Column 9 – All Other Compensation

All other compensation for the covered fiscal year that the reporting entity could not properly report in any other column. Each compensation item that is not properly reportable in other columns, regardless of the amount of the compensation item, must be included.

Such compensation must include, but is not limited to:

- Perquisites and other personal benefits, or property, unless the aggregate amount of such compensation is less than $10,000;
- All "gross-ups" or other amounts reimbursed during the fiscal year for the payment of taxes;
- Reporting entity contributions or other allocations to vested and unvested defined contribution plans;
- A change in control of the reporting entity;
- The dollar value of any insurance premiums paid by, or on behalf of, the reporting entity during the covered fiscal year with respect to life insurance for the benefit of a named officer or employee; and
- The dollar value of any dividends or other earnings paid on stock or option awards, when those amounts were not factored into the grant date fair value required to be reported for the stock or option award.

Part 3

Director Compensation

Reporting entities shall also disclose all compensation paid to or on behalf of all directors, other than full-time officers and employees of the reporting entity whose total compensation included service as a director and is disclosed under Part 2. Amounts disclosed must include all compensation paid for services on board and committees, as well as any other compensation for any other activity or service such as consulting agreements.

Part 4

Provide a narrative description of any material factors necessary to gain an understanding of the information disclosed in the Part 2 and Part 3 tables.

INSURANCE EXPENSE EXHIBIT

This exhibit is to be prepared by all property/casualty insurers and filed no later than April 1 of each year.

The purpose of the Insurance Expense Exhibit (IEE) is to produce useful information that allocates expenses (Part I), allocates elements of total profit (or loss) to lines of business net of reinsurance (Part II); and allocates elements of profit (or loss) to lines of business on a direct basis (Part III). This exhibit is to help users evaluate the profitability of an individual reporting entity's operations by line of business. In addition, the regulators use aggregate data to develop elements of profitability of the industry, both by lines of business and by state.

GENERAL

1. The address requested should be the reporting entity's mailing address.

2. The contact person need not be the same person designated in the annual statement but should be the person to whom questions can be directed.

3. Refer to the Appendix of the NAIC *Annual Statement Instructions* for the Uniform Classification of Expenses for definitions of expense groups and instructions for the allocation of expenses to lines of business.

4. Compute all ratios to nearest fourth place and express as percentages, e.g., 48.2%.

5. There should be submitted in Interrogatory 4 a detailed statement or footnote with respect to any item or items requiring special comment or explanation.

6. Report all amounts in Parts I, II and III to the nearest thousand through rounding or truncation of digits below a thousand. (Example: $602,503 may be reported as $603 by rounding or as $602 by truncation.) Report all amounts in the Interrogatories in whole dollars.

7. Each individual reporting entity whether or not a member of a group must complete this exhibit. Reporting entities that file a Combined Annual Statement must also complete a Combined IEE (due May 1).

8. All references are to annual statement unless otherwise designated.

9. If the reporting entity makes modifications and/or changes to the annual statement affecting this exhibit subsequent to the filing of this exhibit, an amended annual statement and Insurance Expense Exhibit must be filed in writing with the appropriate insurance department.

NOTE: The allocation of investment income from capital and surplus by line of business may not accurately reflect the profitability of a particular line for use in the rate making process.

INTERROGATORIES

Interrogatory 4 shall be used to explain any item or items requiring special comment or explanation. Disclose the method of allocation for any items in Parts II and III that are not allocated by means defined in the Uniform Classification of Expenses found in the Appendix of the *Annual Statement Instructions*.

Part I – Allocation to Expense Groups

Report all dollar amounts in Part I in thousands of dollars ($000's omitted), either by rounding or truncating.

The purpose of Part I is to allocate Other Underwriting Expenses in the Annual Statement with its components: Acquisition, Field Supervision and Collection Expenses; General Expenses; and Taxes, Licenses and Fees.

The data reported in Part I is to be taken from or reconciled to Part 3 of the Underwriting and Investment Exhibit contained in the reporting entity's annual statement. Columns 1, 5, and 6 of the IEE Part I are taken directly from Columns 1, 3, and 4, respectively, of the annual statement's Underwriting and Investment Exhibit, Part 3, Expense Exhibit. Columns 2, 3, and 4 of the IEE are taken from the Underwriting and Investment Exhibit, Part 3, Column 2 and are to be allocated as follows:

The components of Lines 2.1 through 2.8 must be reported in Column 2;

The components of Lines 3 through 18 must be reported in Columns 2 and/or 3;

The components of Line 20.1 through 20.5 must be reported in Column 4;

NOTE: (1) Guaranty association assessments that have resulted in premium tax offsets should be netted in Line 20.1 and the amount of credit taken disclosed in the space provided; and (2) Payroll taxes (Line 6.2) should be allocated to the same column as the related salaries.

Amounts reported in Columns 1, 5, and 6 should equal the amounts reported on the equivalent lines in Columns 1, 3, and 4 respectively in the Underwriting and Investment Exhibit, Part 3. The totals of Line 25, Columns 2, 3, and 4 must equal Line 25, Column 2, less Line 23, Column 2, in the Underwriting and Investment Exhibit, Part 3. The amounts reported in Column 6, Total Expenses, should equal the amounts reported in Column 4, Total Expenses, in the Underwriting and Investment Exhibit, Part 3, less Line 23, Column 4.

Part II – Allocation to Lines of Business Net of Reinsurance

Report all dollar amounts in Part II in thousands of dollars ($000's omitted), either by rounding or truncating.

The purpose of Part II is to allocate elements of total profit (or loss) net of reinsurance to lines of business. Lines of business are displayed vertically, and income and expense categories are displayed horizontally, to be consistent with the annual statement.

In instances where the reporting entity cannot allocate amounts to lines of business by direct and accurate allocation, the methods of allocation stated in the Uniform Classification of Expenses found in the Appendix of the NAIC *Annual Statement Instructions* must be used. Where the instructions do not define means of allocation, a reasonable method of allocation must be applied and disclosed in Interrogatory 4.

The amounts reported in Columns 1 through 42 are taken from, or agree in total to, the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit.

For Columns 1, 3, 7, 13 and 19, the amounts reported in these columns for the individual lines should equal the amounts reported in the identical lines of annual statement schedules as referenced parenthetically below each respective column heading in the exhibit with the following exceptions:

The sum of IEE Lines 2.1, 2.2, 2.3, 2.4 and 2.5 should equal Line 2 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.

The sum of IEE Lines 5.1 and 5.2 should equal Line 5 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.

IEE Line 11 should equal the sum of Lines 11.1 and 11.2 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.

IEE Line 18 should equal the sum of Lines 18.1 and 18.2 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.

The sum of IEE Lines 21.1 and 21.2 should equal Line 21 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.

IEE Line 31, 32 and 33 should equal the sum of Lines 31, 32 and 33 of the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit for Columns 1, 3, 7, 13 and 19.

Allocate by lines of business for Column 5, Dividends to Policyholders, Column 21, Agents' Balances, Column 23, Commission and Brokerage Expenses Incurred, Column 25, Taxes, Licenses & Fees Incurred, Column 27, Other Acquisitions, Field Supervision, and Collection Expenses Incurred, Column 29, General Expenses Incurred, and Column 31, Other Income Less other Expenses.

Line 2.3, Federal Flood, Column 23, commissions and fee allowances received from FEMA should be reported consistent with reinsurance ceding commissions. Refer to *SSAP No. 62R—Property and Casualty Reinsurance*. May be reported as a negative if the amount received exceeds the expense.

Line 14, Credit A & H, to include group and individual business not exceeding 120 months duration.

The total of IEE Part II, Total line, Columns 9 and 11 should agree with IEE Part I, Line 25, Column 1.

The total of each line of business on Part II, Columns 15 and 17 should agree with the corresponding line of business on Underwriting and Investment Exhibit, Part 2A, Column 9.

Although various methodologies might result in reasonable allocations of investment income to lines of business, the following formulae for allocating investment gain must be used in completing the allocation for Column 35, Investment Gain on Funds Attributable to Insurance Transactions and the allocation for Column 39, Investment Gain Attributable to Capital and Surplus. References to prior year refer to the equivalent data from the prior year.

A1 Mean Net Loss and Loss Adjustment Expense Reserves (By Line) = Underwriting and Investment Exhibit, Part 2A, Columns 8 + 9, average of current and prior year **by line of business**.

A2 Mean Net Loss and Loss Adjustment Expense Reserve (All Lines) = Underwriting and Investment Exhibit, Part 2A, Total line, Columns 8 + 9, average of current and prior year.

B1 Mean Net Unearned Premium Reserve (By Line) = Underwriting and Investment Exhibit, Part 1A, Column 5, average of current and prior year **by line of business**.

B2 Mean Net Unearned Premium Reserve (All Lines) = Underwriting and Investment Exhibit, Part 1A, Total line, Column 5, average of the current and prior year.

C Net Acquisition Expenses (By Line) = IEE Part II, Columns 23 + 25 + 27 + 1/2 of Column 29 **by line of business**.

D1 Mean Agents' Balances (By Line) = Annual Statement, Assets page, Line 15.1 plus 15.2, average of current and prior year by line of business. Prior year data must be allocated to line of business using the same method as current year.

D2 Mean Agents' Balances (All Lines) = Annual Statement, Assets page, Lines 15.1 plus 15.2, average of current and prior year.

D3 Mean Ceded Reinsurance Premiums Payable (By Line) = Annual Statement, Liabilities, Surplus and Other Funds, Column 1, Line 12, average of current year and prior year by line of business. Allocate to lines of business for the current year and prior year on the basis of the distribution of ceded premiums written in Underwriting and Investment Exhibit, Part 1B, Columns 4 and 5, for the current year and prior year.

D4 Mean Ceded Reinsurance Premiums Payable (All Lines) = Annual Statement, Liabilities, Surplus and Other Funds, Column 1, Line 12, average of current year and prior year.

E Net Written Premium = IEE Part II, Column 1 **by line of business**.

F1 Net Earned Premium (By Line) = IEE Part II, Column 3 **by line of business**.

F2 Net Earned Premium (All Lines) = IEE Part II, Total line, Column 3.

G Mean Surplus (All Lines) = Annual Statement, Liabilities, Surplus and Other Funds, Line 37, average of Columns 1 and 2.

H Surplus Ratio = G/(A2 + B2 + F2). If (A2 + B2 + F2) equals zero, refer to "NOTE" under M.

I Surplus Allocable to Each Line (Net Basis) = H (A1 + B1 + F1). If (A1 + B1 + F1) equals zero, refer to "NOTE" under M.

J Net Investment Gain = Annual Statement, Statement of Income, Line 11, Column 1 plus capital gains tax excluded from this line on the Statement of Income.

K Investment Gain Ratio = J/(A2 + B2 + G + D4 – D2).

L Part II, for each Line 1 through 34, Column 35: Investment Gain on Funds Attributable to Insurance Transaction = K [A1 + B1 + D3 – D1 – (B1 x C/E)]. If result is zero, enter zeros in this column. Note: If E=0 the result of (B1 x C/E) should be assumed to be 0.

M Part II, for each Line 1 through 34, Column 39: Investment Gain Attributable to Capital and Surplus = [K (A1 + B1 + I + D3 – D1)] – L.

NOTE: If allocation is not calculable due to zero results, allocate J to Details of Write-ins aggregated at Line 34 for Other Lines of Business as "Investment gain."

IMPORTANT: Total line, Column 35 plus Total line, Column 39 MUST equal Item J. The above formula for Items L and M are allocations that due to rounding may not balance to Item J. As required for balancing, the rounding of Lines 1 through 34 in Column 39 should be adjusted to achieve the balance.

Column 33 should equal Part II Column 3 – 5 – 7 – 9 – 11 – 23 – 25 – 27 – 29 + 31.

Column 37 should equal Part II Column 33 + Column 35.

Column 41 should equal Part II Column 37 + Column 39.

Line 30 – Warranty

Data for this line should be reported prospectively (i.e., prior-year amounts need not be restated) starting with the 2008 reporting year.

Part III – Allocation to Lines of Direct Business Written

Report all dollar amounts in Part III in thousands of dollars (S000's omitted), either by rounding or truncating.

The purpose of Part III is to allocate elements of profit (or loss) on a direct basis to lines of business. Part III simulates what the results were without reflecting the effect of reinsurance.

Lines of business are displayed vertically and income and expense categories are displayed horizontally, to be consistent with the annual statement.

In instances where allocation of amounts to lines of business cannot be made by direct and accurate allocation, the methods of allocation stated in the Uniform Classification of Expenses found in the Appendix of the *Annual Statement Instructions* must be used. Where those instructions do not define means of allocation, a reasonable method of allocation must be applied and disclosed in Interrogatory 4.

All companies should relate their direct expense items to their direct written premium as reported on the Exhibit of Premiums and Losses, Statutory Page 14. Companies within a group that participate in a pooling agreement must relate direct expense items to the direct written premiums for that company and make any necessary adjustments to the direct expenses reported in Part III. Do not make adjustments to the direct written premiums for pooling. Indicate which expense adjustments the reporting entity has made and disclose the method of adjustment in Interrogatory 4. The sources indicated in these instructions for expense items in Part III are applicable only when there are no adjustments for pooling.

Companies that are servicing carriers should also relate direct expense items to the direct written premiums as reported on the Exhibit of Premiums and Losses. If the reporting entity includes servicing carrier business with direct written premiums on the Exhibit of Premiums and Losses, the expenses must reflect the servicing carrier business also.

The amounts reported in Columns 1, 3, 7 and 13 are taken from, or agree in total to, the annual statement schedules as referenced parenthetically below each respective column heading in the exhibit. The amounts reported in Column 33 are obtained from the IEE as indicated.

Total line for Columns 5, 9, 11, 15, 17, 19, 21, 23, 25, 27, 29 and 31 are taken from the sources described below:

For Column 3, Premiums Earned, Column 5, Dividends to Policyholders, Column 7, Incurred Losses, Column 13, Unpaid Losses, and Column 23, Commission and Brokerage Expenses Incurred, allocate the property/casualty portion of each item to the appropriate line of business.

IEE Part III, Columns 9, 11, 15 and 17 must agree with IEE Part II, Columns 9, 11, 15 and 17 respectively, excluding expenses relating to reinsurance assumed and ceded.

Column 5 must agree with Annual Statement, Statement of Income, Line 17 excluding dividends related to reinsurance assumed and ceded.

Column 19 must agree with the Exhibit of Premiums and Losses, Column 4 totals for all states plus any alien business.

Column 21 must agree with Annual Statement, Assets page, Line 15.1 plus Line 15.2, Column 3, excluding balances relating to reinsurance.

