Following Expenses When in Connection With the Investigation and Adjustment of Policy Claims:

Independent Adjusters: Fees and expenses of independent adjusters or settling agents

Legal: Fees and expenses of lawyers for legal services in the defense, trial, or appeal of suits, or for other legal services

Bonds: Premium costs of bonds

Appeal Costs and Expenses: Appeal bond premiums, charges for printing records, charges for printing briefs, court fees and incidental to appeals

General Court Costs and Fees: Entry fees and other court costs, and other fees not includible in Losses (Note: Interest and costs assessed as part of or subsequent to judgment are includible in Losses.)

Medical Testimony: Fees and expenses of medical witnesses of attendance or testimony at trials or hearings ("Medical" includes physicians, surgeons, chiropractors, chiropodists, dentists, osteopaths, veterinarians, and hospital representatives.)

Expert Witnesses: Fees and expenses of expert witnesses for attendance or testimony at trials or hearings

Lay Witnesses: Fees and expenses of lay witnesses for attendance or testimony at trials or hearings

Services of Process: Constables, sheriffs, and other fees and expenses for service of process, including subpoenas

Transcripts of Testimony: Stenographers' fees and fees for transcripts of testimony

Medical Examinations: Fees for medical examinations, fees for performing autopsies, fees for impartial examination, x-rays, etc., for the purpose of trial and determining questions of liability (This does not include fees for medical examinations, x-rays, etc., made to determine necessary treatment, or made solely to determine the extent or continuation of disability, or first aid charges, as such fees and charges are includible in Losses.)

Miscellaneous: Costs of appraisals, expert examinations, surveys, plans, estimates, photographs, maps, weather reports, detective reports, audits, credit or character reports, watchmen (Charges for hospital records and records of other kinds, notary fees, certified copies of certificates and legal documents, charges for Claim Adjustment Services by underwriting syndicates, pools, and associations)

Exclude: Compensation to employees (see Salaries)

Expenses of salaried employees (see Travel and Travel Items)

Items includible in Allowances to Managers and Agents

Payments to State Industrial Commissions (see Taxes, Licenses, and Fees)

Payments to claim adjusting organizations except where the expense is billed specifically to individual companies (see Boards, Bureaus, and Associations)

Cost of services of medical examiners for underwriting purposes (see Surveys and Underwriting Reports)

Salvage and subrogation recovery expense, rewards, lost and found advertising, expenses for disposal of salvage (Such expenses shall be deducted from salvage.)

Any expenses which by these instructions are includible elsewhere

Separation of Claim Adjustment Services:

The Statistical Plans filed by certain rating bureaus contain definitions of "Allocated Loss Adjustment Expenses" which exclude for rating purposes certain types of claim adjustment services as defined herein. For the lines of business thus affected, companies that are members of such rating bureaus shall maintain records necessary to the reporting of Claim Adjustment Services—Direct, as follows:

a. As defined in Statistical Plans

b. Other than as defined in Statistical Plans

1.2 Reinsurance Assumed

Include: Claim adjustment expenses in bills rendered by ceding companies

1.3 Reinsurance Ceded

Include: Claim adjustment expenses billed to assuming entities

2. COMMISSION AND BROKERAGE

2.1 Direct excluding contingent

Include: All payments, reimbursements and allowances, on direct writings, computed as a percentage of premiums for production, management, or other services to:

Managers	Office Agents
Supervising General Agents	Brokers
General Agents	Solicitors
Regional and District Agents	Other producers and agents
Local Agents	

Commissions and brokerage to employees when the activities for which the commissions are paid are not a part of their duties as employees.

Not for Distribution

Exclude: Compensation to employees except as noted above (see Salaries)

Allowances, reimbursements and payments not computed as a percentage of premiums (see Allowances to Managers and Agents)

Expenses involved in transactions between insurance companies (see Joint Expenses; Commission and Brokerage—Reinsurance Assumed and Ceded; Expenses for Account of Another, and Income from Special Services)

Contingent commission (see Commission and Brokerage—Contingent)

Fees of investment counsel (see Legal and Auditing)

Expenses includible in Boards, Bureaus, and Associations

Taxes on premiums (see Taxes, Licenses, and Fees)

Commission received for special services such as loss adjustment and inspection not related to policies issued by the company (see Income from Special Services)

2.2 Reinsurance Assumed excluding contingent

Commission and allowances of every nature on reinsurance assumed including tax and board allowances and reinsurance brokerage, except contingent commission, should be included in Commission and Brokerage—Reinsurance Assumed

Exception: Where commission and allowances under reinsurance assumed take the form of accurate proportions of actual expenses incurred, as in some quota share and pooling arrangements, entries shall be made to the actual expenses.

2.3 Reinsurance Ceded excluding contingent

Commission and allowances of every nature on reinsurance ceded including tax and board allowances and reinsurance brokerage, except contingent commission, shall be included in Commission and Brokerage-Reinsurance Ceded.

Exception: Where commission and allowances under reinsurance ceded take the form of accurate proportions of actual expenses incurred, as in some quota share and pooling agreements, entries shall be made to the actual expenses.

Commissions and fee allowances received from FEMA should be reported consistent with reinsurance ceding commissions. Refer to *SSAP No. 62R—Property and Casualty Reinsurance.*

Examples Relating to the Treatment of Commission on Reinsurance Assumed and Reinsurance Ceded

1. Company A cedes business to Company B under a treaty specifying a commission of 35% and an allowance for taxes and board fees of 5%. On the statement filed by Company A, both the 35% and the 5% shall be entered in Commission and Brokerage—Reinsurance Ceded. On the statement filed by Company B, both the 35% and the 5% shall be entered in Commission and Brokerage—Reinsurance Assumed.

Not for Distribution

2. Company A cedes 10% of all of its business to Company B under an agreement whereby Company B pays 10% of all actual expenses on such business incurred by Company A. Assume the expenses of Company A on the business reinsured as follows:

	Paid on Written Business
Commission and Brokerage - Direct	$ 100,000
Salaries	30,000
Rent and Rent Items	7,000
Printing and Stationary	7,000
Postage, etc.	5,000
Surveys and Underwriting Reports	8,000
Total	$ 157,000

(NOTE: These are not intended to show the complete list of expenses involved but are given only for illustrative purposes.)

On the statement filed by Company A the commission and allowances by Company B shall be credited as follows:

	Paid on Written Business
Commission and Brokerage - Ceded	$ 10,000
Salaries	3,000
Rent and Rent Items	700
Printing and Stationary	700
Postage, etc.	500
Surveys and Underwriting Reports	800
Total	$ 15,700

On the statement filed by Company B the commission and allowances made to Company A shall be debited as follows:

	Paid on Written Business
Commission and Brokerage – Reinsurance Assumed	$ 10,000
Salaries	3,000
Rent and Rent Items	700
Printing and Stationary	700
Postage, etc.	500
Surveys and Underwriting Reports	800
Total	$ 15,700

2.4 Contingent Direct

Contingent or profit commission paid

Contingent or profit commission received

Contingent commission to employees when the activities for which the contingent commission is paid is not a part of their duties as employees

2.5 Contingent reinsurance assumed

2.6 Contingent reinsurance ceded

2.7 Policy and Membership Fees

Include: Policy and membership fees retained by or paid to agents

Policy and membership fees to employees when the activities for which the policy and membership fees are paid are not a part of their duties as employees

Not for Distribution

3. ALLOWANCES TO MANAGERS AND AGENTS

Include: Net allowances, reimbursements and payments for expenses of every nature, not computed as a percentage of premiums, to managers, agents, brokers, solicitors, and other producers

