MARKET INFORMATION SYSTEMS (D) TASK FORCE

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Draft: 10/22/10

Market Information Systems (D) Task Force
Orlando, FL
October 19, 2010

The Market Information Systems (D) Task Force met in Orlando, FL, Oct. 19, 2010. The following Task Force members participated: John M. Huff, Chair (MO); Jay Bradford represented by James Winningham (AR); Karen Weldin Stewart represented by Linda Nemes (DE); Michael T. McRaith represented by James Morris (IL); Mike Chaney represented by Chad Bridges (MS); Thomas B. Considine represented by Anne Marie Narcini (NJ); James J. Wrynn represented by Gail Keren (NY); Mary Jo Hudson represented by Lynette Baker (OH); Neal T. Gooch represented by Suzette Green-Wright (UT); Mike Bertrand represented by Charles Piasecki (VT); Mike Kreidler represented by Leslie Krier (WA); Sean Dilweg represented by Jo LeDuc (WI); and Jane L. Cline represented by Mark Hooker (WV). Also participating was: Jim Mealer (MO).

1. Adopt Sept. 3 and Sept. 8 Conference Call Minutes

Mr. Hooker made a motion to adopt the Task Force's Sept. 3 and Sept. 8 conference call minutes (Attachment One and Attachment Two). Ms. Green-Wright seconded the motion and the minutes were adopted.

2. Review of 2010 Charges

Director Huff stated that the Task Force had four charges for 2010: 1) assess the efficacy of existing NAIC Market Information Systems (MIS); 2) appoint a Market Analysis Procedures (D) Working Group to make recommendations to the Task Force on market analysis techniques and required skills of market analysts; 3) develop data reporting standards and editing protocols to ensure consistent and accurate reporting from the states; and 4) serve as the business partner to receive reports from the internal NAIC Advisory Committee overseeing the development of a system for the automation and collection of the Market Conduct Annual Statement (MCAS) and provide direction to the Advisory Committee to ensure business objectives are being met. Director Huff reviewed the progress of the Task Force toward the completion of its 2010 Charges.

3. Update on "Voice of Customer" Calls

Director Huff stated that the Task Force is charged with 1) assessing the efficacy of existing NAIC MIS with respect to the primary objectives of market regulation; and 2) making recommendations for ways the data systems can be enhanced, consolidated or eliminated.

Director Huff stated that he had conducted calls with staff from several of the states and had received great feedback regarding the systems. He stated that a draft report was circulated to regulators for comments and that revisions were being made on the report based on the comments received prior to broader distribution.

Director Huff stated that, because different groups built the systems at different times, it is obvious that there is no overall, high-level plan for the systems to work together. He stated that his goal was to develop a longer-range strategic plan for the systems.

4. Update on Market Conduct Annual Statement (MCAS) Centralization Project

Ginny Ewing (NAIC) provided an update on the MCAS systems' development. All applications necessary to receive and process data for the states have been delivered for testing. Initial load testing results of these systems have been positive. Development of all regulator reports and applications is complete, with testing in progress. Preparation of the beta testing environment is in progress and on schedule to complete in time for beta testing to begin Dec. 1. The industry application development has been defined to be delivered in five iterations. Iteration two testing is in progress. Iteration three deliverables are scheduled for testing in mid- to late-November. Iteration four deliverables are scheduled for testing in early December. Iteration five, which is defined as desired functionality not critical to the initial production release, is planned for late January 2011/early February 2011, depending on the ultimate defined scope. The industry application is scheduled to be available for industry review in the beta testing environment by March 2011. All MCAS systems will be available in production by April 15, 2011.

Director Huff stated that he hoped to be able to have the new MCAS system demonstrated at the 2011 Spring National Meeting.

Director Huff stated that, as of today, 34 states had signed a user agreement with the NAIC regarding the centralized system. He said that, for the states to participate, NAIC staff needed a signed Terms of Use Agreement; an electronic signature; the statutory citation for the collection of the data; and the contact information for the primary person responsible for MCAS.

Director Huff stated that, because the NAIC will be distributing the call letters on behalf of the states in December, all items must be sent to Randy Helder (NAIC) by Dec. 1. He said that any state not making the deadline would risk not participating in MCAS for the collection of the 2010 data.

Director Huff stated that, to ensure the new MCAS system meets the requirements of regulators and the industry, NAIC staff was seeking feedback through beta testing. He stated that the regulator beta testing will begin in approximately six weeks and that individuals from the District of Columbia, Missouri, New Hampshire, New Jersey, Ohio, Utah, Washington and Wisconsin had agreed to participate.