Column 23 must agree with IEE Part I, Line 2.1 plus Line 2.4 plus that portion of Line 2.7 excluding policy and membership fees related to reinsurance assumed or ceded.

Column 25 must agree with that portion of IEE Part I, Line 20.1, Column 4 that relates to the writing of direct business (exclude taxes, licenses and fees related to reinsurance assumed or ceded).

Column 27 must agree with IEE Part I, Line 25 minus Line 2.8, Column 2, excluding expenses related to reinsurance assumed or ceded.

Column 29 must agree with IEE Part I, Line 25, Column 3, excluding expenses related to reinsurance assumed or ceded.

Column 31 must agree with Annual Statement, Statement of Income, Line 14 minus Line 5, excluding expenses and income related to reinsurance assumed or ceded.

Column 33 must agree with Part III Column 3 – 5 – 9 – 11 – 23 – 25 – 27 – 29 + 31.

For Column 1, the amounts reported in these individual lines should agree with the identical lines on the Underwriting and Investment Schedule, Part 1B, Column 1 with the following exceptions:

The sum of IEE Lines 2.1, 2.2, 2.3, 2.4 and 2.5 should equal the Underwriting and Investment Exhibit, Part 1B, Column 1, Line 2.

The sum of IEE Lines 5.1 and 5.2 should equal the Underwriting and Investment Exhibit, Part 1B, Column 1, Line 5.

IEE Line 11 should equal the sum of Lines 11.1 and 11.2, Underwriting and Investment Exhibit, Part 1B, Column 1.

IEE Line 18 should equal the sum of Lines 18.1 and 18.2, Underwriting and Investment Exhibit, Part 1B, Column 1.

The sum of IEE Lines 21.1 and 21.2 should equal the Underwriting and Investment Exhibit, Part 1B, Column 1, Line 21.

Line 14 – Credit A & H

Include: Group and individual business not exceeding 120 months duration.

Line 30 – Warranty

Data for this line should be reported prospectively (i.e., prior-year amounts need not be restated) starting with the 2008 reporting year.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

This set of Supplemental Interrogatories is to assist regulators in identifying and analyzing the risks inherent in the entity's investment portfolio. The Supplemental Investment Risks Interrogatories apply only to general account assets. These lines were determined based upon the investment categories contained in the NAIC Statutory Statement and considered as invested assets. The reported amounts are to be consistent with net admitted amounts reported by the entity in the statement and supporting schedules, not on a consolidated basis. Compute the percentage calculations by dividing the reported amount by the total admitted assets reported in Line 1 of the Interrogatories unless otherwise indicated. It is recommended that the first step in responding to this set of Interrogatories is for the person preparing this document to read through the Interrogatories to gain an understanding of the reporting requirements.

All reporting entities must answer Interrogatories 1 through 4, 11 through 16, 18, 19 and, if applicable 21 through 23. Answer each Interrogatory 5 through 10 only if the reporting entity's aggregate holdings in foreign investments as addressed in Interrogatory 4 equals or exceeds 2.5% of the reporting entity's total admitted assets. Answer Interrogatory 17 only if the reporting entity's aggregate holdings in mortgage loans as addressed in Interrogatory 16 equals or exceeds 2.5% of the reporting entity's total admitted assets. For Life\Fraternal blank, responses are to exclude Separate Accounts. For the Property/Casualty blank, responses are to exclude Protected Cell Accounts.

If listing a Supranational, put Supranational and the union or member on the line (Example: Supranational – World Trade Organization).

The following definitions apply to interrogatories 4 through 10, unless otherwise defined by state statute.

Foreign investment: An investment in a foreign jurisdiction, or an investment in a person, real estate or asset domiciled in a foreign jurisdiction. An investment shall not be deemed to be foreign if the issuing person, qualified primary credit source or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless:

(a) The issuing person is a shell business entity; and

(b) The investment is not assumed, accepted, guaranteed or insured or otherwise backed by a domestic jurisdiction or a person, that is not a shell business entity, domiciled in a domestic jurisdiction.

Domestic jurisdiction: The United States, Canada, any state, any province of Canada or any political subdivision of any of the foregoing.

Foreign jurisdiction: A jurisdiction other than a domestic jurisdiction.

Shell business entity: A business entity having no economic substance, except as a vehicle for owning interests in assets issued, owned or previously owned by a person domiciled in a foreign jurisdiction.

Qualified guarantor: A guarantor against which a reporting entity has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

Qualified primary credit source: The credit source to which a reporting entity looks for payment as to an investment and against which a reporting entity has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

Supranational: Entities with more than one sovereign government as a member

Line 1 – Report the reporting entity's total admitted assets as reported on Page 2 of the annual statement.

Report the total net admitted assets for the current year, Page 2, Assets, Column 3, excluding Separate Account, Protected Cell or Segregated Account business.

Line 2 – Report the single 10 largest exposures to a single issuer/borrower/investment.

Determine the ten largest exposures by first, aggregating investments from all investment categories (except the excluded categories) by issuer. The first six digits of the CUSIP number can be used as a starting point; however, please note that the same issuer may have more than one unique series of the first six digits of the CUSIP. For example, the reporting entity owns bonds issued by the XYZ Company of $500,000 and common stock of the XYZ Company of $600,000. In addition the reporting entity has a mortgage loan to the XYZ Company of $300,000. The total exposure to Issuer XYZ Company is $1.4 million ($500,000+$600,000+$300,000).

For funds that are not diversified within the meaning of the Investment Company Act of 1940, insurance reporting entities are required to identify actual exposures and aggregate those exposures with directly held investments to determine the 10 largest exposures. For example, if a reporting entity directly holds a significant number of investments in Exxon Mobil and holds a non-diversified closed-end fund with a high concentration of Exxon Mobil, the reporting entity shall aggregate the direct investments with the investments in the closed-end funds to determine the aggregate investment risk to Exxon Mobile.

SEC registered investment funds are required by law to disclose holdings within 60 days following the fund's fiscal quarter end. Insurers who own funds classified as "non-diversified" are to use the last publicly available fund holding disclosure to account for holdings which should be included in their Top 10 holdings.

Exclude: U.S. government securities (Part Six, Section 2(e)), U. S. government agency securities (Part Six, Section 2(e)).

Those U. S. Government money market funds (Part Six, Section 2(f)) listed in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* as exempt;

Property occupied by the company;

Policy loans

All SEC and foreign registered funds (open-end, closed-end, UIT and ETFs) and common trust funds that are diversified within the meaning of the Investment Company Act of 1940 [Section 5(b) (1)].

In Column 2 list the categories of securities that are included in the total for each issuer (e.g., bonds, mortgage loans, etc.)

Line 3 – Report by NAIC designation, the amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks.

Report the total amount for each subcategory. The amounts reported in the bond subcategories should be consistent with the amounts reported in Schedule D, Part 1A, Section 1, Column 7, Lines 11.1 – 11.6. Schedule D, Part 1A, Section 1 is reported gross and will not tie to this line if any amounts are reported and nonadmitted for bonds and preferred stocks on the asset page.

Line 4 – Report the amounts and percentages of the reporting entity's total admitted assets held in foreign investments (regardless of whether there is any foreign currency exposure) and unhedged foreign currency exposure.

Line 4.02 – Report the aggregate amount of foreign investments as determined by the rules or statutes of the state of domicile (regardless of whether there is any foreign currency exposure).

Line 4.03 – Report the portion of the aggregate amount of foreign investments that supports insurance liabilities denominated in that same foreign currency.

The amount reported in 4.03 should be included in all answers to Lines 5 through 10.

Line 4.04 – Report the amount of the insurance liabilities associated with the investments reported in 4.03 and that are denominated in the same currency.

Lines 5-10 should be answered only if the reporting entity's aggregate foreign investments exceed 2.5% of total admitted assets (response to 4.01 is no). The NAIC designations for Lines 5, 6, 8 and 9 relate to country ratings, not investment ratings. If the country does not have a rating, include the investment in the NAIC-3 or below category.

Line 5 – Report the aggregate foreign investment exposure (regardless of currency exposure) categorized by the country's NAIC sovereign designation. Aggregate foreign investments first by foreign jurisdiction and then by NAIC sovereign designation.

The sovereign ratings and designation equivalents are available on the NAIC Web site.

Line 6 – Within each of the following three categories of NAIC country sovereign designations, which are available on the NAIC Web site (1, 2, and 3 or below), identify the two countries in which the company has its largest aggregate foreign investment exposures (regardless of currency exposure), and report the dollar value and percentage of company investments issued within each of those countries.

Line 8 – Report the aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation. Aggregate unhedged foreign currency exposures first by foreign jurisdiction and then by NAIC sovereign designation.

The sovereign ratings and designation equivalents are available on the NAIC Web site.

Line 9 – Within each of the following three categories of NAIC country sovereign designations, which are available on the NAIC Web site (1, 2, and 3 or below), identify the two countries in which the company has its largest aggregate unhedged foreign currency exposures, and report the dollar value and percentage of company investments issued within each of those countries.

Line 10 – Report the 10 largest non-sovereign (i.e., non-governmental) exposures to a foreign issuer/borrower/ investment.

Determine the ten largest foreign exposures by first aggregating investments from all foreign investment categories by issuer. See example in Line 2. If an investment does not have an NAIC designation, indicate the investment category, e.g., mortgage loan, in the NAIC Designation Column and list first indicating any available NAIC designations for that issuer/borrower.

Line 11 – Report the amounts and percentages of the reporting entity's total admitted assets held in Canadian investments, including Canadian-currency denominated investments, Canadian insurance liabilities ("Canadian Investments") and unhedged Canadian currency exposure.

Line 11.03 – Report the aggregate amount of Canadian Investments that support insurance liabilities denominated in Canadian currency.

The amount listed in Line 11.03 should be included in all answers to Line 11.

Line 11.04 – Report the aggregate amount of the insurance liabilities associated with the investments reported in Line 11.03.

Line 11.05 – Unhedged Canadian Currency Exposure

If the reporting entity's aggregate Canadian investments exceed 2.5% of total admitted assets, answer this question.

Line 12 – Report the aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions (defined as investments having restrictions that prevent investment from being sold within 90 days).

Line 12.02 – The aggregate amount reported in this line is limited to investments with contractual restrictions. It does not include, for instance, investments that have procedural requirements to be met prior to sale or internal company restrictions.

Line 13.02 through 13.11 – Report the amounts and percentages of admitted assets held in the ten largest equity interests (including investments in the shares of mutual funds, preferred stocks, publicly traded equity securities, and other equity securities (including Schedule BA equity interests), and excluding money market and bond mutual funds listed in Part Six, Sections 2(f) and (g) of the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* as exempt or NAIC 1).

Determine the ten largest equity interests by first aggregating investments included in this line by issuer. For example, the reporting entity owns preferred stock of the XYZ Company of $600,000 and common stock of the XYZ Company of $300,000. The total is $900,000 ($600,000+$300,000). The reporting entity also owns bonds issued by the XYZ Company of $500,000 that are excluded from this calculation because bonds are debt instruments. Other equity securities include partnerships and Limited Liability Companies (LLC) and any other investments reported in Schedule BA classified as equity.

Line 14 – Report the amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities (included in other equity securities) and excluding securities eligible for sale under Securities Exchange Commission (SEC) Rule 144a or SEC Rule 144 without volume restriction.

Line 14.02 – The amount reported in this line is a subset of the Line 14 amount, but excludes any public securities, any affiliated equity interests and any securities that can be sold under SEC Rule 144 or under SEC Rule 144a without any volume restrictions.

Line 14.06
through 14.15 – Report the investments held in the ten largest fund managers, with allocation between funds that are diversified or non-diversified in accordance with the meaning of the Investment Company Act of 1940. This should include all "funds" regardless of the type of fund (private placement, mutual fund, exchange-traded fund, closed-end fund, money market mutual fund, etc), reporting schedule or underlying investments captured in a fund.

SEC registered investment funds are required by law to disclose holdings within 60 days following the fund's fiscal quarter end. Insurers who own funds classified as "non-diversified" are to use the last publicly available fund holding disclosure to account for holdings which should be included in their Top 10 holdings.

Determine the ten largest fund managers by aggregating all "fund" investments by fund manager. For example, if a reporting entity holds a BlackRock SVO-Identified Bond ETF (diversified within the meaning of the Investment Company Act of 1940) reported on Schedule D-1 at $500,000, four BlackRock diversified mutual funds reported on Schedule D-2-2 at $2,200,000, and two BlackRock non-diversified closed-end funds totaling $1,500,000, the reporting entity shall report their aggregated investment in BlackRock funds of $4,200,000, with $2,700,000 in diversified funds and $1,500,000 in non-diversified funds.

SEC registered investment funds are required by law to disclose holdings within 60 days following the fund's fiscal quarter end. Insurers who own funds classified as "non-diversified" are to use the last publicly available fund holding disclosure to account for holdings which should be included in their Top 10 holdings.

Line 15 – Report the amounts and percentages of the reporting entity's total admitted assets held in general partnership interests (included in other equity securities).

Line 15.02 – Report the aggregate amount of all general partnership interests reported in Schedule BA. The amount excludes limited partnership interests in any LLC investments.

Lines 15.03
through 15.05 – Report the details of the three largest general partnership interests if the aggregate amount reported in Interrogatory 15.01 exceeds 2.5% of admitted assets.

Line 16 – With respect to mortgage loans reported in Schedule B, report the amounts and percentages of the reporting entity's total admitted assets.

Line 16.02
through 16.11 – The aggregate mortgage interest represents the combined value of all mortgages secured by the same property or same group of properties.

Report the details of the ten largest mortgage interests if the aggregate amount exceeds 2.5% of admitted assets.

The amounts reported in 16.13, 16.14 and 16.16 should be consistent with the corresponding subtotals reported in Column 8 of Schedule B, Part 1.

Line 17 Report the aggregate mortgage loans having the indicated loan-to-value ratios as determined from the most current appraisal as of the annual statement date.

Line 17.01
through 17.05 – For each mortgage loan, determine its loan-to-value ratio and assign it to one of the five loan-to-value categories, separated into residential, commercial or agricultural. Aggregate the amounts for each category and calculate the percent of admitted assets.

Line 18.02 through 18.06 – Report the amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in one parcel or group of contiguous parcels of real estate reported in Schedule A, excluding property occupied by the company, if the aggregate amount reported in Interrogatory 18.01 exceeds 2.5% of admitted assets.

Line 19 – Report the amounts and percentages of potential exposure (defined as the amount determined in accordance with the *Annual Statement Instructions*) for mezzanine real estate loans.

Line 19.01 – If the response is yes, the reporting entity need not complete the remainder of Interrogatory 19.