Exclude: Compensation to employees (see Salaries)

Expenses of salaried employees (see Travel and Travel Items)

Expenses of management where one insurance company has been appointed manager for another (see Joint Expenses; Commission and Brokerage—Reinsurance Assumed and Ceded; and Expenses for Account of Another)

Contingent commission (see Commission and Brokerage—Contingent)

Policy and membership fees (see Commission and Brokerage—Policy and Membership Fees)

Expenses in connection with owned real estate (see Real Estate Expenses)

Amounts representing exact reimbursements for Losses, Taxes, Licenses and Fees, Boards, Bureaus and Associations, and Advertising, where only the minimum space required by law is taken

Amounts representing exact reimbursements for Claim Adjustment Services, Surveys and Underwriting Reports and Audit of Assureds' Records when these services are performed by others than employees of managers, agents, brokers, solicitors or other producers

4. ADVERTISING

Include

Services of advertising agents

Public relations counsel

Space in newspapers, periodicals, billboards, programs, and other publications

Circulars, pamphlets, calendars and literature issued for advertising or promotional purposes

Drawings, plates, etchings, etc., in connection with advertising

All charges for printing, paper, etc., in bills covering advertising

Media Broadcasts (e.g., radio, television, etc.)

Prospect and mailing lists

Signs, frames, medals, etc., for agents

Souvenirs for general distribution

House organs and similar publications distributed to others than employees

Advertising required by law when more than the minimum space required to comply with the law is taken

Not for Distribution

Exclude: Compensation to employees (see Salaries)

Items includible in Travel and Travel Items, Claim Adjustment Services, and Boards, Bureaus and Associations

Cost of literature, booklets, placards, signs, etc., issued solely for accident and loss prevention (see Surveys and Underwriting Reports)

Advertising and business development expenses allowed, reimbursed or paid to managers, agents, brokers, solicitors, and other producers (see Allowances to Managers and Agents)

Cost of help wanted advertising (see Employee Relations and Welfare)

Cost of advertising in connection with owned real estate (see Real Estate Expenses)

Cost of house organs and similar publications for the use of employees (see Printing and Stationery)

Donations to organized charities (see Miscellaneous)

Cost of souvenirs not generally distributed (see Travel and Travel Items)

5. BOARDS, BUREAUS AND ASSOCIATIONS

Include*:* Dues, assessments, fees and charges of:

- Underwriting boards, rating organizations, statistical agencies, inspection and audit bureaus
- Underwriters' advisory and service organizations
- Accident and loss prevention organizations
- Claim organizations

Specific payments to boards, bureaus and associations for rate manuals, revisions, fillers, rating plans and experience data

Exclude: Cost of inspection, engineering or accident and loss prevention billed specifically to individual companies (see Surveys and Underwriting Reports)

Loss adjustment expenses billed specifically to individual companies (see Claim Adjustment Services)

Allowances under reinsurance contracts for board and bureau expenses (see Commission and Brokerage—Reinsurance Assumed and Ceded)

Payments to State Industrial Commissions (see Taxes, Licenses, and Fees)

Payments into State Security Funds (see Taxes, Licenses, and Fees)

Commission and Brokerage, Claim Adjustment Services, and Taxes, Licenses and Fees of underwriting syndicates, pools, and associations

Cost of Survey, credit, moral hazard, character and commercial reports obtained for underwriting purposes (see Surveys and Underwriting Reports)

Cost of commercial reporting services (see Surveys and Underwriting Reports)

Dues and subscriptions to social or civic clubs or affairs (see Travel and Travel Items)

Dues and subscriptions to accounting, legal, actuarial or similar societies and associations (see Travel and Travel Items)

Not for Distribution

6. SURVEYS AND UNDERWRITING REPORTS

Include:

Survey, credit, moral hazard, character and commercial reports obtained for underwriting purposes

Commercial reporting services

Appraisals for underwriting purposes

Fire records

Inspection, engineering, and accident and loss prevention billed specifically

Literature, booklets, placards, signs, etc., issued solely for accident and loss prevention

Maps and corrections

Services of medical examiners for underwriting purposes

Exclude: Compensation to employees (see Salaries)

Expenses of salaried employees (see Travel and Travel Items)

Items includible in Boards, Bureaus and Associations, Claim Adjustment Services, and Allowances to Manager and Agents

Cost of character or credit reports on employees or applicants for employment (see Employee Relations and Welfare)

Fees for physical examination of employees or applicants for employment (see Employee Relations and Welfare)

Income from inspections, which shall be classified in accordance with the instruction "Income from Special Services"

7. AUDIT OF ASSUREDS' RECORDS

Include: Auditing fees and expenses of independent auditors for auditing payrolls and other premium bases

Exclude: Compensation to employees (see Salaries)

Expenses of salaried employees (see Travel and Travel Items)

Items includible in Claim Adjustment Services

Items includible in Allowances to Managers and Agents

Not for Distribution

8. SALARY AND RELATED ITEMS

8.1 Salaries

Include: Salaries, bonus, overtime, contingent compensation, pay while on leave, dismissal allowance, pay while training and other compensation of employees

Commission and brokerage to employees when the activities for which the commission is paid are a part of their duties as employees

Exclude: Salaries or wages of janitors, caretakers, maintenance workers and agents paid in connection with owned real estate (see Real Estate Expenses)

8.2 Payroll Taxes

Include: Old age benefit taxes

Unemployment insurance taxes

Exclude: Payroll taxes includible in Real Estate Taxes

9. EMPLOYEE RELATIONS AND WELFARE

A. Pensions and Insurance Benefits for Employees

Include: Cost of retirement insurance

Payments or appropriations to funds irrevocably devoted to the payment of pensions or other employees' benefits

Pensions or other retirement allowances

Accident, health and hospitalization insurance for employees

Group life insurance for employees

Workers' compensation insurance

Payments to or on behalf of employees under self-insurance

Any other insurance for the benefit of employees

Exclude: Cost of insurance on lives of employees when the company is the beneficiary

Payments or appropriations to pension funds not irrevocably devoted to the payment of pensions or other employees' benefits (such payments or appropriations shall not appear among expenses.)

Items includible in Real Estate Expenses

All other types of insurance premiums

Not for Distribution

B. All Other

Include:

Advertising—help wanted

Training and welfare of employees

Physical examinations of employees or applicants for employment

Character or credit reports on employees or applicants for employment

Gatherings, outings and entertainment for employees

Visiting nurse service for or on behalf of employees

Medical and hospital bills for employees (not covered by 9A)

Direct payments, other than salaries, to employees for injury and sickness (not covered by 9A)

Supper money

Donations to or on behalf of employees

Food and catering for employees

Exclude: Salaries, bonus, overtime, contingent compensation, pay while on leave, dismissal allowances, pay while training and other compensation of employees (see Salaries)

Items includible in Real Estate Expenses

Cost of house organs and similar publications (see Advertising, and Printing and Stationery)

10. INSURANCE

Include: Fidelity or surety bonds covering employees and agents

Burglary and robbery insurance premiums

Public liability insurance premiums (Excluding owned Real Estate)

Premiums for insurance on office contents

Cost of insurance on automobiles

All other insurance premiums not specifically provided for in other operating accounts

Exclude: Items includible in Employee Relations and Welfare

Items includible in Real Estate expenses

Not for Distribution

11. DIRECTORS' FEES

Include: Directors' fees and other compensation of directors for attendance at board or committee meetings

Other fees, compensation, and expenses paid to directors

Exclude: Commission to directors for the production of business (see Commission and Brokerage—Direct)

12. TRAVEL AND TRAVEL ITEMS

Include: Transportation, hotel, meals, postage, telephone, telegraph, express and incidental living expenses of employees while traveling