Director Huff stated that the NAIC was asking companies to volunteer to beta-test the new system and provide feedback regarding possible enhancements to the system and instructional materials. He stated that any companies interested in participating in the beta-test of the MCAS system should send an e-mail to Craig Leonard (NAIC) by Dec. 1.

5. Overview of the MCAS Communication and Education Plans

Director Huff stated that he had been working with NAIC staff to ensure a comprehensive plan is developed for the communication and education surrounding the new MCAS system. He stated that his goals included ensuring that all of the states were aware of the new processes and receive opportunities for education on the use of the new system and the analysis of the data collected; and to publicize the changes to be expected for next year's MCAS data collection to be sure all companies are aware of the changes and their requirements.

Director Huff stated that, after this meeting, he would work with NAIC staff to issue a news release regarding the addition of new states to the MCAS process and the 2011 due date.

Director Huff stated that NAIC staff would distribute several e-mails to all companies writing a line of business collected in MCAS. He stated the e-mails would inform the companies of the new states, new process and due date. Those letters will include the call letters to market conduct contacts on behalf of the states for the collection of 2010 data due June 30, 2011.

Director Huff stated that NAIC staff are in the process of developing an article to be submitted for the Insurance Regulatory Examiners Society (IRES) *Regulator* newsletter, describing the history and future of MCAS and focusing on the major changes for 2011 and 2012.

Director Huff stated that he and Commissioner Sevigny would be willing to discuss the changes to MCAS and the future of MCAS with any trade publications, such as *National Underwriter* and *Business Insurance.* He also offered to collaborate with trade associations to ensure that their members are prepared for the MCAS filing process.

Director Huff stated that, beginning in April 2011, NAIC staff would conduct a series of MCAS process webinars for the industry, which will include an overview of the new automated process, demonstrations of how to navigate within the system, and explanations and examples of how to apply the MCAS definitions.

Director Huff stated that NAIC staff also would conduct regulator-only training in each of the four NAIC zones, which would provide an overview of the new process and system demonstrations of I-SITE tools, as well as techniques for analyzing the data. He stated that the training would provide opportunities for feedback about what they would like to see in the future. He stated that the training was tentatively scheduled for Baltimore, MD, in July 2011; Minneapolis, MN, in August 2011 (in conjunction with the IRES Career Development Seminar); Orlando, FL, in September 2011 (in conjunction with the Association of Insurance Compliance Professionals (AICP) conference), and Denver, CO, in October 2011. He stated that NAIC staff would also conduct abbreviated classroom training sessions in conjunction with the 2011 Summer National Meeting and 2011 Fall National Meeting.

Director Huff stated that, for regulators who cannot travel, NAIC staff would be offering webinars that focus on the administration and organization of incoming MCAS data, as well as demonstrations outlining the use of the new "Waivers

and Extensions" tool. He stated that NAIC staff also would provide beginner and advance training for the QuickLink application.

Director Huff also announced that the Market Regulation track of the 2011 NAIC/NIPR E-Reg Conference would be exclusively dedicated to the MCAS. He stated that there would be a public track open for industry and regulators, in addition to a special regulator-only track for part of the conference that will focus on the regulator tools and analyzing the data.

Mr. Hooker suggested that it might be beneficial to offer MCAS training in conjunction with the IRES Foundation School. Dave Kenepp (Liberty Mutual Insurance Company), as an IRES Foundation Board member, said he was confident that the Foundation would welcome the opportunity to collaborate on MCAS training. Director Huff stated that NAIC staff would explore the opportunity.

Ms. LeDuc stated that any article for the IRES *Regulator* would need to be submitted by Jan. 10, 2011. Director Huff stated that NAIC staff would have no problem meeting that deadline.

6. Report of Market Analysis Procedures (D) Working Group

Ms. Baker stated that the Market Analysis Procedures (D) Working Group had adopted Market Analysis Core Competencies. She stated that, due to the ongoing changes with the systems, she was recommending that the Working Group's charges to update the NAIC *Market Regulation Handbook* and to provide a best practices guide be deferred until 2011.

Ms. Baker stated that the Working Group had voted to suspend the collection of any 2010 group life data in the new system. She said she asked NAIC staff to determine whether it could be suspended without causing any programming difficulties. Ms. Ewing stated that she believed the data collection could easily be suspended, but that she would know more in the next few days. Director Huff stated that an e-mail would be distributed to interested parties regarding any decision to suspend the data and that the call letters would indicate whether the data was not being collected.