Line 20 – Report the amounts and percentages of the reporting entity's total admitted assets subject to securities lending agreements, repurchase agreements, reverse repurchase agreements, dollar repurchase agreements and dollar reverse repurchase agreements.

Line 20.01 through 20.05 – Report the aggregate amount for each category at year-end and at the end of each quarter. Calculate the percentage of admitted assets at year-end.

Line 21 – Report the amounts and percentages for warrants not attached to other financial instruments, options, caps and floors.

Line 21.01 through 21.03 – Report the aggregate amount for each category and calculate the percentage of admitted assets. The amounts should also agree with amounts reported in Schedule DB.

Line 22 – Report the amounts and percentages of potential exposure (defined as the amount determined in accordance with the *Annual Statement Instructions*) for collars, swaps and forwards.

Line 22.01 through 22.04 – Report the aggregate amount for each category at year-end and at the end of each quarter. Calculate the percentage of admitted assets at year-end. The amounts should also agree with amounts reported in Schedule DB.

Line 23 – Report the amounts and percentages of potential exposure (defined as the amount determined in accordance with the *Annual Statement Instructions*) for futures contracts.

Line 23.01 through 23.04 – Report the aggregate amount for each category at year-end and at the end of each quarter. Calculate the percentage of admitted assets at year-end. The amounts should also agree with amounts reported in Schedule DB.

SCHEDULE SIS

STOCKHOLDER INFORMATION SUPPLEMENT

The Stockholder Information Supplement shall be completed by all stock companies incorporated in the U.S.A. that have 100 or more stockholders. Such supplement shall be filed with the insurance commissioner of the company's domiciliary state as a part of its annual statement. The information required to be contained in this supplement is to be furnished to the best of the knowledge of the company. Where appropriate, the company should obtain the required information, in writing, from its directors or officers and from any person known to the company to be the beneficial owner of more than 10% of any class of its equity securities.

The term "officer" means a president, vice-president, treasurer, actuary, secretary, controller and any other person who performs for the company functions corresponding to those performed by the foregoing officers.

INFORMATION REGARDING MANAGEMENT AND DIRECTORS

1. This information applies to any person who was a director or officer of the company at any time during the year. However, information need not be given for any portion of the year during which such person was not a director or officer of the company.

2. Include under "Other Employee Benefits" information for such items as pension plans, deferred compensation plans, thrift plans, profit-sharing plans, etc., or other contracts, authorizations or arrangements, whether or not set forth in any formal document. Briefly describe such "plans" and the basis upon which directors or officers participate therein, if not previously described in a prior "Stockholder Information Supplement" indicating date thereof. Company cost of benefits accrued or set aside need not be stated with respect to payments computed on an actuarial basis under any plan that provides for fixed benefits on retirement at a specified age or after a specified number of years of service.

3. Information need not be included as to payments made for or benefits received from, group life or accident insurance, group hospitalization or similar group payments or benefits.

4. If it is impractical to state the amount of the estimated annual benefits proposed to be made upon retirement, the aggregate amount set aside or accrued to date in respect of such payment should be stated, together with an explanation of the basis for future payments.

5. Attach separate sheets if necessary to fully answer questions.

STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES

Column 1 – Name and Title

Indicate relationship of the person to the company, for example: "director," "director and vice-president," "beneficial owner of more than 10% of the company's common stock," etc.

Column 2 – Title of Security

The statement of the title of a security should be such as to clearly identify the security, even though there may be only one class, for example: "common stock," "4% convertible preferred stock," etc.

Column 3 – Nature of Ownership

Under the "Nature of Ownership", state whether ownership of securities is "direct" or "indirect." If the ownership is indirect (i.e., through a partnership, corporation, trust or other entity), indicate in a footnote or other appropriate manner the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and from those owned through a different type of indirect ownership.

Column 4 – Number of Shares Owned at the End of Prior Year and
Column 8 – Number of Shares Owned at the End of Current Year

In the case of securities owned indirectly, the entire amount of securities owned by the partnership, corporation, trust or other entity shall be stated. There may also be indicated in a footnote or other appropriate manner the extent of the security holder's interest in such partnership, corporation, trust or other entity.

If a transaction in securities of the company was with the company or one of its subsidiaries, so state. If it involved the purchase of securities through the exercise of options, so state. If any other purchase or sale was effected otherwise than in the open market, that fact shall be indicated. If the transaction was not a purchase or sale, indicate its character, for example, gift, stock dividend, etc., as the case may be.

Any additional information or explanation deemed relevant by the company should be included as a footnote or in other appropriate manner.

Column 9 – Percentage of Voting Stock Directly and Indirectly Owned or Controlled at the End of the Current Year

Report the percentage of voting stock directly and indirectly owned or controlled at the end of the current year by each director, officer and/or any other entity/person who directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10% of more of the voting interests of the entity. See *SSAP No. 25—Affiliates and Other Related Parties* for the definition of control.

FINANCIAL GUARANTY INSURANCE EXHIBIT

All reporting entities reporting financial guarantees on Line 10 of the Annual Statement Underwriting and Investment Exhibit, Part 1 and/or Part 2 must prepare this Exhibit.

Parts 1, 3, 5 and 7 should be completed by reporting entities with outstanding and in force (as of the statement date) municipal bond guarantees.

Parts 3 and 4 (Contingency Reserve) require, for each year listed, separate reporting for guarantees written for a one-time, single premium and those written on an installment premium basis.

Parts 2, 4, 6 and 7 should be completed by reporting entities with outstanding and in force (as of the statement date) guarantees of non-municipal bond guarantees.

The following definitions should be used in completing the Financial Guaranty Insurance Exhibit:

a. "Municipal obligation bond" means any security, or other instrument, including a state lease but not a lease of any other governmental entity, under which a payment obligation is created, issued by or on behalf of a governmental unit to finance a project serving a substantial public purpose, and

   1. Payable from tax revenues, but not tax allocations, within the jurisdiction of such governmental unit;

   2. Payable or guaranteed by the United States of America or any agency, department or instrumentality thereof, or by a state housing agency;

   3. Payable from rates or charges (but not tolls) levied or collected in respect of a non-nuclear utility project, public transportation facility (other than an airport facility) or public higher education facility; or

   4. With respect to lease obligations, payable from future appropriations.

b. "Special revenue bond" means any security, or other instrument under which a payment obligation is created, issued by or on behalf of a governmental unit to finance a project serving a substantial public purpose and not payable from the sources enumerated in paragraph (a) of this section in connection with the payment of municipal obligation bonds.

c. "Industrial development bond or (IDB)" means any security, or other instrument under which a payment obligation is created, issued by or on behalf of a governmental unit to finance a project serving a private industrial, commercial or manufacturing purpose and not payable or guaranteed by a governmental unit:

   1. Type I – all investment grade IDBs that are collateralized or have a term of less than (7) years.

   2. Type II – all other investment grade IDBs.

   3. Type III – all non-investment grade IDBs.

d. "Governmental unit" means a state, territory, or possession of the United States of America, the District of Columbia, a province of Canada, a municipality, or a political subdivision of any of the foregoing, or any public agency or instrumentality thereof.

e. "Investment grade" means that the obligation has been determined to be in one of the top four generic lettered rating classifications by a securities rating agency acceptable to the commissioner, that the obligation has been identified in writing by such a rating agency to be of investment grade quality, or, if the obligation has not been submitted to any such rating agency, that the obligation has been determined to be investment grade (NAIC 1 and NAIC 2) by the Securities Valuation Office of the National Association of Insurance Commissioners (see 11NYCRR).

f. "Corporate obligations":

   1. Type I – all investment grade obligations that are collateralized or have a term of less than seven (7) years.

   2. Type II – all other investment grade obligations.

   3. Type III – all non-investment grade obligations.

PART 1

Report the reporting entity's exposures for each category of municipal bonds shown in the Exhibit by year in which the principal and/or interest on said obligations guaranteed would be payable by the reporting entity in the event of default.

Exposures should be reported net of collateral and reinsurance.

PART 2

Report the reporting entity's exposures for each category of non-municipal bonds shown in the Exhibit by year in which the principal and/or interest on said obligations guaranteed would be payable by the reporting entity in the event of default.

Exposures should be reported net of collateral and reinsurance.

PARTS 3 AND 4

Column 1 – Net Premiums Written

Insert premium written, net of reinsurance, for each of the years.

Column 2 – Net Principal Guaranteed

For each of the years, insert the principal amount of indebtedness guaranteed at time guaranty was written (issued), net of reinsurance but without deduction for collateral held.

Column 4 – Current Year Earned Premium

Insert current year earned premium on guarantees written in each of the years.

PART 6B

Total of Column 6, Line 9 equals Part 1, Line 19, Column 9 of this supplement.

PART 7

Reinsurance reported in Columns 1, 2 and 3 includes:

1. Received in cash, and
2. Recoverable (charged during year of statement) if carried as a ledger asset.

Total, Column 7, Line 16, should equal Annual Statement Underwriting and Investment Exhibit Part 2, Column 4, Line 10 divided by 1000.

Total, Column 15, Line 16, should equal Annual Statement Underwriting and Investment Exhibit, Part 2A, prior year Column 8, Line 10 divided by 1000.

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

Medicare Supplement is defined as those forms which are qualified as Medicare Supplement under the Federal Certification Requirements or the NAIC Medicare Supplement Insurance Minimum Standards Model Act and Regulation, or that are filed under other state programs to satisfy separate form filing requirements for Medicare Supplement forms.

This exhibit should be completed on a direct basis and should include all Medicare Supplement insurance acquired through assumption of a block of business. In the event that a policyholder of the company relocates to another state, experience under that policy is to continue to be reported in the state in which the policy was originally issued. The nationwide aggregate earned premium on all Medicare supplement policies should be disclosed in the annual statement General Interrogatory related to Medicare Supplement insurance.

This exhibit is to be completed on a state basis.

In the event that a refiling of any state page is warranted, the amended page should be filed with the NAIC and with the state.

1. Experience on policies issued more than three years prior to the reporting year should be shown separately as indicated on the form. For example, for the reporting year ended December 31, 2019 (filed on March 1, 2020), experience on policies issued in 2016 and prior should be shown separately from that of policies issued in 2017 and later. For group insurance, the year of issue should be based on when the certificate was issued, if available. Otherwise, use the master policy year of issue.

2. Allocation of reserves on a state-by-state basis should rely on sound actuarial principles and be consistent as to methodology from year to year.

3. Include membership or policy fees, if any, with premiums earned.

4. Include mass marketed group insurance subject to individual loss ratio standards with individual.

5. Subtract dividends from premiums earned.

6. Do not adjust incurred claims nor premiums earned for changes in policy (additional) reserves.

DEFINITIONS

Column 1 – Compliance with OBRA

Respond with "YES", "NO" or "NA", to indicate compliance with OBRA requirements.

Column 3 – Standardized Medicare Supplement Benefit Plan

Means the standard plans A-N as required by Section 9E of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. This includes all plans identified as A-N issued prior to a state's revisions to its regulatory program and identified as a standard plan at the time of issue. Policies issued prior to the effective date of this state's revisions to its Medicare supplement regulatory program pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990, and no longer offered in a state, should be designated with "P." Policies not meeting either of these definitions should be designated with "O." This includes policies issued in MN, MA, and WI (states that qualified for and received a waiver under federal law from the A-N requirements). A policy issued in these three states that did not require changes, as the result of modifications to the state regulatory program should be reported as "O." All policies identified as "O" must be explained in Medicare Supplement General Interrogatory 4. Theoretically, a policy should never be identified as "O" except in those states receiving a waiver from the A-N requirements.

Column 5 – Plan Characteristics

Means one or more of the following identifiers of the features of a policy or certificate form (all applicable identifiers must be shown).

"1" Means inclusion of new or innovative benefits.

"2" Means direct response solicited.

"3" Means agent solicited.

"4" Means underwritten policy or certificate.

"5" Means the policy or certificate is guaranteed issued to all applicants.

"6" Means the policy is offered to individuals eligible for Medicare by reason of disability.

"7" Means the policy or certificate was assumed from another carrier.

Column 6 – Date Approved

Means the date the policy form was approved for sale in the state by the insurance department.

Column 7 – Date Approval Withdrawn

Means the date the policy form approval was withdrawn by the insurance department.

Column 8 – Date Last Amended

Means the date of approval of a rider or endorsement for this policy form. Do not reflect the date of optional riders added to an individual policy.

Column 9 – Date Closed

Means the date when the policy form is no longer actively marketed or offered for sale in this state.

Column 10 – Policy Marketing Trade Name

Means the title or name under which a policy is (was) marketed.

Columns 12 & 16 – Incurred Claims

Incurred claims equal paid claims plus the change in claim reserves. Claim reserves include only those unpaid liabilities for claims that have been incurred. Incurred claims in this exhibit do not include policy (additional) reserves.

The sum of Columns 11 and 15, and the sum of Columns 12 and 16, Lines 0199999 and 0299999 for all states should equal the amounts disclosed in the General Interrogatories, Part 2, Line 1.2 minus Line 1.3 and Line 1.5, respectively.

Columns 14 & 18 – Number of Covered Lives

Means the number of individuals covered under the policy form as of December 31 of the reporting year.

SUPPLEMENT A TO SCHEDULE T

EXHIBIT OF MEDICAL PROFESSIONAL LIABILITY PREMIUMS WRITTEN ALLOCATED BY STATES AND TERRITORIES

A separate Supplement A must be used for each designated type of health care provider, which are:

1. (PII) Physicians, including surgeons and osteopaths;
2. (HS) Hospitals;
3. (OP) Other health care professionals, including dentists;
4. (OF) Other health care facilities.

All premiums and losses reflected on this supplement should be on the direct basis, except as noted in the instruction for Column 8.

Column 1 – Direct Premiums Written
Column 2 – Direct Premiums Earned

Include: Gross premiums, including policy and membership fees, less return premiums on policies not taken.

The medical professional liability portion of any policy for which the premiums for medical professional liability are separately stated.

All indivisible premium policies for which at least one-half of the premium is for medical professional liability coverage.

Column 4 – Number of Claims (Direct Losses Paid)

If a claim count is included in losses paid, it must not be included in losses unpaid, or vice versa.

Column 5 – Direct Losses Incurred

The direct losses incurred shown in Column 5 should equal Column 3 plus Column 6 plus Column 8 less the sum of Column 6 and 8 for the end of the prior year.

Column 6 – Amount Reported (Direct Losses Unpaid)

The total amount of unpaid losses in Column 6 should be on a gross direct basis, which shall agree with Underwriting and Investment Exhibit, Part 2A, Line 11, Column 1 of the annual statement.