Expenses for transfer of employees

Depreciation, repairs and other operating expenses of automobiles

Rent of automobiles

Fees for automobile license plates

Cost of transportation, hotel, meals and entertainment of guests

Cost of favors and presents given or extended to others than employees

Cost of souvenirs not generally distributed

Dues and subscriptions to social or civic clubs or affairs

Dues and subscriptions to accounting, legal, actuarial, or similar societies and associations

Exclude: Items includible in Salaries, Advertising, Commission and Brokerage, Taxes, Licenses and Fees, Boards, Bureaus and Associations, and Equipment

Cost of gatherings, outings, etc., and entertainment for employees (see Employee Relations and Welfare)

Travel and Travel Items expenses paid, reimbursed, or allowed to managers, agents, brokers, solicitors and other producers (see Allowances to Managers and Agents)

Items includible in Real Estate Expenses

Donations to organized charities (see Miscellaneous)

Cost of souvenirs for general distribution (see Advertising)

Not for Distribution

13. RENT AND RENT ITEMS

Include:

Rent of home office and branch offices

Rent for space occupied in buildings owned

Light, heat, power and water charges in leased premises

Interest, taxes, etc., paid in lieu of rent for leased premises

Cost of alternations and repairs of leased premises

Rent of storage, safekeeping and warehouse space

Rent of safe deposit boxes

Rent of post office boxes

Time clock service charges

Cost of cleaning, towels, ice, water, electric lamp replacements and other expenses incidental to office maintenance

Exclude:

Compensation to employees (see Salaries)

Rent of automobiles (see Travel and Travel Items)

Rent allowed, reimbursed, or paid to managers, agents, brokers, solicitors and other producers (see Allowances to Managers and Agents)

Items includible in Real Estate Expenses

Rent income from owned real estate

14. EQUIPMENT

Include:

Rent and repairs of furniture, equipment, and office machines (including printers' equipment, postage machines and data processing equipment)

Depreciation of furniture, equipment and office machines (including printers' equipment, postage machines and data processing equipment)

Exclude:

Compensation to employees (see Salaries)

Rent, repairs and depreciation of automobiles (see Travel and Travel Items)

Cost of insurance on automobiles (see Insurance)

Cost of alterations and repairs of leased premises (see Rent and Rent Items)

Equipment expenses allowed, reimbursed or paid to managers, agents, brokers, solicitors and other producers (see Allowances to Managers and Agents)

Items includible in Real Estate Expenses

Not for Distribution

16. PRINTING AND STATIONERY

Include:

Printing, stationery and office supplies such as: letterhead, envelopes, paper stock, printed forms or manuals, adding machine tape, carbon paper, binders and posts, photostatic copies, pencils, pens, leads, ink, glue, stamps and stamp pads, staplers, staples, clips and pins, desk top equipment (calendars, trays, etc.), waste baskets, analysis pads, ledgers, journals, minute books, etc.

Policies and policy forms

House organs and similar publications for the use of employees

Books, newspapers and periodicals including investment, tax and legal publications and services

Exclude:

Compensation to employees (see Salaries)

Specific payments to boards, bureaus and associations for rate manuals, revisions, fillers, rating plans and experience data (see Boards, Bureaus and Associations)

Literature, booklets, placards, signs, etc., issued solely for accident and loss prevention (see Surveys and Underwriting Reports)

Items includible in Claim Adjustment Services

Items includible in Advertising

Printers' equipment in company owned printing departments (see Equipment)

Printing and stationery allowed, reimbursed or paid to managers, agents, brokers, solicitors and other producers (see Allowances to Managers and Agents)

House organs and similar publications distributed to others than employees (see Advertising)

Commercial reporting services (see Surveys and Underwriting Reports)

Items includible in Real Estate Expenses

Not for Distribution

17. POSTAGE, TELEPHONE AND TELEGRAPH, EXCHANGE AND EXPRESS

Include:

- Express, freight and cartage
- Postage
- Cost of telephone and telegrams, cable, radiograms and teletype
- Bank charges for collection and exchange

Exclude:

- Compensation to employees (see Salaries)
- Rent, repairs and depreciation of postage machines (see Equipment)
- Postage, telephone, telegraph and express of employees while traveling (see Travel and Travel Items)
- Postage, telephone and telegraph, exchange, and express allowed, reimbursed or paid to managers, agents, brokers, solicitors and other producers (see Allowances to Managers and Agents)
- Profits or losses resulting from exchange on remittances to Home Office by a United States Branch. Such profits or losses shall not be included in expenses
- Items includible in Real Estate Expenses
- Rent of post office boxes (see Rent and Rent Items)

18. LEGAL AND AUDITING

Include:

- Legal retainers, fees and other legal expenses (except on losses and salvage)
- Auditing fees of independent auditors for examining records of home and branch offices
- Cost of services of tax experts
- Fees of investment counsel
- Registrar fees
- Custodian fees
- Trustees' fees
- Transfer agent fees
- Fees and expenses of others than employees, for collecting balances
- Notary fees

Exclude:

- Compensation to employees (see Salaries)
- Expenses of salaried employees (see Travel and Travel Items)
- Items includible in Claim Adjustment Services
- Items includible in Real Estate Expenses
- Cost of auditing of assureds' records (see Audit of Assureds' Records)

Not for Distribution

20. TAXES, LICENSES AND FEES

20.1 State and Local Insurance Taxes deducting guaranty association assessment association credits

Include: State, county and municipal taxes, licenses and fees based upon premiums

Fire Patrol assessments

Payments to State Industrial (or other) Commissions for administration of Workers' Compensation or other State Benefit Acts (including assessments for administering Financial Responsibility Laws) regardless of basis of assessment

Net payments to State Security Funds, Reopened Case Funds, Second Injury Funds and other State Funds, when construed by the company as operating expenses, regardless of basis of assessment

Exclude: Allowances for taxes under reinsurance contracts (see Commission and Brokerage Reinsurance Assumed and Ceded)

20.2 Insurance Department Licenses and Fees

Include: Agents' Licenses

Certificates of authority, compliance, deposit, etc.

Filing fees

Fees and expenses of examination by insurance departments or other governmental agencies

Exclude: Items includible in Claim Adjustment Services

20.4 All Other (Excluding Federal Income and Real Estate)

Include: Qualifying bond premiums

Statement publication fees

Advertising required by law

Personal property taxes

State income taxes

Capital stock taxes

Business or corporation licenses or fees (not includible under 20.1 or 20.2)

Marine profits taxes

Documentary stamps on reinsurance

Any other taxes not assignable under 20.1, 20.2, and 20.3 and not otherwise excluded

Not for Distribution

Exclude: Cost of advertising required by law where more than minimum space required to comply with the law is taken. Such expense shall be included in Advertising.

Real estate taxes, licenses and fees (see Real Estate Taxes)

Items includible in Claim Adjustment Services

Fees for automobile license plates (see Travel and Travel Items)

Federal income tax

Sales taxes, etc., included on invoices of vendors. Such taxes are to follow allocation of cost of items purchased.