Column 7 – Number of Claims (Direct Losses Unpaid)

The number of claims shown in Column 7 is in respect to the amounts shown in Column 6.

If a claim count is included in losses paid, it must not be included in losses unpaid, or vice versa.

Column 8 – Direct Losses Incurred But Not Reported

The total amount of incurred but not reported losses shown in Column 8 should be on a direct basis, which shall agree with Underwriting and Investment Exhibit, Part 2A, Line 11, Column 5 of the annual statement. The amounts shown for the individual states may be calculated to be the proportionate part of the total IBNR, as the state's direct premiums earned are to the total direct premiums earned. If another method is utilized, attach a description of that method to this supplement. No claim count is required for amounts shown in Column 8.

**** Column 9 will be electronic only ****

Column 9 – Branch Operations Indicator

Include the indicator "B" if any direct premium in the alien jurisdiction is written via branch operations. If the premium in the jurisdiction represents both branch operations and other direct business (e.g., the policyholder or group member residence changed to that jurisdiction), then indicate "B." If there are no branch operations in the jurisdiction, then leave blank. The definition of "branch operations" is the definition used by the reporting entity's state of domicile.

Line 58 – Aggregate Other Alien

Enter the total of the write-ins listed in schedule Detail of Write-ins Aggregated at Line 58 for Other Alien.

All U.S. business must be allocated by state regardless of license status.

Details of Write-ins Aggregated at Line 58 for Other Alien

List separately each alien jurisdiction for which there is no pre-printed line on Supplement A to Schedule T.

TRUSTEED SURPLUS STATEMENT

The Trusteed Surplus Statement must be completed by each United States branch of a non-U.S. insurer licensed to do any insurance business in any state. The Trusteed Surplus Statement shall be submitted together with its accompanying schedules and the inventory(ies) of trusteed assets. The Trusteed Surplus Statement shall be submitted together with the annual statement (showing business transacted by the U.S. branch of the non-U.S. insurer in the United States) on or before March 1.

Page 1

Affidavit of U.S. Managers, General Agents, or Attorneys

1. The Trusteed Surplus Statement shall be signed and verified by the United States Manager, attorney-in-fact or a duly empowered assistant United States manager of the non-U.S. insurer.

2. In the case of a Canadian life insurance company, the title United States Manager shall refer to the president, vice-president, secretary, or treasurer of the company at its home office in Canada.

Affidavit of Trustee

Each trustee must execute an Affidavit of Trustee.

Page 2

Schedule A – Deposits with State Officers

1. Include only securities deposited with insurance departments or officers of the various states and territories of the United States for the protection of all of the company's policyholders or policyholders and creditors within the United States. For each state and territory, provide a complete and accurate description of each of the assets deposited therein.

2. Exclude special state deposits that are deposited with officers of any state in trust for the security of the policyholders, or policyholders and creditors in that particular state.

3. Line 1.99, minus Line 1.98 where appropriate, should agree with the total of special deposits held for the benefit of all policyholders, claimants and creditors in Schedule E, Part 3 of the annual statement.

Schedules B, C, and D – Deposits with United States Trustees

1. List in Schedules B, C, and D, totals of the assets held by the categories pre-printed therein.

2. A U.S. Branch having deposits with two or more U.S. trustees should list the assets deposited with one trustee in Schedule B and the assets deposited with other trustees in Schedules C and D. The trustee holding the assets listed under Schedule B should execute the first Affidavit of Trustee and the trustees holding the assets listed in Schedules C and D should execute the respective affidavits.

   In the event that there are more than three separate trusts, attach additional affidavits and corresponding schedules.

3. Each trustee shall submit to the U.S. Manager for inclusion with the Trusteed Surplus Statement, an inventory of each asset held by that trustee. Such inventory shall include the location of the assets (if there is more than one location, indicate which assets are at which location), the complete and accurate description of each asset, the information required to be provided in the Columns 3 through 5 of Schedules B, C, and D of this supplement, and as much additional information as is available (e.g., number of shares of stocks). The subtotal of each category of assets should agree with the amounts shown on Page 2 and Schedules B, C and D.

4. If market or admitted asset values are not known by the trustee, such information shall be inserted on the inventory by the U.S. Manager.

Page 3

Liabilities and Trusteed Surplus

Line 1 – Total Liabilities

Should agree with the amount reported on Annual Statement Page 3, Line 28 of the annual statement.

Additions to Liabilities

Liabilities used to offset admitted assets in the annual statement.

Line 2 – Ceded Reinsurance Balances Payable

Include: Any ceded reinsurance balances payable that are included as an offset in the agents' balances or uncollected premiums asset.

Line 3 – Agents' Credit Balances

Include: Any agents' credit balances (i.e., balances owed to agents) that are included as an offset in the agents' balances or uncollected premiums asset. Do not include ceded reinsurance balances payable.

Line 4 – Aggregate Write-ins for Other Additions to Liabilities

Enter the total of write-ins listed in schedule Detail of Write-ins Aggregated at Line 4 for Other Additions to Liabilities.

Deductions from Liabilities

No item of deduction should exceed the net asset value thereof allowed in the annual statement of the United States branch.

Line 7 – Reinsurance Recoverable on Paid Losses and Loss Adjustment Expenses

Line 7.1 – Authorized Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from authorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 7.2 – Unauthorized Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from unauthorized companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 7.3 – Certified Companies

Include: Any reinsurance recoverables on paid losses and loss adjustment expenses from certified companies that are included in the asset on Page 2, Line 16.1, Column 3 of the annual statement.

Line 11 – Aggregate Write-ins for Other Deductions from Liabilities

Enter the total of write-ins listed in schedule Detail of Write-ins Aggregated at Line 11 for Other Deductions from Liabilities.

Line 14 – Trusteed Surplus

Should equal the excess of Total Gross Assets and the Total Adjusted Liabilities reported on Line 13 of this page. Total Gross Assets are the Total Trusteed Assets reported in Schedules A, B, C and D on Page 2 of the Trusteed Surplus Statement.

Details of Write-ins Aggregated on Line 4 for Other Additions to Liabilities

List separately each category of other additions to liabilities for which there is no pre-printed line on Page 3.

Include: Any other net amounts (less commissions) due to companies, agents, and brokers, etc., and any other credit balances excluded in deductions from assets in the annual statement.

Details of Write-ins Aggregated on Line 11 for Other Deductions from Liabilities

List separately each category of other deductions from liabilities for which there is no pre-printed line on Page 3.

Include: Any secured accrued retrospective premiums reported as an admitted asset that are collateralized by cash, letters of credit, trust funds, or other collateral permitted under rules established by the Commissioner.

PREMIUM ATTRIBUTED TO PROTECTED CELLS EXHIBIT

Schedule documents underwriting impact of risks attributed to all the company's protected cells. This includes total written premium attributed to the company's protected cells as well as the resulting impacts on earned premium and unearned premium reserve. The impact to the company's loss and loss adjustment expenses as a result of any attribution to protected cells must be disclosed in total.

This exhibit is to be filed on or before March 1.

REINSURANCE SUMMARY SUPPLEMENTAL FILING FOR GENERAL INTERROGATORY 9 (Part 2 P&C)

Reporting entities may be required to file a supplement to the annual statement titled Reinsurance Summary Supplemental Filing for General Interrogatory 9 by March 1 each year. The following provides a list of what is required within this filing.

If the response to General Interrogatory 9.1 or 9.2 (Part 2 Property & Casualty Interrogatories) is yes, please provide the following information:

A. The aggregate financial statement impact gross of all such ceded reinsurance contracts on the balance sheet and statement of income;

B. A summary of the reinsurance contract terms and indicate whether it applies to the contracts meeting the criteria in interrogatory 9.1 or 9.2; and

C. A brief discussion of management's principal objectives in entering into the reinsurance contract including the economic purpose to be achieved.

The response to questions (B) and (C) above **for each contract** should be presented as if there were one response to one question. The illustration below demonstrates this by showing how the response to (B) and (C) are parallel to each other for each contract.

The financial impact of reinsurance contracts (A) is intended to provide the regulator with what the financial statements would look like without the reinsurance contracts. For purposes of this summary, "Column 1-As Reported" represents the amount reported in the applicable line of the basic financial statements while "Column 2-Interrogatory 9 Effect" represents the impact the contracts had on surplus. For example, if the net effect of the contracts over the years was an increase to surplus, the item would be reported as a positive number, such as $5,386,703 as shown in the illustration. Similarly, if the net effect of the contracts on the net liabilities was a decrease, the item would be reported as a negative number, such as (S129,904,160). Therefore, "Column 3-Restated Without Interrogatory 9 Reinsurance" represents Column 1 minus Column 2. Also for purposes of this summary, all information in Column 2 (Reinsurance Effect) should be reported on a pre-tax basis. Further, row "A04-Income Before Taxes" represents only the current year Income Statement effect of an Interrogatory 9 contract or contracts while row "A05-Surplus as Regards to Policyholders" represents an inception to date figure.

The summary of reinsurance contract terms (B) should at a minimum provide a brief description of the key terms of the contract and the applicable interrogatory and feature that triggered the reporting. The description of the contract should be detailed enough so that the domestic insurance regulator could identify the contract for subsequent review, if necessary. The information provided for management's objectives (C) should at a minimum provide the primary reason(s) for entering into the contract as well as any ancillary reason(s).

If the response to General Interrogatory [illegible] (Part 2 Property & Casualty Interrogatories) is yes, explain below why the contract is treated differently for GAAP and SAP.

The following provides an illustration of the above requirement. Alternate formatting is permitted for (B) and (C) provided that the responses **for each contract** are clearly identified and presented together, as if they were one response to one question.

(A) Financial Impact			
	1 As Reported	2 Interrogatory 9 Reinsurance Effect	3 (Column 1 minus Column 2) Restated Without Interrogatory 9 Reinsurance
A01. Assets	1,215,027,734	(124,517,457)	1,339,545,191
A02. Liabilities	866,244,684	(129,904,160)	996,148,844
A03. Surplus as regards to policyholders	348,783,050	5,386,703	343,396,347
A04. Net income	31,649,873	702,767	30,947,106

(B) Summary of Reinsurance Contract Terms

1. Calendar year 2005 quota share with a loss ratio cap and sliding scale commission that allows payment of losses to be deferred until the end of the contract. This contract is being reported pursuant to Interrogatory 9.1(e).

2. Calendar year 2005, Aggregate Stop Loss attaching at a loss ratio of 130%, with a unilateral commutation clause. This contract is being reported pursuant to Interrogatory 9.1(c) and Interrogatory 9.1(d).

3. Calendar year 2005 through 2007 noncancellable catastrophe excess of loss contract. This contract is being reported pursuant to Interrogatory 9.1(a).

(C) Management's Objectives

To reduce volatility from a single line of business as well as increase the Company's capacity to write new business without straining the Company's Surplus.

To reduce volatility from a single line of business by creating a layer in which the Company's exposure is capped.

To reduce the cost of reinsurance by purchasing multi-year catastrophe excess coverage.

MEDICARE PART D COVERAGE SUPPLEMENT

NET OF REINSURANCE

The federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created a prescription drug coverage, referred to as "Part D" coverage. This form is intended to capture information about the coverage net of reinsurance.

The form applies to the following **stand-alone** Medicare Part D coverage:

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).

The form does not apply to:

Part D coverage that is provided through a Medicare Advantage plan (referred to as MA-PD); and

Employer coverage that is part of the employer's comprehensive medical coverage and where the reporting entity does **not** provide claim data directly to CMS including instances where the employer and the medical provider are one and the same but the administration and reporting to CMS is handled by a third party vendor.

The statutory accounting treatment of Medicare Part D coverage is addressed by Interpretation 05-05 in the *Accounting Practices and Procedures Manual* (INT 05-05). Although most of the coverage is treated as an insured plan, a portion is treated as uninsured. Refer to INT 05-05 for specifics of the accounting treatment, as well as for definitions of many of the capitalized terms used below.

Group "Uninsured" would be only the aspects of any group coverage for which the entity has federal payments that are to be considered "Uninsured" per INT 05-05, e.g., payments for low income subsidy (cost-sharing portion) and the group plan is an insured plan. Group coverage where the basic coverage is uninsured is not reported in this supplement.

Since a reporting entity may offer multiple prescription drug plans (PDPs) with varying benefits, it is possible for a portion of the entity's coverage to be subject to reinsurance coverage and another portion to be part of the Part D Payment Demonstration, where no reinsurance coverage is provided. Where there is reinsurance coverage, the corresponding funds received or receivable are reported in Lines 12.1 through 12.3.

Columns 1 – Individual Coverage Insured and
Columns 2 – Individual Coverage Uninsured

Report here the amounts for coverage written through individual contracts. Amounts treated as insured business pursuant to INT 05-05 should be reported in column 1. Amounts treated as uninsured business pursuant to INT 05-05 should be reported in column 2.

Columns 3 – Group Coverage Insured and
Columns 4 – Group Coverage Uninsured

Report here the amounts for coverage written through group contracts and certificates, including coverage of employer groups as described above. Amounts treated as insured business pursuant to INT 05-05 should be reported in column 3. Amounts treated as uninsured business pursuant to INT 05-05 should be reported in column 4.

Column 5 – Total Cash

Report here the totals of Columns 1 through 4 for the indicated lines. This column is intended to measure the cash flow impact of the Part D coverage on the reporting entity (i.e., including both insured and uninsured business).

Line 1 – Premiums Collected

Line 1.11 – Standard Coverage with Reinsurance Coverage

Report the Beneficiary Premium (Standard Coverage Portion), Low-Income Subsidy (Premium Portion) and Direct Subsidy amounts received for PDPs that are subject to Reinsurance Coverage. These amounts represent the premium as approved by CMS (including the effect of the "health status risk adjustments") for the Part D coverages that qualify as Standard Coverage. Note that the actual coverage does not have to be identical to the "standard coverage" as defined by the MMA, but may instead be coverage approved as actuarially equivalent by CMS.

Line 1.12 – Standard Coverage without Reinsurance Coverage

Report the Beneficiary Premium (Standard Coverage Portion), Low-Income Subsidy (Premium Portion), Direct Subsidy and Part D Payment Demonstration amounts received for PDPs that are not subject to Reinsurance Coverage. These amounts represent the premium as approved by CMS (including the effect of the "health status risk adjustments") for the Part D coverages that qualify as Standard Coverage. Note that the actual coverage does not have to be identical to the "standard coverage" as defined by the MMA, but may instead be coverage approved as actuarially equivalent by CMS.

Line 1.13 – Standard Coverage, Risk Corridor Payment Adjustments

Report any amounts paid to or received from CMS as Risk Corridor Payment Adjustments (based on where actual loss experience falls within the various MMA-defined risk corridors). Amounts paid to CMS should be reported as negative amounts; amounts received from CMS should be reported as positive amounts.

Line 1.2 – Supplemental Benefits

Report all other premiums received for Part D coverage. These will be the additional premiums that the PDP requires participants to pay for Supplemental Benefits.

Line 2 – Premiums Due and Uncollected – Change

Exclude any receivable or payable for Risk Corridor Payment Adjustments, which should be reported on Lines 4.1 and 4.2. Note that, per the reference in INT 05-05 to SSAP No. 84, receivables from CMS are not subject to the 90-day rule for non-admission.

Line 4 – Risk Corridor Payment Adjustments – Change

The reporting entity will need to estimate the Risk Corridor Payment Adjustment that is receivable (Line 4.1) or payable (Line 4.2) at year-end for each PDP, consistent with the reported experience through year-end. The receivable or payable should exclude any amounts already settled in cash, which should be reported in Line 1.13. An increase in a receivable or a decrease in a payable should be reported as a positive amount; a decrease in a receivable or an increase in a payable should be reported as a negative amount.

Line 5 – Earned Premiums

Earned premium = Premiums Collected +
Change in Due and Uncollected –
Change in Unearned and Advance Premium +
Change in Risk Corridor Payment Adjustments Payable/Receivable.

Note that Lines 5.11, 5.12, and 5.2 will exclude any amounts associated with the Risk Corridor Payment Adjustments, whereas Line 5.13 relates solely to the Risk Corridor Payment Adjustments.

Line 6 – Total Premiums

Sum of Lines 5.11 through 5.2 (Columns 1 and 3) and Sum of Lines 1.11 through 1.2 (Column 5).

Line 7 – Claims Paid

Follow similar rules as for premiums above.

Line 8 – Claims Reserves and Liabilities – Change

Follow similar rules as for premiums above.

Line 9 – Health Care Receivables – Change

For Lines 9.1 and 9.2, report the portion of Health Care Receivables (pharmacy rebates, loans to providers, etc.) that relate to the Part D coverage that is included in this supplement. This does not include any amounts receivable for the Risk Corridor Payment Adjustments, which are reported on Line 4.1.

Line 10 – Claims Incurred

Claims Incurred – Claims Paid +
Change in Claim Reserves and Liabilities +
Change in Health Care Receivables

Line 11 – Total Claims

Sum of Lines 10.11 through 10.2 (Columns 1 and 3) and Sum of Lines 7.11 through 7.2 (Column 5).

Line 12 – Reinsurance Coverage and Low-Income Cost Sharing

Line 12.1 – Claims Paid Net of Reimbursements Applied

Report claims paid less amounts received for the following portions of any Part D coverage that is included in the supplement. These amounts are considered payments under an uninsured plan.

Low-Income Subsidy (Cost-Sharing Portion).

Reinsurance Coverage.

Line 12.2 – Reimbursements Received but Not Applied – Change

Report the change during the year in the liability for amounts received from CMS that are in anticipation of future uninsured claim payments by the PDP sponsor.

Line 12.3 – Reimbursements Receivable – Change

Report the change during the year for amounts due from CMS for uninsured claim payments already made by the PDP Sponsor. This will exclude amounts that are already reported on Line 12.2.

Line 12.4 – Health Care Receivables – Change

Report any portion of Health Care Receivables (pharmacy rebates, loans to providers, etc.) that relate to uninsured Part D coverage that is included in this supplement.

Line 13 – Aggregate Policy Reserves – Change

Report the change during the year in any policy reserves, including any premium deficiency reserves, established for Part D coverage included in this supplement.

Line 14 – Expenses Paid and
Line 15 – Expenses Incurred

Report the allocated expenses relating to Part D coverage included in this supplement. The allocated expenses will be treated as relating entirely to the insured portion, to avoid the necessity of a separate allocation to the uninsured portion.

Line 16 – Underwriting Gain or Loss

Line 6 – Line 11 – Line 13 – Line 15.

Line 17 – Cash Flow Result (Column 5 only)

Sum of Lines 1– sum of (Lines 7 – Line 12.1 + Line 12.2 – Line 14).

BAIL BOND SUPPLEMENT

Only reporting entities writing bail bond coverage are required to complete this supplement. This supplement must be filed with the NAIC by March 1 each year.

DEFINITIONS

Gross Basis:	Reporting of bail bond premium before any permitted practice of adjusting premium for agent commission and brokerage expenses.
Gross Premiums:	Premiums reported on a gross basis.
GPW:	Gross Premium Written
GPE:	Gross Premium Earned
NPE:	Net Premium Earned
Build-Up Fund:	Agent-owned accounts maintained as collateral against loss and liability that are controlled by the reporting entity. These funds are maintained on an individual basis for each liable agent and are available to offset losses on bonds written by those specific agents. Build-up funds are sometimes called collateral funds.

Line 1 – Answer "YES" if the bail bond premium in the financial statement was reported on a gross basis.

Line 10 – Refer to *SSAP No. 53—Property Casualty Contracts – Premiums* for guidance.

Line 11 – Refer to the Uniform Classification of Expenses found in the Appendix of the NAIC *Annual Statement Instructions* for the definition of Taxes, Licenses and Fees. Includes amounts deposited in the agent's build-up fund.

Line 12 – The amounts reported in the Current Year and Prior Year column should equal Line 10 minus Line 11.

Line 13 – Refer to *SSAP No. 53—Property Casualty Contracts – Premiums* for guidance.

Line 15 – Refer to *SSAP No. 53—Property Casualty Contracts – Premiums* for accounting guidance.

Line 16 – Only include that portion of Losses Paid that was paid by the reporting entity. Exclude any Losses Paid that was paid by the agent from the agent's build-up fund. Refer to *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* and *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* for guidance.

Line 17 – Only include that portion of Losses Incurred that were paid or expected to be paid by the reporting entity. Exclude any Losses Incurred that was paid or expected to be paid by the agent from the agent's build-up fund. Refer to *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* and *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* for guidance.

Line 18 – Only include that portion of Losses Unpaid expected to be paid by the reporting entity. Exclude any Losses Unpaid expected to be paid by the agent from the agent's build-up fund. Refer to *SSAP No. 5R— Liabilities, Contingencies and Impairments of Assets* and *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* for guidance.

Line 19 – Only include that portion of Defense and Cost Containment Expense Paid that was paid by the reporting entity. Exclude any Defense and Cost Containment Expense Paid that was paid by the agent from the agent's build-up fund. Refer to *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* and *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* for guidance.

Line 20 – Only include that portion of Defense and Cost Containment Expense Incurred that was paid or expected to be paid by the reporting entity. Exclude any Defense and Cost Containment Expense Incurred that was paid or expected to be paid by the agent from the agent's build-up fund. Refer to *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* and *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* for guidance.

Line 21 – Only include that portion of Defense and Cost Containment Expense Unpaid expected to be paid by the reporting entity. Exclude any Defense and Cost Containment Expense Unpaid expected to be paid by the agent from the agent's build-up fund. Refer to *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* and *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* for guidance.

Line 22 – Refer to the Uniform Classification of Expenses found in the Appendix of the NAIC *Annual Statement Instructions* for the definition of Taxes, Licenses and Fees.

Line 23 – Should equal Line 26 of the Prior Year Column.

Line 24 – Includes agent commission and brokerage fees deposited in the build-up fund. Also includes any interest earned on the balance held in the fund.

Line 25 – Includes amounts withdrawn from the build-up fund to pay Loss and Loss Adjustment expenses as part of the agent's performance obligation under the agent's contract.

Line 26 – The amounts reported in the Current Year and Prior Year column should equal Line 23 plus Line 24 minus Line 25.

DIRECTOR AND OFFICER INSURANCE COVERAGE SUPPLEMENT

This supplement should be completed by those reporting entities that provide director and officer (D&O) liability coverage in a monoline policy or as part of a commercial multiple peril (CMP) policy. The supplement should be reported on a direct basis (before assumed and ceded reinsurance).

Director and Officer Liability

Coverage when a director or officer is alleged to have committed a negligent act or omission, or misstatement or misleading statement, and a successful claim is brought against the directors or officers as a result. The policy provides coverage for directors' and officers' liability exposure if claims are made against the directors or officers as individuals.

Line 1 – Direct premiums, losses and defense and cost containment expenses for monoline policies are to be reported before reinsurance for Columns 1 through 6.

For Columns 7 and 8, provide the percentage of in force policies that are claims made vs. occurrence.

Line 2.3 – If the answer to question 2.2 is "yes," provide the amount of direct premium earned (quantified or estimated) for CMP policies before reinsurance.

Line 2.4 – Direct losses and defense and cost containment expenses for CMP policies are to be reported before reinsurance for Columns 1 through 4.

For Columns 5 and 6, provide the percentage of in force policies that are claims made vs. occurrence.

SUPPLEMENTAL SCHEDULE FOR REINSURANCE COUNTERPARTY REPORTING EXCEPTION – ASBESTOS AND POLLUTION CONTRACTS

DETAIL OF ORIGINAL REINSURERS AGGREGATED ON SCHEDULE F AS OF DECEMBER 31, CURRENT YEAR

Upon approval by the reporting entity's domestic state insurance department, aggregation of individual reinsurers may also be allowed pursuant to the Counterparty Reporting Exception for Asbestos and Pollution Contracts under *SSAP No. 62R—Property and Casualty Reinsurance*. Under this exception, a reporting entity may aggregate reinsurers into one line in Schedule F reflecting the retroactive counterparty under the retroactive agreement for the purposes of determining the Provision for Reinsurance regarding overdue amounts paid by the retroactive counterparty (both authorized and unauthorized). This exception would allow the Provision for Reinsurance to be reduced by reflecting that amounts have been recovered by the reporting entity under the duplicate coverage provided by the retroactive contract, and that inuring balances from the original contract(s) are payable to the retroactive counterparty. In addition, such approval would also permit the substitution of the retroactive counterparty for authorized original reinsurers without overdue balances for purposes of reporting on the primary section of the annual statement Schedule F. If a reporting entity has approval for this exception, pursuant to SSAP No. 62R, the Supplemental Schedule for Reinsurance Counterparty Reporting Exception – Asbestos and Pollution Contracts must be completed in order to continue to detail the reporting of original reinsurers that are aggregated for one-line reporting. This reporting decreases the provision of reinsurance liability for overdue on paid amounts related to a qualifying asbestos and pollution reinsurance contract.

With the approval of the reporting entity's domestic state commissioner pursuant to the applicable state credit for reinsurance law regarding the use of other forms of collateral acceptable to the commissioner, the reporting entity shall present the amount of other approved security related to the retroactive reinsurance agreement as an "Other Allowed Offset Item" with respect to the uncollateralized amounts recoverable from unauthorized reinsurers for paid and unpaid losses and loss adjustment expenses under the original reinsurance contracts. Amounts approved as "Other Allowed Offset Items" shall be reflected as amounts recoverable from the retroactive counterparty and aggregated reporting described in SSAP No. 62R shall also be applied for unpaid losses and loss adjustment expenses under the original reinsurance contracts. The security applied as an "Other Allowed Offset Item" shall also be reflected in the designated sub-schedule. Such a prescribed or permitted variation from Appendix A-785 in the *Accounting Practices and Procedures Manual* would be disclosed in Annual Statement Note 1. In addition, Note 1 shall disclose the part of the total impact on the provision for reinsurance the impact on the overdue aspects of the calculation if the reporting entity also receives commissioner approval pursuant to SSAP No. 62R related to overdue paid amounts (both authorized and unauthorized). Reporting in Schedule F, Part 3 will be subject to the authorized status of the retroactive counterparty, but full reporting of each entity's status is required in the sub schedule.

If a reporting entity has amounts reported for any of the following required groups, categories or subcategories, it shall report the subtotal amount of the corresponding group, category or subcategory, with the specified subtotal line number appearing in the same manner and location as the pre-printed total or grand total line and number:

Group or Category	Line Number
Total Authorized	
Affiliates	
U.S. Intercompany Pooling	0199999
U.S. Non-Pool	
Captive	0299999
Other	0399999
Total	0499999
Other (Non-U.S.)	
Captive	0599999
Other	0699999
Total	0799999
Total Authorized – Affiliates	0899999
Other U.S. Unaffiliated Insurers	0999999
Pools	
Mandatory Pools*@	1099999
Voluntary Pools*%	1199999
Other Non-U.S. Insurers#	1299999
Protected Cells	1399999
Total Authorized Excluding Protected Cells (Sum of 0899999, 0999999, 1099999, 1199999 and 1299999)	1499999
Total Unauthorized	
Affiliates	
U.S. Intercompany Pooling	1599999
U.S. Non-Pool	
Captive	1699999
Other	1799999
Total	1899999
Other (Non-U.S.)	
Captive	1999999
Other	2099999
Total	2199999
Total Unauthorized – Affiliates	2299999
Other U.S. Unaffiliated Insurers	2399999
Pools	
Mandatory Pools*@	2499999
Voluntary Pools*%	2599999
Other Non-U.S. Insurers#	2699999
Protected Cells	2799999
Total Unauthorized Excluding Protected Cells (Sum of 2299999, 2399999, 2499999, 2599999 and 2699999)	2899999

Total Certified

Affiliates

U.S. Intercompany Pooling 2999999

U.S. Non-Pool

Captive 3099999

Other 3199999

Total 3299999

Other (Non-U.S.)

Captive 3399999

Other 3499999

Total 3599999

Total Certified – Affiliates 3699999

Other U.S. Unaffiliated Insurers 3799999

Pools

Mandatory Pools*@ 3899999

Voluntary Pools*% 3999999

Other Non-U.S. Insurers# 4099999

Protected Cells 4199999

Total Certified Excluding Protected Cells (Sum of 3699999, 3799999, 3899999, 3999999 and 4099999) 4299999

Total Authorized, Unauthorized and Certified Excluding Protected Cells (Sum of 1499999, 2899999 and 4299999) 4399999

Total Protected Cells (Sum of 1399999, 2799999 and 4199999) 4499999

Totals (Sum of 4399999 and 4499999) 9999999

* – Pools and Associations consisting of affiliated companies should be listed by individual company names.

@ – Include in Mandatory Pools all U.S. government programs (e.g., National Flood Insurance, National Crop Insurance Corporation), all state residual market mechanisms, the Workers Compensation Reinsurance Pool, and the National Council on Compensation Insurance.

% – Include in Voluntary Pools all pool participation that is voluntary on the part of the reporting entity. Include participation in any state program for which participation is not mandatory.

– Alien Pools and Associations should be reported on Schedule F under the category "Other Non-U.S. Insurers."