21. REAL ESTATE EXPENSES

Include: Salaries, wages and other compensation of janitors, caretakers, maintenance workers and agents paid in connection with owned real estate

Cost of operating and maintaining owned real estate

Cost of insurance in connection with owned real estate

Cost of advertising in connection with owned real estate

22. REAL ESTATE TAXES

Include: Taxes, licenses and fees on owned real estate

24. MISCELLANEOUS

Expenses not listed as includible in other operating expense classifications, and not analogous thereto, shall be included in "Miscellaneous." Specifically, the following shall be included:

Cost of tabulating service when such service is rendered by outside organizations

Amounts received and handled in accordance with the Instruction "Income from Special Services"

Donations to organized charities

Differences between actual amounts paid, and amounts apportioned in accordance with the Instruction "Joint Expenses"

Not for Distribution

GENERAL INSTRUCTIONS IN CONNECTION WITH OPERATING EXPENSE CLASSIFICATIONS

A. Joint Expenses

Whenever personnel or facilities are used in common by two or more companies, or whenever the personnel or facilities of one company are used in the activities of two or more companies, the expenses involved shall be apportioned in accordance with the instructions relating to Joint Expenses, and such apportioned expenses shall be allocated by each company to the same operating expense classifications as if the expenses had been borne wholly. Any difference between the actual amount paid, and the amount of such apportioned expenses shall be included in the operating expense classification "Miscellaneous."

This instruction does not apply to the allocation of the following, which are covered by separate instructions herein:

Reinsurance commission and allowances (see Commission and Brokerage—Reinsured Assumed and Ceded)

Commission and brokerage paid to managers and agents (see Commission and Brokerage—Direct)

Allowances to managers and agents (see Allowances to Managers and Agents)

Expenses allocable in accordance with the instruction "Income from Special Services"

B. Expenses for Account of Another

Whenever expenses are paid by one company for account of another, the payments shall not appear among the expenses reported by the former, and shall be included by the latter in the same expense classifications as if originally paid by it.

C. Income from Special Services

Whenever an insurance company receives compensation for sales or services, such as loss adjustment or inspection not related to policies written by the company and such compensation is not calculated as a joint expense reimbursement, the amount thereof shall be included in the operating expense classification "Miscellaneous." Where an insurance company pays the compensation, allocation shall be made to the expense classification dictated by the nature of the expense.

Reinsurance commission and allowances (see Commission and Brokerage—Reinsurance Assumed and Ceded)

Expenses incurred for the benefit of companies in the same group or fleet are covered by the instruction "Joint Expenses."

D. Analogous Items

The lists of expenses includible in the operating expense classifications are representative and do not exclude analogous items that are omitted from the lists.

Not for Distribution

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Notary fees, Sec. 18
Notary fees relating to claim adjustment, Sec. 1 (A)
Nurse service to employees, Sec. 9
Office agents, payments to, Sec. 2 (A) and Sec. 3
Office machines, depreciation, rent repairs and insurance of, Sec. 14
Office maintenance expense, Sec. 13
Old age benefit taxes, Sec. 8 (B)
Operating expenses of owned real estate, Sec. 21
Overtime, Sec. 8 (A)
Outings for employees, Sec. 9
Pamphlets, advertising in, Sec. 4
Paper in bills covering advertising, Sec. 4
Paper stock, Sec. 16
Payroll audit, Sec. 7
Payroll taxes, Sec. 8 (B)
Pencils and pens, Sec. 16
Pensions, Sec. 9
Periodicals, advertising in, Sec. 4
Periodicals, newspapers, books, etc., including investment, tax and legal publications and services, Sec. 16
Personal property taxes, Sec. 20 (D)
Photographs relating to claim adjustment, Sec. 1 (A)
Photo static copies, Sec. 16
Physical examinations of employees, Sec. 9
Pins, Sec. 16
Placards for accident and loss prevention, Sec. 6
Plates in connection with advertising, Sec. 4
Policies and policy forms, Sec. 16
Policy and membership fees, Sec. 2 (E)
Policy claims, investigation and adjustment, Sec. 1 (A)
Pools and associations, Sec. 5
Pool and quota share agreements, Sec. 2 (B) (C)
Post office boxes, rent of, Sec. 13
Postage machines, Sec. 14
Postage expenses incurred by employees while traveling, Sec. 12
Postage, telephone, telegraph, exchange and express, Sec. 17
Power, light, heat and water charges in leased premises, Sec. 13
Premium cost of bonds relating to claim adjustment, Sec. 1 (A)
Premium taxes, licenses and fees, Sec. 20 (A)
Premiums for insurance on office contents, Sec. 10
Presents and favors given to others than employees, Sec. 12
Printed forms, Sec. 16
Printers' equipment, rent, repairs, depreciation and insurance of, Sec. 14
Printing and stationary, Sec. 16
Printing and stationary relating to claim adjustment, Sec. 1 (A)
Printing in bills covering advertising, Sec. 4
Process, service of, relating to claim adjustment, Sec. 1 (A)
Producers, payments to, Sec. 2 (A) and Sec. 3
Profit commission, Sec. 2 (D)

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Programs, advertising in, Sec. 4
Prospect lists, Sec. 4
Public liability insurance premiums, Sec. 10
Public relations counsel, Sec. 4
Publication fees, Sec. 20 (D)
Publications, advertising in, Sec. 4
Publications such as house organs, for use of employees, Sec. 16
Qualifying bond premiums, Sec. 20 (D)
Quota share and pool arrangements, Sec. 2 (B) (C)
Radio broadcasts, Sec. 4
Radiograms, Sec. 17
Rate manuals, Sec. 5
Rating organizations, Sec. 5
Rating plans, Sec. 5
Real estate expenses, Sec. 21
Real estate taxes, Sec. 22
Regional agents, payments to, Sec. 2 (A) and Sec. 3
Registrar fees, Sec. 18
Reinsurance assumed, claim adjustment services, Sec. 1 (B)
Reinsurance assumed, commission and brokerage, Sec. 2 (B)
Reinsurance ceded, claim adjustment services, Sec. 1 (C)
Reinsurance ceded, commission and brokerage, Sec. 2 (C)
Rent and rent items, Sec. 13
Rent of furniture, equipment and office machines, Sec. 14
Rent of automobiles, Sec. 12
Reopened case funds, Sec. 20 (A)
Repairs and alterations in leased premises, Sec. 13
Repairs of automobiles, Sec. 12
Repairs of furniture, equipment and office machines, Sec. 14
Retirement allowances, Sec. 9
Retirement insurance, Sec. 9
Safe deposit boxes, rent of, Sec. 13
Safekeeping, storage and warehouse space, rent of, Sec. 13
Salaries, operating expense classification, Sec. 8 (A)
Salaries, paid in connection with owned real estate, Sec. 21
Second injury funds, Sec. 20 (A)
Security funds, Sec. 20 (A)
Service organizations, Sec. 5
Services, tabulating, rendered by outside organizations, Sec. 24
Sickness payments to employees, Sec. 9
Signs for accident and loss prevention, Sec. 6
Signs for agents, Sec. 4
Solicitors, payments to, Sec. 2 (A) and Sec. 3
Souvenirs for general distribution, Sec. 4
Souvenirs not generally distributed, Sec. 12
Social clubs, dues and subscriptions to, Sec. 12
Space occupied in buildings owned, Sec. 13
Stamp pads, Sec. 16
Staples and staplers, Sec. 16
State income taxes, Sec. 20 (D)
State industrial commissions, Sec. 20 (A)
State insurance taxes, Sec. 20 (A)
State licenses and fees, Sec. 20 (B)
State premium taxes, licenses and fees, Sec. 20 (A)
State security funds, Sec. 20 (A)
Statement publication fees, Sec. 20 (D)
Stationery, Sec. 16
Statistical services, Sec. 24
Statistical agencies, Sec. 5

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Stenographers' fees relating to claim adjustment, Sec. 1 (A)
Stock taxes, Sec. 20 (D)
Storage, safekeeping and warehouse space, rent of, Sec. 13
Subpoenas relating to claim adjustment, Sec. 1 (A)
Subscriptions to accounting, legal, actuarial and similar societies, Sec. 12
Subscription to social or civic clubs or affairs, Sec. 12
Supper money, Sec. 9
Surety bonds covering employees, Sec. 10
Survey reports relating to claim adjustment, Sec. 1 (A)
Surveys and underwriting reports, Sec. 6
Syndicates, underwriting, Sec. 5
Tabulating services, Sec. 24
Tax allowances, reinsurance, Sec. 2 (B) (C)
Tax expert services, Sec. 18
Taxes, interest, etc., paid in lieu of rent for leased premises, Sec. 13
Taxes, licenses and fees, Sec. 20
Taxes, real estate, Sec. 22
Telephone and telegraph, Sec. 17
Telephone and telegraph expenses of employees while traveling, Sec. 12
Teletype, Sec. 17
Television broadcasts, Sec. 4
Time clock service charges, Sec. 13
Towels, Sec. 13
Training of employees, Sec. 9
Training pay of employees, Sec. 9
Transcripts of testimony relating to claim adjustment, Sec. 1 (A)
Transfer agents' fees, Sec. 18
Transfer of employees, Sec. 12
Transfer taxes, Sec. 20 (D)
Transportation of guests, Sec. 12
Transportation of employees, Sec. 12
Travel and travel items, Sec. 12
Traveling expenses of employees, Sec. 12
Trustees' fees, Sec. 18
Underwriters' boards, Sec. 5
Underwriting reports, Sec. 6
Unemployment insurance taxes, Sec. 8 (B)
Visiting nurse service, Sec. 9
Wages paid in connection with owned real estate, Sec. 21
Warehouse, storage and safekeeping space, rent of, Sec. 13
Wastebasket, Sec. 16
Water, light, heat and power in leased premises, Sec. 13
Watchman expenses relating to claim adjustment, Sec. 1 (A)
Weather reports relating to claim adjustment, Sec. 1 (A)
Welfare of employees, Sec. 9
Witnesses relating to claim adjustment, Sec. 1 (A)

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EARNED BUT UNBILLED (EBUB) PREMIUM IMPLEMENTATION
STATUTORY REPORTING PRO FORMA EXHIBITS

These exhibits are intended to apply to reporting entities that record earned but unbilled (EBUB) premium as an adjustment to earned premium. See *SSAP No. 53—Property Casualty Contracts – Premiums* for guidance.

The x's represent normal (non-EBUB) activity and balances for the purpose of these illustrations.

A. In January 2018, the following entry is booked to record the initial adoption of SSAP 53 with respect to EBUB (amounts in $ millions):

	Dr.	Cr.
Dr. Earned but unbilled premium receivable (Page 2, Line 15.2)	60.0	
Cr. Cumulative effect of changes in accounting principles (surplus) (Page 4, Line 31)		48.0
Cr. Commissions payable (Page 3, Line 4)		9.0
Cr. Premium taxes payable (Page 3, Line 6)		1.2
Cr. Premium-based assessments accrual (Page 3, Line 6)		1.8
Dr. Change in nonadmitted assets (surplus) (Page 4, Line 27)	6.0	
Cr. Earned but unbilled premium receivable (Page 2, Line 15.2)		6.0

Assume that the lines of business to which the EBUB applies are workers' compensation (80%), other liability (10%) and commercial auto (10%).

Assume that EBUB is estimated quarterly and does not change until December 2018.

B. The following entry is made in December 2018 to reflect the estimated EBUB at December 31, 2018 (amounts in $ millions):

	Dr.	Cr.
Dr. Earned but unbilled premium receivable (Page 2, Line 15.2)	15.0	
Dr. Commission expense (Page 4, Line 4)	2.25	
Dr. Premium tax expense (Page 4, Line 4)	.3	
Dr. Cr. Premium-based assessment expense (Page 4, Line 4)	.45	
Cr. Change in unearned premium reserve (Page 4, Line 1)		15.0
Cr. Commissions payable (Page 3, Line 4)		2.25
Cr. Premium taxes payable (Page 3, Line 6)		.3
Cr. Premium-based assessments accrual (Page 3, Line 6)		.45
Dr. Change in nonadmitted assets (surplus) (Page 4, Line 27)	1.5	
Cr. Earned but unbilled premium receivable (Page 2, Line 15.2)		1.5

The effects of above entries are detailed in the attached statutory quarterly/annual balance sheets, statement of income and annual underwriting and investment exhibit (Parts 1, 1A and 3).

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EXAMPLE A

STATEMENT AS OF MARCH 31, 2018 OF THE

ASSETS

		Current Statement Date			4
		1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	December 31 Prior Year Net Admitted Assets
1.	Bonds				
2.	Stocks:				
	2.1 Preferred stocks				
	2.2 Common stocks				
3.	Mortgage loans on real estate:				
	3.1 First liens				
	3.2 Other than first liens				
4.	Real estate:				
	4.1 Properties occupied by the company (less $.......... encumbrances)				
	4.2 Properties held for the production of income (less $.......... encumbrances)				
	4.3 Properties held for sale (less $.......... encumbrances)				
5.	Cash ($........), cash equivalents ($........) and short-term investments ($........)				
6.	Contract loans (including $.......... premium notes)				
7.	Derivatives				
8.	Other invested assets				
9.	Receivables for securities				
10.	Securities lending reinvested collateral assets				
11.	Aggregate write-ins for invested assets				
12.	Subtotals, cash and invested assets (Lines 1 to 11)				
13.	Title plants less $.......... charged off (for Title insurers only)				
14.	Investment income due and accrued				
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection				
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including **$60** earned but unbilled premiums)	**60.0**	**6.0**	**54.0**	**0**
	15.3 Accrued retrospective premiums				
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers				
	16.2 Funds held by or deposited with reinsured companies				
	16.3 Other amounts receivable under reinsurance contracts				
17.	Amounts receivable relating to uninsured plans				
18.1	Current federal and foreign income tax recoverable and interest thereon				
18.2	Net deferred tax asset				
19.	Guaranty funds receivable or on deposit				
20.	Electronic data processing equipment and software				
21.	Furniture and equipment, including health care delivery assets ($........)				
22.	Net adjustment in assets and liabilities due to foreign exchange rates				
23.	Receivables from parent, subsidiaries and affiliates				
24.	Health care ($........) and other amounts receivable				
25.	Aggregate write-ins for other than invested assets				
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)				
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28.	Total (Lines 26 and 27)				
DETAILS OF WRITE-INS					
1101.					
1102.					
1103.					
1198.	Summary of remaining write-ins for Line 11 from overflow page				
1199.	Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501.					
2502.					
2503.					
2598.	Summary of remaining write-ins for Line 25 from overflow page				
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)				

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LIABILITIES, SURPLUS AND OTHER FUNDS