Column 1 – ID Number (Original Reinsurer)

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

Federal Employer Identification Number	(FEIN)
Alien Insurer Identification Number	(AIIN)
Certified Reinsurer Identification Number	(CRIN)
Pool/Association Identification Number	

Column 2 – NAIC Company Code (Original Reinsurer)

If a reinsurer has merged with another entity, report the company code for the surviving entity.

Column 3 – Name of Reinsurer (Original Reinsurer)

Report the name of the counterparty under the original reinsurance agreement for which amounts recoverable have been aggregated into one line reporting on Schedule F, Part 3 reflecting the counterparty under the retroactive reinsurance agreement.

Column 4 – Domiciliary Jurisdiction (Original Reinsurer)

Report the two-character U.S. postal code abbreviation for the domiciliary jurisdiction for U.S. states, territories and possessions. A comprehensive listing of three-character (ISO Alpha-3) abbreviations for foreign countries is available in the appendix of these instructions.

For Pools and Associations, enter the state where the administrative office of such pool or association is located.

If a reinsurer has merged with another entity, report the domiciliary jurisdiction of the surviving entity.

Column 5 – ID Number (Retroactive Reinsurer)

Enter one of the following as appropriate for the entity being reported on the schedule. See the Schedule F General Instructions for more information on these identification numbers.

Federal Employer Identification Number (FEIN)
Alien Insurer Identification Number (AIIN)
Certified Reinsurer Identification Number (CRIN)
Pool/Association Identification Number

Column 6 – Name of Reinsurer Reported in Schedule F, Part 3 (Retroactive Reinsurer)

Report the name of the counterparty under the retroactive agreement that is reflected in the aggregated one line reporting on Schedule F, Part 3.

Column 7 – Reinsurance Recoverable on Paid Losses

Report amounts with respect to paid losses that have been recovered by the reporting entity under the duplicate coverage provided by the retroactive contract, with inuring balances from the original contracts payable to the retroactive counterparty.

Column 8 – Reinsurance Recoverable on Paid LAE

Report amounts with respect to paid loss adjustment expenses that have been recovered by the reporting entity under the duplicate coverage provided by the retroactive contract, with inuring balances from the original contracts payable to the retroactive counterparty.

Column 9 – Reinsurance Recoverable on Unpaid Case Losses & LAE

Report amounts related to the original reinsurance agreement on unpaid Case and LAE that have not been recovered.

Column 10 – Reinsurance Recoverable on IBNR Losses & LAE

Report amounts related to the original reinsurance agreement on IBNR losses and LAE. Columns 12 through 14 detail the collateral related to the original underlying reinsurers.

Column 12 – Funds Held (Original Reinsurer Collateral)

Report any funds held with respect to the original reinsurance agreements.

Column 13 – Letters of Credit (Original Reinsurer Collateral)

Report any letters of credit with respect to the original reinsurance agreements

Column 14 – Trust Funds and Other Allowed Offset Items (Original Reinsurer Collateral)

Report any trust funds or other allowed offsets items with respect to the original reinsurer collateral.

Column 15 – Amounts Approved as Other Offset Items

Column 15 provides detail of amounts approved as other collateral acceptable to the commissioner to offset the provision for reinsurance related to unauthorized original reinsures. These amounts are subject to disclosure in Note 1.

Columns 16 through 24 provide an aging schedule with respect to inuring balances for paid losses and loss adjustment expenses from the original reinsurance contract that are payable to the counterparty under the retroactive reinsurance agreement. The aging schedule is intended to facilitate analysis with respect to SSAP No. 62R, i.e., credit analysis and contingent liability analysis for these inuring balances.

For purposes of completing Columns 16 through 24, a paid loss or paid loss adjustment expense recoverable is due pursuant to original contract terms (as the contract stood on the date of execution).

Where the reinsurance agreement specifies or provides for determination of a date at which claims are to be paid by the reinsurer, the aging period shall commence from that date.

Where the reinsurance agreement does not specify a date for payment by the reinsurer, but does specify or provide for determination of a date at which claims are to be presented to the reinsurer for payment, the aging period shall commence from that date.

Where the reinsurance agreement does not specify or provide for the determination of either of such dates, the aging period shall commence on the date on which the reporting company enters in its accounts a paid loss recoverable which, with respect to the particular reinsurer, exceeds $50,000. If the amount is less than $50,000, it should be reported as currently due. Any such amounts so reported in a prior year's annual statement and still outstanding as of the date of this annual statement must be reported under Column 20 and included in Column 21.

In the event that reinsurance is placed through a broker or intermediary, notice to such broker or intermediary shall constitute notice to the reinsurer. Aging of overdue paid loss and paid loss adjustment expense recoverables begins the day after the due date.

CREDIT INSURANCE EXPERIENCE EXHIBIT

NOTE: The sections of these standardized instructions dealing with credit life coverages are not applicable to property and casualty companies. The sections of these instructions dealing with other than credit life and credit accident and health coverages are not applicable to life companies in those states that do not permit them to issue such coverages.

1. This exhibit must be filed with the NAIC by April 1 of each year. An exhibit must be filed for each state (jurisdiction). If the company does not write credit life, accident and health, unemployment, property or other insurance in a state or states, the forms may be filed indicating "NO" to the question on Page 1 of the exhibit. If "NO" is indicated, Pages 2 through 8 are unnecessary.

2. Data is to be reported for all life insurance, accident and health, unemployment, property or other insurance written in the state for which the exhibit is being prepared in connection with loans or other credit transactions entered into for personal, family or household purposes, under which the creditor is the primary beneficiary, without regard to the scope of any applicable credit insurance statute, the term of the insurance or the duration of the credit transaction, but excluding the following: insurance written on a non-contributory basis; insurance written in connection with agricultural loans or other agricultural credit transactions through banks or production credit associations, insurance written in connection with loans or other credit transactions secured by purchase money liens on residential real property, insurance written in connection with isolated transactions not related to a plan or agreement of the reporting entity for insuring the debtors of the creditor. In view of the differences between these specifications and those applicable to other annual statement exhibits, the data may not balance with the credit insurance data exhibited elsewhere in the annual statement.

3. The data reported is to be the direct business of the reporting entity only; reinsurance ceded is not to be deducted and reinsurance assumed is not to be included.

4. Copies of all work papers, calculations and other data used in preparing this exhibit, including forms used in the conversion of actual earned premiums to earned premiums at prima facie rates, must be maintained at the home office of the reporting entity and be available for examination by or submission to the respective insurance departments upon request. In addition, each company shall prepare a nationwide summary of the state exhibits, which shall also be available for submission to the respective insurance departments upon request.

5. Gross Written Premiums (Line 1.1 – Parts 1, 2, 3, 4, and 5)

   Report gross premiums before deductions for dividends or experience rating refunds or credits.

6. Earned Premiums at Prima Facie Rates (Line 1.7 – Parts 1, 2, 3, 4, and 5)

   As of December 31 of the reporting year, actual earned premiums are to be adjusted to the amount that would have been earned if all the insurance in force during the year had been written at rates actuarially equivalent to the current prima facie or statutory rates (the rates in effect at the end of the reporting year). Utilizing credit life, credit accident and health, credit unemployment, credit property or other credit insurance earned premium conversion worksheets, the conversion must be performed for each premium rate (or schedule of rates) which is not actuarially equivalent to the current prima facie rate and which had premiums earned during the year. (For the conversion of actual earned premiums on business for which prima facie rates have not been promulgated, see paragraph C., Special Instructions.) The earned premium conversion worksheets call for actual earned premiums at prima facie rates on Line A; this is for balancing purposes only. If all actual earned premiums were written at rates actuarially equivalent to current prima facie rates, Lines 1.6 and 1.7 will be equal and earned premium conversion worksheets need not be completed. Earned premium conversion worksheets are not to be submitted with the exhibit but are to be retained in accordance with Instruction 4.

   A. Credit Life, Credit Unemployment, Credit Property, or Other Credit Insurance Earned Premium Conversion Worksheet

      Actual earned premiums are converted to prima facie earned premiums by using a conversion factor that is the ratio of the current prima facie rate to the premium rate actually charged.

B. Credit Accident & Health Earned Premiums Conversion Worksheet

Actual earned premiums are converted to prima facie earned premiums by using a conversion factor which is the average of the ratios of the current prima facie rates to the premium rates actually charged for 12, 24 and 36 month terms.

C. Special Instructions

In the absence of specific instructions adopted by an insurance department for the conversion of actual earned premiums on unregulated business in that state, the following shall apply:

1. For business written in states that have not promulgated any prima facie rates, actual earned premiums need not be converted; the amounts shown on Lines 1.6 and 1.7 will be equal.

2. For business written in states which have promulgated prima facie rates that apply only to insurance written in connection with transactions of specific durations (e.g., 10 years or less), the conversion factor for actual earned premiums on unregulated business (i.e., over 10 years), shall be based on the prima facie rate for regulated business, observing any class of business rate differentials, where applicable.

7. Other Incurred Compensation (Line 3.2 – Parts 1, 2, 3, 4 and 5)

Include all experience refunds, retrospective rate credits, or policyholder dividends (excluding amounts paid to insureds), and anything else of value provided as compensation. All amounts should be stated on an incurred basis, (i.e., amounts should equal paid amounts plus the change during the year in liabilities for incurred but unpaid compensation.)

8. Mean Insurance In Force (Line 5 – Part 1 only)

The average of the monthly amounts of insurance in force should be calculated and entered, without adjustment for reinsurance assumed or ceded. For joint coverage, the amount in force should equal twice the death benefit.

9. "Critical Period" Accident and Health Insurance

Report in the "Other" column of the appropriate page. For purposes of this exhibit, "critical period" insurance is that which covers loan payments for the lesser of (a) a specified number of months; or (b) the remaining duration of the loan. Coverages which are limited in number by statutory requirements should not be considered "critical period" coverages.

10. Part 4 Coverage Definitions

"Creditor Placed Insurance" means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to 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. "Creditor Placed Home" means "Creditor Placed Insurance" on homes, mobile homes and other real estate. "Creditor Placed Auto" means insurance on automobiles, boats or other vehicles.

"Single Interest" means insurance that protects only the creditor's interest in the collateral securing a debtor's credit transaction.

"Dual Interest" means insurance that protects the creditor's and the debtor's interest in the collateral securing the debtor's credit transaction. "Dual Interest" includes insurance commonly referred to as "Limited Dual Interest."

"Credit Personal Property Insurance" means insurance written in connection with a credit transaction where the collateral is not a motor vehicle, mobile home or real estate and that:

1. Covers perils to the goods purchased through a credit transaction or used as collateral for a credit transaction and that concerns a creditor's interest in the purchased goods or pledged collateral, either in whole or in part; or

2. Covers perils to goods purchased in connection with an open-end credit transaction.

11. Part 5 Coverage Definitions

GAP insures the excess of the outstanding indebtedness over the primary property insurance benefits in the event of a total loss to a collateral asset. Primary property insurance refers to the underlying P&C insurance policy insuring the property, such as automobile physical damage insurance. For reporting experience in the CIEE, "Personal GAP" refers to contributory coverage for which the borrower pays the premium for the insurance and receives a certificate or policy of coverage.

"Credit Family Leave" provides a monthly or lump sum benefit during an unpaid leave of absence from employment resulting from specified causes, such as illness of a close relative, adoption or birth of a child. If the Credit Family Leave benefit is included with the involuntary unemployment benefit without a specific identification charge, Credit Family Leave experience may be included with the Involuntary Unemployment Experience in Part 3.

12. Part 6 Coverage Definitions

This exhibit is to be completed on a nationwide basis. The expense definitions follow those used in the Insurance Expense Exhibit.

EARNED PREMIUM CONVERSION WORKSHEET
PART 1 – Credit Life Insurance
STATE OF _____
Calendar Year 20___

Single Premium ___ MOB ___ Single Life ___ Joint Life ___ Open-End ___ Closed-End ___

	Actual Earned Premiums Col. (1)	Prima Facie Rate Col. (2)	Actual Premium Rate Col. (3)	Prima Facie Earned Prem. Col. (4)
A. Earned premiums at prima facie rate		XXX	XXX	
B. Earned premiums at other than prima facie rates:				
1.				
2.				
3.				
4.				
5.				
Totals		XXX	XXX	
	To Line 1.6, Part 1			To Line 1.7, Part 1

C. State method used to calculate unearned premiums:

Note: Companies making a direct calculation of prima facie earned premium will complete only Col. 1 and Col. 4 Totals, and Line 1.3.

EARNED PREMIUM CONVERSION WORKSHEET
PART 2 – Credit Accident & Health Insurance
STATE OF _____
Calendar Year 20____

Plan of Benefits _____
SP, Closed-End ___ MOB, Open-End ___ MOB, Closed-End ___ Other ___

		Actual Earned Premiums Col. (1)	Premium Rates 12 mo Col. (2)	24 mo Col. (3)	36 mo Col. (4)	Prima Facie Earned Premium Col. (5)*
A. Earned Premium at prima facie rate						
B. Earned Premium at other than prima facie rate:						
1.	a. Actual rate	XXX				XXX
	b. Ratio	XXX				XXX
	c. Average Ratio of Columns 2 – 3 – 4	XXX	XXX		XXX	XXX
	d. Earned Premium		XXX	XXX	XXX	
2.	a. Actual rate	XXX				XXX
	b. Ratio	XXX				XXX
	c. Average Ratio of Columns 2 – 3 – 4	XXX	XXX		XXX	XXX
	d. Earned Premium		XXX	XXX	XXX	
3.	a. Actual rate	XXX				XXX
	b. Ratio	XXX				XXX
	c. Average Ratio of Columns 2 – 3 – 4	XXX	XXX		XXX	XXX
	d. Earned Premium		XXX	XXX	XXX	
Totals			XXX	XXX	XXX	
		To Line 1.6, Part 2				To Line 1.7, Part 2

C. State method used to calculate unearned premiums: ( ) Rule of 78;
( ) Straight Line; ( ) Average of Rule of 78 and Straight Line;
( ) Tabular Basis; ( ) Other, specify basis: _____

* Prima Facie Earned Premiums in Column (5) are found by multiplying the Actual Earned Premium (Col. 1) by the Average Ratio shown in Line 1.2.

Note: Companies making a direct calculation of prima facie earned premium will complete only Column 1 and Column 5 Totals.