		1 Current Statement Date	2 December 31, Prior Year
1.	Losses (current accident year $......................................)		
2.	Reinsurance payable on paid losses and loss adjustment expenses		
3.	Loss adjustment expenses		
4.	Commissions payable, contingent commissions and other similar charges	9.0	0
5.	Other expenses (excluding taxes, licenses and fees)		
6.	Taxes, licenses and fees (excluding federal and foreign income taxes)	[illegible]	0
7.1	Current federal and foreign income taxes (including $.......... on realized capital gains (losses))		
7.2	Net deferred tax liability		
8.	Borrowed money $.........and interest thereon $		
9.	Unearned premiums (after deducting unearned premiums for ceded reinsurance of $................and including warranty reserves of $..............)		
10.	Advance premium		
11.	Dividends declared and unpaid:		
	11.1 Stockholders		
	11.2 Policyholders		
12.	Ceded reinsurance premiums payable (net of ceding commissions)		
13.	Funds held by company under reinsurance treaties		
14.	Amounts withheld or retained by company for account of others		
15.	Remittances and items not allocated		
16.	Provision for reinsurance		
17.	Net adjustments in assets and liabilities due to foreign exchange rates		
18.	Drafts outstanding		
19.	Payable to parent, subsidiaries and affiliates		
20.	Derivatives		
21.	Payable for securities		
22.	Payable for securities lending		
23.	Liability for amounts held under uninsured accident and health plans		
24.	Capital notes $........................and interest thereon $..............		
25.	Aggregate write-ins for liabilities		
26.	Total liabilities excluding protected cell liabilities (Lines 1 through 25)		
27.	Protected cell liabilities		
28.	Total liabilities (Lines 26 and 27)		
29.	Aggregate write-ins for special surplus funds		
30	Common capital stock		
31.	Preferred capital stock		
32.	Aggregate write-ins for other-than-special surplus funds		
33.	Surplus notes		
34.	Gross paid in and contributed surplus		
35.	Unassigned funds (surplus)	42.0	0
36.	Less treasury stock, at cost:		
	36.1 .... shares common (value included in Line 30 $....................)		
	36.2 .... shares preferred (value included in Line 31 $....................)		
37.	Surplus as regards policyholders (Lines 29 to 35, less 36)		
38.	Totals		
DETAILS OF WRITE-INS			
2501.			
2502.			
2503.			
2598.	Summary of remaining write-ins for Line 25 from overflow page		
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)		
2901.			
2902.			
2903.			
2998.	Summary of remaining write-ins for Line 29 from overflow page		
2999.	Totals (Lines 2901 through 2903 plus 2998) (Line 29 above)		
3201.			
3202.			
3203.			
3298.	Summary of remaining write-ins for Line 32 from overflow page		
3299.	Totals (Lines 3201 through 3203 plus 3298) (Line 32 above)		

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STATEMENT OF INCOME

UNDERWRITING INCOME	1 Current Year to Date	2 Prior Year to Date	3 Prior Year Ended December 31
1. Premiums earned:			
1.1 Direct (written $..................)			
1.2 Assumed (written $..................)			
1.3 Ceded (written $..................)			
1.4. Net (written $..................)			
DEDUCTIONS:			
2. Losses incurred (current accident year $..................):			
2.1 Direct			
2.2 Assumed			
2.3 Ceded			
2.4 Net			
3. Loss adjusting expenses incurred			
4. Other underwriting expenses incurred			
5. Aggregate write-ins for underwriting deductions			
6. Total underwriting deductions (Lines 2 through 5)			
7. Net income of protected cells			
8. Net underwriting gain (loss) (Line 1 minus Line 6 + Line 7)			
INVESTMENT INCOME			
9. Net investment income earned			
10. Net realized capital gains (losses) less capital gains tax of $..............			
11. Net investment gain (loss) (Lines 9 + 10)			
OTHER INCOME			
12. Net gain or (loss) from agents' or premium balances charged off (amount recovered $.................. amount charged off $..................)			
13. Finance and service charges not included in premiums			
14. Aggregate write-ins for miscellaneous income			
15. Total other income (Lines 12 through 14)			
16. Net income before dividends to policyholders, after capital gains tax and before all other federal and foreign income taxes (Lines 8 + 11 + 15)			
17. Dividends to policyholders			
18. Net income, after dividends to policyholders, after capital gains tax and before all other federal and foreign income taxes (Line 16 minus Line 17)			
19. Federal and foreign income taxes incurred			
20. Net income (Line 18 minus Line 19) (to Line 22)			
CAPITAL AND SURPLUS ACCOUNT			
21. Surplus as regards policyholders, December 31 prior year			
23. Net transfers (to) from Protected Cell accounts			
24. Change in net unrealized capital gains or (losses) less capital gains tax of $			
25. Change in net unrealized foreign exchange capital gain (loss)			
26. Change in net deferred income tax			
27. Change in nonadmitted assets	**(6.0)**	**0**	**0**
28. Change in provision for reinsurance			
29. Change in surplus notes			
30. Surplus (contributed to) withdrawn from protected cells			
31. Cumulative effect of changes in accounting principles	**48.0**	**0**	**0**
32. Capital changes:			
32.1 Paid in			
32.2 Transferred from surplus (Stock Dividend)			
32.3 Transferred to surplus			
33. Surplus adjustments:			
33.1 Paid in			
33.2 Transferred to capital (Stock Dividend)			
33.3 Transferred from capital			
34. Net remittances from or (to) Home Office			
35. Dividends to stockholders			
36. Change in treasury stock			
37. Aggregate write-ins for gains and (losses) in surplus			
38. Change in surplus as regards policyholders (Lines 22 through 37)			
39. Surplus as regards policyholders, as of statement date (Lines 21 plus 38)			
DETAILS OF WRITE-INS			
0501.			
0502.			
0503.			
0598. Summary of remaining write-ins for Line 5 from overflow page			
0599. TOTALS (Lines 0501 through 0503 plus 0598) (Line 5 above)			
1401.			
1402.			
1403.			
1498. Summary of remaining write-ins for Line 14 from overflow page			
1499. TOTALS (Lines 1401 through 1403 plus 1498) (Line 14 above)			
3701.			
3702.			
3703.			
3798. Summary of remaining write-ins for Line 37 from overflow page			
3799. TOTALS (Lines 3701 through 3703 plus 3798) (Line 37 above)			

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EXAMPLE B

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE

ASSETS

		Current Year			Prior Year
		1	2	3	4
		Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1.	Bonds (Schedule D)				
2.	Stocks (Schedule D):				
	2.1 Preferred stocks				
	2.2 Common stocks				
3.	Mortgage loans on real estate (Schedule B):				
	3.1 First liens				
	3.2 Other than first liens				
4.	Real estate (Schedule A):				
	4.1 Properties occupied by the company (less $.......... encumbrances)				
	4.2 Properties held for the production of income (less $.......... encumbrances)				
	4.3 Properties held for sale (less $.......... encumbrances)				
5.	Cash ($......., Schedule E-Part 1), cash equivalents ($…….., Schedule E-Part 2) and short-term investments ($…….., Schedule DA)				
6.	Contract loans (including $………. premium notes)				
7.	Derivatives				
8.	Other invested assets (Schedule BA)				
9.	Receivables for securities				
10.	Securities lending reinvested collateral assets				
11.	Aggregate write-ins for invested assets				
12.	Subtotals, cash and invested assets (Lines 1 to 11)				
13.	Title plants less $……….charged off (for Title insurers only)				
14.	Investment income due and accrued				
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection				
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including **$75**. earned but unbilled premiums)	**75.0**	**7.5**	**67.5**	**0**
	15.3 Accrued retrospective premiums				
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers				
	16.2 Funds held by or deposited with reinsured companies				
	16.3 Other amounts receivable under reinsurance contracts				
17.	Amounts receivable relating to uninsured plans				
18.1	Current federal and foreign income tax recoverable and interest thereon				
18.2	Net deferred tax asset				
19.	Guaranty funds receivable or on deposit				
20.	Electronic data processing equipment and software				
21.	Furniture and equipment, including health care delivery assets ($.........)				
22.	Net adjustment in assets and liabilities due to foreign exchange rates				
23.	Receivables from parent, subsidiaries and affiliates				
24.	Health care ($……….) and other amounts receivable				
25.	Aggregate write-ins for other than invested assets				
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)				
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28.	Total (Lines 26 and 27)				
DETAILS OF WRITE-INS					
1101.					
1102.					
1103.					
1198.	Summary of remaining write-ins for Line 11 from overflow page				
1199.	Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501.					
2502.					
2503.					
2598.	Summary of remaining write-ins for Line 25 from overflow page				
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)				