EARNED PREMIUM CONVERSION WORKSHEET
PART 3 – Credit Unemployment Insurance
STATE OF _____
Calendar Year 20____

30 Day Retro, SP___ 30 Day Non-Retro, SP___ 30 Day Retro, MOB___
30 Day Non-Retro, MOB___ Other___

	Actual Earned Premiums Col. (1)	Prima Facie Rate Col. (2)	Actual Premium Rate Col. (3)	Prima Facie Earned Prem. Col. (4)
A. Earned premiums at prima facie rate	_____	XXX	XXX	_____
B. Earned premiums at other than prima facie rates:				
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
Totals	_____	XXX	XXX	_____
	To Line 1.6, Part 3			To Line 1.7, Part 3

C. State method used to calculate unearned premiums:

_____
_____
_____

Note: Companies making a direct calculation of prima facie earned premium will complete only Col. 1 and Col. 4 Totals, and Line 1.3.

EARNED PREMIUM CONVERSION WORKSHEET
PART 4 – Credit Property Insurance
STATE OF _____
Calendar Year 20____

Plan of Benefits_____
Single Interest ___ Dual Interest ___ Not Applicable ___

	Actual Earned Premiums Col. (1)	Prima Facie Rate Col. (2)	Actual Premium Rate Col. (3)	Prima Facie Earned Prem. Col. (4)
A. Earned premiums at prima facie rate	_____	XXX	XXX	_____
B. Earned premiums at other than prima facie rates:				
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
Totals	_____	XXX	XXX	_____
	To Line 1.6, Part 4A			To Line 1.7, Part 4A

C. State method used to calculate unearned premiums:

_____

_____

Note: Companies making a direct calculation of prima facie earned premium will complete only Col. 1 and Col. 4 Totals, and Line 1.3.

EARNED PREMIUM CONVERSION WORKSHEET
PART 5 – Other Credit Insurance
STATE OF _____
Calendar Year 20____

Plan of Benefits_____

	Actual Earned Premiums Col. (1)	Prima Facie Rate Col. (2)	Actual Premium Rate Col. (3)	Prima Facie Earned Prem. Col. (4)
A. Earned premiums at prima facie rate	_____	XXX	XXX	_____
B. Earned premiums at other than prima facie rates:				
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
Totals	_____	XXX	XXX	_____
	To Line 1.6, Part 5			To Line 1.7, Part 5

C. State method used to calculate unearned premiums:

_____
_____
_____

Note: Companies making a direct calculation of prima facie earned premium will complete only Col. 1 and Col. 4 Totals, and Line 1.3.

LONG-TERM CARE INSURANCE EXPERIENCE REPORTING FORMS 1 THROUGH 5

These reporting forms must be filed with the NAIC by April 1 each year.

The purpose of the Long-Term Care Insurance Experience Reporting Forms is to monitor the amount of such coverage and to provide data specific to this coverage on a nationwide basis. Long-term care expenses may be paid through life policies, annuity contracts and health contracts. When the long-term benefits portion of the contract is subject to rating rules based on the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio and premium rate increases), the adequacy of the pricing and reserve assumptions is critical to meeting the expectation of those sections.

For life or annuity products where no portion is subject to these rating rules, the products are not being included in the reporting in these forms. Companies may use an assumption that long-term care benefits that are "incidental" regardless of the date of issue, may be excluded. Incidental means that the value of long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy (measured as of the date of issue). If a policy form has had no policies in force and all claims on the policy form have been settled for more than five years, then the policy form is no longer reported on Forms 1, 2 and 4.

Form 1 focuses on the critical assumptions of morbidity and persistency while still presenting loss ratio data (without the level of detail in the original forms). As noted in the instructions specific to the form, prior-year values will be filled in over time. Only information as of 2009 and subsequent years is required on the forms unless it was required on the previous Long-Term Care Insurance Experience Reporting Forms. Companies are not required to supply information for spaces on the forms corresponding to any year prior to adoption of the forms, unless that information was previously reported. Form 2 focuses on the developing level of funds from the issue age premium basis and compares this to the active life reserve. As noted in the instructions specific to the form, prior-year values will be filled in over time. Form 3 focuses on the adequacy of claims reserves by presenting experience based on incurred years over the next several years. Because prior-year values should already be available; this form should be completed for at least the current and past four years. If available, all prior years should be completed. Form 4 is to include life and annuity products that are not exempt as outlined in the Long-Term Care Insurance Model Regulation. Form 5, which replaces the LTC Experience Form C, requires information at the state level. In addition to the considerable changes in the structure and purpose of the forms, the new forms are based on adding additional calendar years of experience to prior results. To more appropriately compare the actual results with expectations, the expected values are based on the exposure at the beginning of that year, *not* the original assumed sales distribution used when completing the original forms.

Because of the relatively small claim rates and variable length and size of long-term care claims, the statistical credibility of long-term care insurance experience is lower than the amount of credibility assigned to similar amounts of experience on other types of health insurance. This should be taken into account when reviewing experience and assessing the adequacy of reserves and the critical assumptions underlying them.

The Long-Term Care Insurance Experience Reporting Forms 1 through 5 should be filed whenever long-term care insurance has been sold, regardless of which annual statement has been filed. These forms are not only applicable to companies filing the life, accident and health annual statement. The list of the various annual statements is: life, accident and health, property/casualty, fraternal and health.

Include under the Individual portion both Individual policies and Group certificates if the group is approved by the state under statutes similar to Section 4E(4) of the Long-Term Care Insurance Model Act. Include under the Group portion group certificates if the group is approved by the state under statutes similar to Section 4E(1), (2) or (3) of the model act.

Experience for LTC insurance should be reported separately by stand-alone LTC policy form or by rider where experience is to be reported by form. Reporting by rider is applicable only to riders having distinct premiums for LTC coverage that are attached to products other than stand-alone LTC policies. Experience under forms that provide substantially similar coverage and provisions, that are issued to substantially similar risk classes and that are issued under similar underwriting standards, may be combined. If this option is utilized, the forms combined should be identified in the column captioned "Policy Form."

Claims incurred will need to reflect the loss of future premiums. These will occur because of the waiver of premium provision in the contract, waiver due to spouse's benefit status or other provisions in the contract that make it paid-up or not subject to collection of additional premiums for some future period. The claim incurred in each year will include the amount of the reserve established to reflect the loss of future expected premiums. The effect in future years will depend on the manner in which premiums from these policies are reported in following periods. If the assumption is that the policy is paid-up (no future premiums to be collected), the reserve and experience fund would be the paid-up value and future incurred claims will be only for LTC benefits. If the assumption is that future premiums (gross or net) will be considered as "paid by waiver," the reserve and experience fund will include in the reserve the present value of future premiums to be waived and the premium waived will be reported as both earned premium and a portion of the incurred claims.

INSTRUCTIONS FOR FORM 1

OVERVIEW

Long-Term Care Insurance Experience Reporting Form 1 is intended to track actual claims and persistency against expected on a nationwide basis. Certain group business is reported separately from individual and some group business. (See Section 4(E) of the Long-Term Care Insurance Model Act.) Policy forms are grouped into three categories: comprehensive, institutional only or non-institutional. Yearly and cumulative comparisons are exhibited. Even though only policy form groupings are displayed, policy form level information should be kept. It may facilitate rating reviews by the regulators. If a policy form has had no policies in force and all claims on the policy form have been settled for more than one year, then the policy form is no longer reported on this form.

DEFINITIONS AND FORMULAS

Comprehensive

Policy forms that provide a combination of institutional or facility and non-institutional coverage. These include institutional only policies with non-institutional riders.

Institutional Only

Policy forms that provide institutional coverage only.

Non-Institutional Only

Policy forms that provide only non-institutional coverage.

Current

Current calendar year of reporting.

Example: For a specific policy form category, the first year of issue was 2001. This Form 1 is required starting for the year 2009 and the reporting year is 2011. The current year would be 2011.

Prior

The year immediately prior to the year of reporting.

Example: 2010

2nd Prior

Two years prior to the year of reporting.

Example: 2009

3rd Prior

Three years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

4th Prior

Four years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

5th Prior

Five years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

Form Inception-to-Date

Aggregate experience data since the adoption of this Form 1.

Example: Data from 2009 through 2011.

Actual and expected in force counts are sums of counts for all years since adoption of Form 1.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Example: Data from 2001 through 2011.

Column 1 – Earned Premiums

Collected Premiums + Change in Due Premiums – Change in Advanced Premiums – Change in Unearned Premium Reserves.

Life, Accident & Health, Fraternal and Property/Casualty Only

Total earned premium should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2.

Column 2 – Incurred Claims

If iy = Incurred year
T = Report year – incurred year
V = Discount rate
${}_t\text{Paid Claims}_{iy}$ = Paid claims during claim duration t from claims incurred in year iy, t = 0, 1, 2, 3, . . . T
${}_T\text{Case Reserve}_{iy}$ = Case reserve at end of report year from claims incurred in iy

Incurred claims for incurred year iy :

For T=0

$${}_0\text{Paid Claims}_{iy} \times v^{1/2} + {}_0\text{Case Reserve}_{iy} \times v^{1/2} + {}_0\text{IBNR}_{iy} \times v^{1/2}.$$

For T>0

$${}_0\text{Paid Claims}_{iy} \times v^{1/2} + {}_1\text{Paid Claims}_{iy} \times v^{1} + {}_2\text{Paid Claims}_{iy} \times v^{2} + \ldots + {}_T\text{Paid Claims}_{iy} \times v^{T} + {}_T\text{Case Reserve}_{iy} \times v^{T+1/2} + ({}_T\text{IBNR}_{iy} \times v^{T+1/2})$$

This is the developed claim amounts for claims incurred during the specific calendar year. For each claim, the incurred claim equals the present values of all claim payments and the present value of any outstanding case reserve. This will be different from the reported financial incurred claims. The financial incurred claims, including the change in claim reserves that contains gain or loss due to reserve estimation different from actual payments for claims incurred in prior years.

For purposes of the present value calculation, assume all payments are made in the middle of the calendar year and the case reserve is at the end of the calendar year. The discount rate is the statutory valuation interest rate for case reserve. For the current calendar year, an Incurred But Not Reported (IBNR) reserve should be assigned. If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the direct liability attributable to long-term care business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities, which are incurred but not yet paid, both reported and not reported.

The incurred claims should be consistent with the claims exhibited on Form 3.

Column 3 – Valuation Expected Incurred Claims

The expected claim cost for an individual covered under a policy in force[1] at the beginning of the calendar year based on statutory active life reserve morbidity assumption. This is the interpolation of successive policy year expected claim costs for all coverages in force at the beginning of the year. Simple averaging is acceptable.

An acceptable approximation is the expected claim cost multiplied by an exposure adjustment, where expected claim cost is the sum of claim costs during the year based on the valuation morbidity assumption of each life in force at the beginning of the year. The valuation claim cost during the year is an interpolation of successive claim costs by policy year. Other approximations may also be acceptable. Any changes in method should be disclosed on the form.

The exposure adjustment is:

> [Actual Number of Lives In Force at Beginning of Year – (Expected Deaths + Expected Lapses) / 2] / Actual Number of Lives In Force at Beginning of Year,

where Expected Deaths and Expected Lapses are based on valuation assumptions. They can be derived from a single average decrement rate combining deaths and lapses, or specific decrement rates applying to actual exposures. If there is no in force at the beginning of the year, the expected claim cost can be zero.

Column 4 – Actual to Expected Incurred Claims

Actual incurred claims as a percentage of valuation expected incurred claims.

Column 5 – Open Claim Count

Number of claims that have at least one benefit payment made during the year after the elimination period. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. Examples are payments of caregiver training benefits and optional care coordination benefits. For these examples, if the amounts paid are included as benefits under the policy, they should be included in the claim amounts but excluded from the claim counts. A claim should be included in the count, even though it has terminated by the end of the year.

[1] If active life reserves are not held for claimants, then exclude the claimants.

Column 6 – New Claim Count

Number of claims that have at least one benefit payment made during the year after the elimination period but have no payments in previous years. If a claimant has prior claims, he or she should be counted if the current claim is considered as a new claim. For the purpose of including a claim in this count, payments that do not require satisfaction of the elimination period are excluded. A new claim should be included in the count even though it has terminated by the end of the year.

Column 7 – 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.

Column 8 – Expected Lives In Force End of Year

Expected number of lives in force at the end of the year:

Actual Number of Lives In Force at Beginning of Year + New Issue Lives – Expected Deaths – Expected Lapses,

where Expected Deaths and Expected Lapses are based on valuation assumptions. They can be derived from a single average decrement rate combining deaths and lapses or specific decrement rates applying to actual exposures. Joint policies should be counted by number of lives.

Column 9 – Actual to Expected Lives In Force

Actual number of lives in force as a percentage of expected number of lives in force at the end of the year.

NOTES

1. Form 1 applies to direct business only.

2. Prior years' figures, except for incurred claims, should be the same as the figures from prior years' Form 1.

3. Form Inception-to-Date figures, except for incurred claims, should be the corresponding figures from prior-year Form 1 plus the figures for the current year. No interest discounting is required to determine Form Inception-to-Date and Total Inception-to-Date figures.

4. If Incurred But Not Reported reserves must be allocated by policy form, the allocation should be based on paid claims and changes in case reserves.

5. Use the valuation assumptions corresponding to the current reserves being held. They are not necessarily the original reserve assumptions if strengthening or release of reserves has been made in the past. The assumptions for each year should be applied to the actual in-force (age, gender, plan distribution), not the distribution originally expected or issued.

6. An insurance company may use more refined methods in determining the required information than those described in the definitions and instructions. Methods must be consistent from report year to report year.

INSTRUCTIONS FOR FORM 2

OVERVIEW

The purpose of Form 2 is to calculate a ratio of an experience reserve to the reported reserve by calendar year on a nationwide basis. Summary data by policy form is to be reported. Data for the current reporting year, as well as that reported in each of the prior two reporting years, is to be shown on Form 2.

The following formulae specify data by calendar duration (t) and calendar year of issue (n). Data at this detail is required for the calculation of the experience reserve, although only totals by policy form are illustrated. Experience data is notated by a superscript E to distinguish from valuation assumptions. The experience reserve reported in column 13 is developed from: 1) the experience reserve at the end of the prior reporting year (t-1); 2) valuation net premiums and interest rates; and 3) experience incurred claims, earned premiums, and actual persistency. The valuation net premiums used are the actual net premiums used for that reporting year. *As an example, if a factor file method is used, the valuation net premiums used to calculate the reserve factors would be used for Form 2.*

For 2009, the experience reserve (column 13) was calculated using the reported reserves as of the end of 2008 as the prior year's reserve. Similarly, for acquired business, the experience reserve as of the year-end following acquisition is set equal to the reported reserve as of that date. The experience reserve as of subsequent periods is developed from the first experience reserve reported in this form. If a policy form has had no policies in force and all claims on the policy form have been settled for more than one year, then the policy form is no longer reported on this form.