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LIABILITIES, SURPLUS AND OTHER FUNDS

		1 Current Year	2 Prior Year
1.	Losses (Part 2A, Line 34, Column 8)		
2.	Reinsurance payable on paid losses and loss adjustment expenses (Schedule F, Part 1, Column 6)		
3.	Loss adjustment expenses (Part 2A, Line 34, Column 9)		
4.	Commissions payable, contingent commissions and other similar charges	**11.25**	**0**
5.	Other expenses (excluding taxes, licenses and fees)		
6.	Taxes, licenses and fees (excluding federal and foreign income taxes)	**3.75**	**0**
7.1	Current federal and foreign income taxes (including $……… on realized capital gains (losses))		
7.2	Net deferred tax liability		
8.	Borrowed money $………and interest thereon $		
9.	Unearned premiums (Part 1A, Line 37, Column 5) (after deducting unearned premiums for ceded reinsurance of $……..…and including warranty reserves of $…………..)		
10.	Advance premium		
11.	Dividends declared and unpaid:		
	11.1 Stockholders		
	11.2 Policyholders		
12.	Ceded reinsurance premiums payable (net of ceding commissions)		
13.	Funds held by company under reinsurance treaties (Schedule F, Part 3, Column 19)		
14.	Amounts withheld or retained by company for account of others		
15.	Remittances and items not allocated		
16.	Provision for reinsurance (Schedule F, Part 7)		
17.	Net adjustments in assets and liabilities due to foreign exchange rates		
18.	Drafts outstanding		
19.	Payable to parent, subsidiaries and affiliates		
20.	Derivatives		
21.	Payable for securities		
22.	Payable for securities lending		
23.	Liability for amounts held under uninsured accident and health plans		
24.	Capital notes $………………..and interest thereon $………………		
25.	Aggregate write-ins for liabilities		
26.	Total liabilities excluding protected cell liabilities (Lines 1 through 25)		
27.	Protected cell liabilities		
28.	Total liabilities (Lines 26 and 27)		
29.	Aggregate write-ins for special surplus funds		
30.	Common capital stock		
31.	Preferred capital stock		
32.	Aggregate write-ins for other-than-special surplus funds		
33.	Surplus notes		
34.	Gross paid in and contributed surplus		
35.	Unassigned funds (surplus)	**52.5**	**0**
36.	Less treasury stock, at cost:		
	36.1 ………….. shares common (value included in Line 30 $…………………)		
	36.2 ………….. shares common (value included in Line 31 $…………………)		
37.	Surplus as regards policyholders (Lines 29 to 35, less 36) (Page 4, Line 40)		
38.	Totals (Page 2, Line 28, Col. 3)		
	DETAILS OF WRITE-INS		
2501.			
2502.			
2503.			
2598.	Summary of remaining write-ins for Line 25 from overflow page		
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)		
2901.			
2902.			
2903.			
2998.	Summary of remaining write-ins for Line 29 from overflow page		
2999.	Totals (Lines 2901 through 2903 plus 2998) (Line 29 above)		
3201.			
3202.			
3203.			
3298.	Summary of remaining write-ins for Line 32 from overflow page		
3299.	Totals (Lines 3201 through 3203 plus 3298) (Line 32 above)		

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STATEMENT OF INCOME

	UNDERWRITING INCOME	1 Current Year	2 Prior Year
1.	Premiums earned (Part 1, Line 34, Column 4)	**15.0**	**0**
	DEDUCTIONS:		
2.	Losses incurred (Part 2, Line 34, Column 7)		
3.	Loss expenses incurred (Part 3, Line 25, Column 1)		
4.	Other underwriting expenses incurred (Part 3, Line 25, Column 2)	**3.0**	**0**
5.	Aggregate write-ins for underwriting deductions		
6.	Total underwriting deductions (Lines 2 through 5)		
7.	Net income of protected cells		
8.	Net underwriting gain (loss) (Line 1 minus Line 6 plus Line 7)	**12.0**	**0**
	INVESTMENT INCOME		
9.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		
10.	Net realized capital gains (losses) less capital gains tax of $……….(Exhibit of Capital Gains (Losses))		
11.	Net investment gain (loss) (Lines 9 + 10)		
	OTHER INCOME		
12.	Net gain (loss) from agents' or premium balances charged off (amount recovered $.......... amount charged off $..........)		
13.	Finance and service charges not included in premiums		
14.	Aggregate write-ins for miscellaneous income		
15.	Total other income (Lines 12 through 14)		
16.	Net income before dividends to policyholders, after capital gains tax and before all other federal and foreign income taxes (Lines 8+11+15)		
17.	Dividends to policyholders		
18.	Net income, after dividends to policyholders, after capital gains tax and before all other federal and foreign income taxes (Line 16 minus Line 17)		
19.	Federal and foreign income taxes incurred		
20.	Net income (Line 18 minus Line 19) (to Line 22)	**12.0**	**0**
	CAPITAL AND SURPLUS ACCOUNT		
21.	Surplus as regards policyholders, December 31 prior year (Page 4, Line 39, Column 2)		
	GAINS AND (LOSSES) IN SURPLUS		
22.	Net income (from Line 20)	**12.0**	**0**
23.	Net transfers (to) from Protected Cell accounts		
24.	Change in net unrealized capital gains or (losses) less capital gains tax of $..........		
25.	Change in net unrealized foreign exchange capital gain (loss)		
26.	Change in net deferred income tax		
27.	Change in nonadmitted assets (Exhibit of Nonadmitted Assets, Line 26, Col. 3)	**(7.5)**	**0**
28.	Change in provision for reinsurance (Page 3, Line 16, Column 2 minus Column 1)		
29.	Change in surplus notes		
30.	Surplus (contributed to) withdrawn from protected cells		
31.	Cumulative effect of changes in accounting principles	**48.0**	**0**
32.	Capital changes:		
	32.1 Paid in		
	32.2 Transferred from surplus (Stock Dividend)		
	32.3 Transferred to surplus		
33.	Surplus adjustments:		
	33.1 Paid in		
	33.2 Transferred to capital (Stock Dividend)		
	33.3 Transferred from capital		
34.	Net remittances from or (to) Home Office		
35.	Dividends to stockholders		
36.	Change in treasury stock (Page 3, Lines 34.1 and 34.2, Column 2 minus Column 1)		
37.	Aggregate write-ins for gains and losses in surplus		
38.	Change in surplus as regards policyholders for the year (Lines 22 through 37)	**52.5**	**0**
39.	Surplus as regards policyholders, December 31 current year (Line 21 plus Line 38) (Page 3, Line 35)		
	DETAILS OF WRITE-INS		
0501.			
0502.			
0503.			
0598.	Summary of remaining write-ins for Line 5 from overflow page		
0599.	Totals (Lines 0501 through 0503 plus 0598) (Line 5 above)		
1401.			
1402.			
1403.			
1498.	Summary of remaining write-ins for Line 14 from overflow page		
1499.	Totals (Lines 1401 through 1403 plus 1498) (Line 14 above)		
3701.			
3702.			
3703.			
3798.	Summary of remaining write-ins for Line 37 from overflow page		
3799.	Totals (Lines 3701 through 3703 plus 3798) (Line 37 above)		

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UNDERWRITING AND INVESTMENT EXHIBIT

PART 1 – PREMIUMS EARNED

Line of Business	1 Net Premiums Written per Column 6, Part 1B	2 Unearned Premiums Dec. 31 Prior Year- per Col. 3, Last Year's Part 1	3 Unearned Premiums Dec. 31 Current Year- per Col. 5 Part 1A	4 Premiums Earned During Year (Cols. 1 + 2 - 3)
1. Fire				
2. Allied lines				
3. Farmowners multiple peril				
4. Homeowners multiple peril				
5. Commercial multiple peril				
6. Mortgage guaranty				
8. Ocean marine				
9. Inland marine				
10. Financial guaranty				
11.1 Medical malpractice—occurrence				
11.2 Medical malpractice—claims-made				
12. Earthquake				
13. Group accident and health				
14. Credit accident and health (group and individual)				
15. Other accident and health				
16. Workers' compensation		**X – (48.0)**	**X – (60.0)**	**12.0**
17.1 Other liability—occurrence		**X – (6.0)**	**X – (7.5)**	**1.5**
17.2 Other liability—claims-made				
17.3 Excess Workers' Compensation				
18.1 Products liability—occurrence				
18.2 Products liability—claims-made				
19.1,19.2 Private passenger auto liability		**[illegible] – (6.[illegible]**	**X – (7.5)**	**1.5**
19.3,19.4 Commercial auto liability				
21. Auto physical damage				
22. Aircraft (all perils)				
23. Fidelity				
24. Surety				
26. Burglary and theft				
27. Boiler and machinery				
28. Credit				
29. International				
30. Warranty				
31. Reinsurance-Nonproportional Assumed Property				
32. Reinsurance-Nonproportional Assumed Liability				
33. Reinsurance-Nonproportional Assumed Financial Lines				
34. Aggregate write-ins for other lines of business				
35. TOTALS		**X – (60.0)**	**X- (75.0)**	**15.0**
DETAILS OF WRITE-INS				
3401.				
3402.				
3403.				
3498. Sum. of remaining write-ins for Line 34 from overflow page				
3499. Totals (Lines 3401 through 340[illegible] plus 3498) (Line 34 above)				

Note: Line 35 Un[illegible]rned P[illegible]mium am[illegible]nts (for the purposes of this example) include Earned but unbilled premium debits.

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UNDERWRITING AND INVESTMENT EXHIBIT

PART 1A – RECAPITULATION OF ALL PREMIUMS

(a) Gross premiums (less reinsurance) and unearned premiums on all unexpired risks and reserve for return premiums under rate credit or retrospective rating plans based upon experience.

Line of Business	1 Amount Unearned (Running One Year or Less from Date of Policy) (b)	2 Amount Unearned (Running More Than One Year from Date of Policy) (b)	3 Earned but Unbilled Premium	4 Reserve for Rate Credits and Retrospective Adjustments Based on Experience	5 Total Reserve for Unearned Premiums Cols. 1+2+3+4
1. Fire					
2. Allied lines					
3. Farmowners multiple peril					
4. Homeowners multiple peril					
5. Commercial multiple peril					
6. Mortgage guaranty					
8. Ocean marine					
9. Inland marine					
10. Financial guaranty					
11.1 Medical malpractice—occurrence					
11.2 Medical malpractice—claims-made					
12. Earthquake					
13. Group accident and health					
14. Credit accident and health (group and individual)					
15. Other accident and health					
16. Workers' compensation	**X**		**(60.0)**		**X – 60.0**
17.1 Other liability—occurrence	**X**		**(7.5)**		**X – 7.5**
17.2 Other liability—claims-made					
17.3 Excess Workers' Compensation					
18.1 Products liability—occurrence					
18.2 Products liability—claims-made					
19.1,19.2 Private passenger auto liability					
19.3,19.4 Commercial auto liability	**X**		**(7.5)**		**X – 7.5**
21. Auto physical damage					
22. Aircraft (all perils)					
23. Fidelity					
24. Surety					
26. Burglary and theft					
27. Boiler and machinery					
28. Credit					
29. International					
30. Warranty					
31. Reinsurance-Nonproportional Assumed Property					
32. Reinsurance-Nonproportional Assumed Liability					
33. Reinsurance-Nonproportional Assumed Financial Lines					
34. Aggregate write-ins for other lines of business					
35. TOTALS	**X**		**(75.0)**		**X – 75.0**
36. Accrued retrospective premiums based on experience					
37. Earned but unbilled premiums					**75.0**
38. Balance (Sum of Line 34 through 36)					**X**
DETAILS OF WRITE-INS					
3401.					
3402.					
3403.					
3498. Sum. of remaining write-ins for Line 34 from overflow page					
39. Totals (Lines 3401 through 3403 plus 3498) (Line 34 above)					

(a) By gross premiums is meant the aggregate of all the premiums written in the policies or renewals in force.
Are they so returned in this statement? Yes [ ] No [ ]

(b) State here basis of computation used in each case..

Note: Line 35 amounts include Earned but unbilled premium debits (these totals tie to Underwriting and Investment Exhibit, Part 1). Line 38 Unearned Premium amount, which ties to the balance sheet, excludes Earned but unbilled premium debits.

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UNDERWRITING AND INVESTMENT EXHIBIT
PART 3 – EXPENSES

	1 Loss Adjustment Expenses	2 Other Underwriting Expenses	3 Investment Expenses	4 Total
1. Claim adjustment services:				
1.1 Direct				
1.2 Reinsurance assumed				
1.3 Reinsurance ceded				
1.4 Net claim adjustment services (1.1+1.2-1.3)				
2. Commission and brokerage:				
2.1 Direct, excluding contingent		2.25		
2.2 Reinsurance assumed, excluding contingent				
2.3 Reinsurance ceded, excluding contingent				
2.4 Contingent—direct				
2.5 Contingent—reinsurance assumed				
2.6 Contingent—reinsurance ceded				
2.7 Policy and membership fees				
2.8 Net commission and brokerage (2.1+2.2-2.3+2.4+2.5-2.6+2.7)				
3. Allowances to manager and agents				
4. Advertising				
5. Boards, bureaus and associations				
6. Surveys and underwriting reports				
7. Audit of assureds' records				
8. Salary and related items:				
8.1 Salaries				
8.2 Payroll taxes				
9. Employee relations and welfare				
10. Insurance				
11. Directors' fees				
12. Travel and travel items				
13. Rent and rent items				
14. Equipment				
15. Cost or depreciation of EDP equipment and software				
16. Printing and stationery				
17. Postage, telephone and telegraph, exchange and express				
18. Legal and auditing				
19. Totals (Lines 3 to 18)				
20. Taxes, licenses and fees:				
20.1 State and local insurance taxes deducting guaranty association credits of $		.3		
20.2 Insurance department licenses and fees				
20.3 Gross guaranty association assessments		.45		
20.4 All other (excluding federal and foreign income and real estate)				
20.5 Total taxes, licenses and fees (20.1+20.2+20.3+20.4)				
21. Real estate expenses				
22. Real estate taxes				
23. Reimbursements by uninsured accident and health plans				
24. Aggregate write-ins for miscellaneous expenses				
25. Total expenses incurred		3.0		(a)
26. Less unpaid expenses—current year				
27. Add unpaid expenses—prior year				
28. Amounts receivable relating to uninsured accident and health plans, prior year				
29. Amounts receivable relating to uninsured accident and health plans, current year				
30. TOTAL EXPENSES PAID (Lines 25 - 26 + 27 - 28 + 29)				
DETAILS OF WRITE-INS				
2401.				
2402.				
2403.				
2498. Summary of remaining write-ins for Line 24 from overflow page				
2499. Totals (Lines 2401 through 2403 plus 2498) (Line 24 above)				

(a) Includes management fees of $............... to affiliates and $............... to non-affiliates.

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