Experience and valuation data are reported by base policy form. Rider forms will be reported with the base forms to which they are attached.

Only summary data by reporting year is illustrated. *The reporting company should have detail by calendar duration available upon request.*

DEFINITIONS AND FORMULAS

Column 3 – Last Year Issue

For closed blocks of business, report the last year a policy was issued for the policy form. For open blocks of business, leave blank.

Column 4 – Earned Premiums

${}_tEP_n$ = The direct earned premium in calendar duration t for all business of Calendar Year of Issue (CYI) n. Include earned premiums only for the reporting year. Total direct earned premiums should equal direct earned premiums for LTC business from Schedule H, Part 1, Line 2 for life, accident & health, fraternal and property/casualty only.

Column 5 – Incurred Claims

${}_tIC^E_n$ = The experience incurred claims of all business of CYI n in calendar duration t for the reporting year.

${}_tIC^E_n$ = $[{}_t(\text{Paid Claims})_n] + [{}_tCLiab^E_n \times (1+i_n)^{-1/2} - ({}_{t-1}CLiab^E_n) \times (1+i_n)^{1/2}]$

Where:

${}_t(\text{Paid Claims})_n$ – The paid claims of all business of CYI n in calendar duration t for the reporting year. Paid claims is the total direct paid claims for LTC business from Exhibit 8, Part 2, Line 1.1 for life, accident & health and fraternal only.

i_n – The valuation interest rate for CYI n.

$_tCLiab^L_n$ = The claim liability of all business of CY1 n in calendar duration t for the reporting year. $_tCLiab^F$ is the portion of the total direct claim liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health, and fraternal only. This amount includes accrued and unaccrued claims liabilities, which are incurred but not yet paid, both reported and not reported.

$_{t-1}CLiab^F_n$ = The claim liability of all business of CYI n in calendar duration t-1 for the prior reporting year. $_{t-1}CLiab^F_n$ is the total direct claim liability for LTC business from Exhibit 8, Part 2, Line 4.1 (life, accident & health and fraternal) of the current year's annual statement plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business on the prior year's annual statement for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities that were incurred but not paid at the prior year-end, both reported and not reported.

Column 6 – Loss Ratio

$_tLR_n$ = The incurred claims loss ratio in calendar duration t for all business of CYI n.

$_tLR_n$ = $_tIC^E_n$ / $_tEP_n$

Column 6 = Column 5 / Column 4 x 100

Column 7 – Annual Net Premium/Annual Gross Premium

The ratio of annual net premium to annualized gross premium.

Annual Net Premium = ∑ (annual valuation net premiums for policies issued in calendar year n at the start of calendar duration t). Companies may report zero (0) for net premiums during the Preliminary Term period.

Annual Gross Premium = ∑ (Annualized Premium In Force, including mode loadings for policies issued in calendar year n at the start of calendar duration t).

For calendar duration 0, the net premiums and gross premiums at issue should be used.

Column 8 – Current Year Net Premiums

$_tP_n$ The annual valuation net premium for all business of CYI n in calendar duration t.

$_tP_n$ = $_tEP_n$ x ∑ (annual valuation net premiums for policies issued in calendar year n at the start of calendar duration t)/ ∑ (Annualized Premium In Force for policies issued in calendar year n at the start of calendar duration t). At the detail level of CY1 n and calendar duration t, Column 8 = Column 4 x Column 7.

Column 9 – In Force Count Beginning of Year

$_{t-1}IF_n$ = The in force count in calendar duration t-1 for all business of CYI n at the end of the calendar year preceding the reporting year. In force Count Beginning of Years should equal in force end of prior year from the Exhibit of Number of Policies (Accident and Health Insurance, Line 1) for LTC business for life, accident & health and fraternal only.

Column 10 – New Issues Current Year

The new issues count during the reporting year. New Issues Current Year should equal issued during year from the Exhibit of Number of Policies (Accident and Health Insurance, Line 2) for LTC business for life, accident & health and fraternal only.

Column 11 – In Force Count End of Year

${}_tIF_n$ = The in force count in calendar duration t for all business of CYI n at the end of the reporting year. In Force Count End of Years should equal in force end of year from the Exhibit of Number of Policies (Accident and Health Insurance, Line 9) for LTC business for life, accident & health and fraternal only.

Column 12 – Persistency Rate

(Column 11 – .5 x Column 10) / (Column 9 + .5 x Column 10)

Column 13 – Experience Policy Reserves

$${}_tV^E{}_n = [({}_{t-1}V^E{}_n) + {}_tP_t] \times (1+i_n) - {}_tIC^E{}_n \times (1+i_n)^{1/2}$$

Where:

${}_tV^E{}_n$ = The experience reserve as of the end of the reporting year for calendar duration t, and CYI n.

${}_{t-1}V^E{}_n$ = The experience reserve as of the end of the prior reporting year for calendar duration t-1, and CYI n. For the first filing of this form, the experience reserve as of the second prior year is set equal to the reported reserve as of that date.

${}_tP_t$ = The annual valuation net premium for all business of CYI n in calendar duration t. The total for the reporting year is the amount reported in Column (8).

i_n = The valuation interest rate for CYI n.

${}_tIC^E{}_n$ = The experience incurred claims for all business of CYI n in calendar duration t. The total amount for the reporting year is reported in Column (5).

Column 14 – Reported Policy Reserve

The amount reported in annual statement Exhibit 6, Line 2 for life, accident & health and fraternal only.

Column 15 – Experience Reported Ratio

Column 15 = Column 13 / Column 14 x 100

Section C – Summary

Line 1 –	Total Current - Individual	=	Sum of each Section A, Line 1 (all policy forms)
Line 2 –	Total Prior - Individual	=	Sum of each Section A, Line 2 (all policy forms)
Line 3 –	Total 2nd Prior - Individual	=	Sum of each Section A, Line 3 (all policy forms)
Line 4 –	Total Current - Group	=	Sum of each Section B, Line 1 (all policy forms)
Line 5 –	Total Prior - Group	=	Sum of each Section B, Line 2 (all policy forms)
Line 6 –	Total 2nd Prior - Group	=	Sum of each Section B, Line 3 (all policy forms)
Line 7 –	Current Year Total	=	Section C, Line 1 + Section C, Line 4

INSTRUCTIONS FOR FORM 3

The purpose of this form is to test the adequacy of reserves held on long-term care policies. This form allows for the development of a seven-year trend of losses incurred by a specific year group of claimants. This form is to be prepared on a nationwide basis.

Report all dollar amounts in thousands ($000 omitted).

Part 1 – Total Amount Paid Policyholders

Show paid claims by year paid and year incurred. Claims are on a direct basis, including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Column 1.

The "Prior" values in these sections will not be directly comparable to prior statements, as the current year's statement will include an additional incurred year's values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 2 – Sum of Total Amount Paid Policyholders and Claim Liability and Reserve Outstanding at End of Year

This section provides a claim cost development overview to show the adequacy of claim reserves for a particular incurral year at the end of that year and at the end of subsequent years. The entry in Line X and Column Y is the cumulative claims incurred during year X and paid through the end of year Y for claims incurred in year X, plus the reserve at the end of year Y for claims incurred in year X.

Claims are on a direct basis including transfers before any reinsurance. Claims incurred prior to the year shown on Line 2 should be included in Line 1, Columns 1 through 8.

The "Prior" values in these sections will not be directly comparable to prior statements, as the current year's statement will include an additional incurred year's values.

Transfer policies are defined as policies that are either purchased or sold, typically through assumption reinsurance. These policies will be recorded in these parts of this exhibit while the company owns them.

Part 3 – Transferred Reserves

Claim reserves for ***transfer claims (acquired or sold)*** are shown here, by claim incurred year, starting from the year of transfer. For sold business, the entries are positive. For acquired business, the entries are negative. For years after the transfer year, the reserves are increased with interest.

Claim reserves for the buyer are the reserves initially set by the buyer, not necessarily equal to the reserves for the seller.

Part 4 – Present Value of Incurred Claims (Interest Adjusted Development of Incurred Claims)

Because claim reserves for long-duration claims are generally discounted, the year-to-year comparison in Part 2 is misleading to the extent interest income on claim reserves is material. To show consistent values; paid claims; transferred reserves and claim reserves are discounted to a common point in time (assumed to be July 1 of the incurred year).

- Paid claims in the year of incurral are discounted one-quarter year.
- Paid claims subsequent to the year of incurral are assumed to be paid mid-year and discounted back to the midpoint of the incurred year.
- Outstanding claim reserves for a given incurred year plus transferred reserves from Part 3 are discounted from the valuation date to the midpoint of the incurred year.
- Negative results are possible for acquired business only. Negative results indicate downward development of ultimate claims.

If

	iy	=	Incurred year
	T	=	Report year – incurred year
	v	=	Discount rate
	${}_{t}\text{Paid Claims}_{iy}$	=	Paid claims during current or prior calendar year t from claims incurred in year iy
	${}_{t}\text{Case Reserve}_{iy}$	=	Case reserve at end of calendar year t from claims incurred in iy
	${}_{t}\text{Transferred Reserve}_{iy}$	=	Transferred reserve at end of calendar year t from claims incurred in iy and
	t	=	iy, iy+1, iy+2, . . . , iy + T

then the Present Value of Incurred Claims for incurred year iy:

For T=0

$${}_{iy}\text{Paid Claims}_{iy} \times v^{½} + {}_{iy}\text{Case Reserve}_{iy} \times v^{½} + {}_{iy}\text{IBNR}_{iy} \times v^{½} + {}_{iy}\text{Transferred Reserve}_{iy} \times v^{½}$$

For T>0

$${}_{iy}\text{Paid Claims}_{iy} \times v^{½} + {}_{iy+1}\text{Paid Claims}_{iy} \times v^{1} + {}_{iy+2}\text{Paid Claims}_{iy} \times v^{2} + \ldots + {}_{iy+T}\text{Paid Claims}_{iy} \times v^{T}$$
$$+ {}_{iy+T}\text{Case Reserve}_{iy} \times v^{T+½} + ({}_{iy+T}\text{IBNR}_{iy} \times v^{T+½}) + {}_{iy}\text{Transferred Reserve}_{iy} \times v^{T+½}$$

If a portion of the IBNR is held for years other than the current calendar year, the value in the parentheses should be used.

The total case reserves and IBNR equal the portion of the total direct liability attributable to LTC business from Exhibit 8, Part 2, Line 2.1 (life, accident & health and fraternal) plus the portion of the claim liabilities reported on Exhibit 6, Line 14 (life, accident & health) and Line 13 (fraternal) attributable to LTC business for life, accident & health and fraternal only. This amount includes accrued and unaccrued claims liabilities that are incurred but not yet paid, both reported and not reported.

INSTRUCTIONS FOR FORM 4

OVERVIEW

Long-Term Care Insurance Experience Reporting Form 4 is intended to track life insurance and annuity products that have long-term care benefits provided by acceleration of certain benefits within these products. Include only the products that are not exempt as outlined in the Long-Term Care Insurance Model Regulation (sections on required disclosure or rating practices to customers, loss ratio, and premium rate increases also defined as "incidental" at the beginning of these experience forms instructions). This form is not to include stand-alone LTC products. Individual and group business is separated in this form.

DEFINITIONS AND FORMULAS

Current

Current calendar year of reporting.

Example: For a specific policy form category, the first year of issue was 2001. This Form 4 is required starting for the year 2009 and the reporting year is 2010. The current year would be 2010.

Prior

The year immediately prior to the year of reporting.

Example: 2009

2nd Prior

Two years prior to the year of reporting.

Example: Blank, because the first year of reporting is 2009.

Total Inception-to-Date

Aggregate experience data since issuance of policies.

Example: Data from 2001 through 2010.

Column 1 – Number of Policies In Force

The total number of policies in force as of end of calendar year.

Column 2 – Number of Certificates

The total number of certificates as of end of calendar year.

Column 3 – Death Claims

The total number of death claims for a calendar year.

Column 4 – Long-Term Care Accelerated Claims

The total number of long-term care accelerated claims for a calendar year. Only the long-term claims that have been triggered due to acceleration should be totaled.

Column 5 – Total Reserves

The total amount of non-claim reserves for these life insurance or annuity products.

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).

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.

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, traveler 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.

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):

Single Employer:

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.

Multiple Employer Associations and Trusts:

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. These 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.

Other Associations and Discretionary Trusts:

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.

Other Comprehensive/Major Medical:

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.

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).

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.

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.

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. For Administrative Services Only or Administrative Services Contracts, include number of persons covered. See *SSAP No. 47—Uninsured Plans*.

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. For Administrative Services Only or Administrative Services Contracts, include number of lives covered. See *SSAP No. 47—Uninsured Plans*.

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. For Administrative Services Only or Administrative Services Contracts, include number of lives covered for each month of the reported year. See *SSAP No. 47—Uninsured Plans*.

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.

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 the 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 Exhibit) 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 its 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.

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

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.

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) …

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.

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.

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 2019 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.

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).

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.

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 5.1 (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.

(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.

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

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; state, 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 relieving 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 offset 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.

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 9, 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).

Include: 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.

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.

Health Statement:

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

Line 4 – Deductibles, 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.

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 the 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.

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

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.

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

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.

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 10.4)

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 10.4)

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.)

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 5, 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.

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 2.5 of Part 2:

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

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 2.5 (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.

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.

Line 2 – Direct Claims Incurred:

Hospital/Medical Benefits

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 services 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.

Other Professional Services

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.

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).

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.

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 Reduce 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 Part 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 reducing 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.

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.

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.

- 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, medical 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 diseases; or
5. Provision of electronic health records and patient portals.

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.

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 1 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 producer 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 1% 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.

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.

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.

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.

Life/Fraternal Statement:

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

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

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/Fraternal 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 S__ for employee benefits

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

Exhibit 3, Line 6 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)

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.

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

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

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.

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.

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.

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.

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).

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).

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.

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.

(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	5	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	4	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	-3	X	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 Columns 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).

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.

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 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).

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.

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.

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.

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.

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 (1 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 and 3, Subtotals and Totals only
> Schedule H, Parts 1 through 4 only
> Schedule P except interrogatories
> Schedule T
> Schedule Z
> Insurance Expense Exhibit (Supplemental Filing)

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.

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 the 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 (Page 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.

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.

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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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-in lines 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.

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.

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.

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 Underwriter 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.

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.

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.

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.

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.

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.

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.

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 in 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 2019 annual statement due March 1, 2020, the year would be 2019.

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.

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 MUST 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 not 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.

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.

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

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

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
WLF	–	Wallis and Futu Islands
ESH	–	Western Saha
YEM	–	Yemen
ZMB	–	Zambia
ZWE	–	Zimbab e

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.