Ms. LeDuc made a motion to adopt the report of the Market Analysis Procedures (D) Working Group. Mr. Hooker seconded the motion and the report was adopted (Attachment Three).

7. Adoption of 2011 Proposed Charges

Director Huff stated that the Task Force needed to adopt their 2011 Proposed Charges.

Mr. Hooker stated the Special Activities Database (SAD) should be included in the charges as a Market Information System. Director Huff suggested that the language in the charge be changed to show that oversight of SAD would be in conjunction with the Antifraud (D) Task Force.

Ms. LeDuc stated that MCAS should be added to the charge as a Market Information System. Director Huff agreed.

Deirdre Manna (Property Casualty Insurers Association of America—PCI) suggested that workers' compensation should not be the next line of business collected via the MCAS due to the amount of data currently collected and the joint regulation by state departments of insurance and other agencies.

Cate Paolino (American Insurance Association—AIA) stated that she also was concerned about adding workers' compensation as the next line of business and suggested the word "develop" be changed to "consider." Director Huff stated that "develop" was broad enough to allow for the consideration.

Marsha Brown (National Association of Mutual Insurance Companies—NAMIC) stated that, because workers' compensation was a different product than many other kinds of insurance and because there was already a great deal of data collected, she believed other lines of business might be more beneficial to regulators to collect via the MCAS.

Ms. Manna stated that she would like to know the status of any new blank regarding the collection of health insurance data. Director Huff stated that he was not aware that there were any current plans to collect health data using the MCAS.

Director Huff stated that he believed the charge should be broad enough to allow for the addition of any line of business and suggested the language be generalized to include any line of business.

Ms. Narcini stated that she thought the charges might need to include a decision about the record retention of the MCAS data. Ms. Ewing stated that, because the MCAS data remained state-owned, each state's record-retention policy would be followed.

Mr. Hooker made a motion to adopt the charges as amended. Ms. Green-Wright seconded the motion and the charges were adopted (Attachment Four).

Having no further business, the Market Information Systems (D) Task Force adjourned.

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Draft: 9/16/2010

Market Information Systems (D) Task Force
Conference Call
September 3, 2010

The Market Information Systems (D) Task Force met via conference call Sept. 3, 2010. The following Task Force members participated: John M. Huff, Chair (MO); Mary Jo Hudson, Vice Chair, represented by Lynette Baker (OH); Jay Bradford represented by Alice Jones (AR); Gennet Purcell represented by Luther Ellis (DC); Michael T. McRaith represented by Robert Rapp (IL); Thomas B. Considine represented by Anne Marie Narcini (NJ); James J. Wrynn represented by Sylvia Lawson (NY); Robert L. Pratter represented by Peter Camacci (PA); Mike Kreidler represented by Leslie Krier (WA); Sean Dilweg represented by Jo LeDuc (WI); and Jane L. Cline represented by Mark Hooker (WV). Also participating were: Keith Nyhen (NH); Jim Mealer (OH); and Doug Pennington (WA).

1. Timing for Collection of Adopted Market Conduct Annual Statement Life and Annuity Data Elements

Director Huff said that, at the Summer National Meeting, the Task Force agreed to work closely with the industry on the timing for implementing the changes to the data elements that were adopted by the Market Analysis Procedures (D) Working Group. He said the industry representatives promised to work in good faith to determine which of the data elements could be captured in 2011 for submission in 2012. For all the other data elements, the NAIC would, in good faith, hold off collection until the following year to allow the companies time to program their systems to capture the data.

Kelly Ireland (American Council of Life Insurers—ACLI) said that the main concern of the companies they represent is programming their systems to capture the data by Jan. 1, 2011. Some of their companies would need until at least June 1, 2011, to program their systems to capture the data. She said that each of the schedules include breaking out surrenders by the number of years from the date of issuance. Previously, companies only had to report the total number of surrenders on the Market Conduct Annual Statement (MCAS). Although the ACLI recognizes the value of the breaking out the surrenders by policy years, the information systems that were built for collecting this data were only designed to collect total numbers and do not calculate the years from inception for each surrender. She said the inception date and surrender date are captured for each surrender, but the system does not make the calculations and total the surrenders by policy years and that would need to be programmed.

Director Huff said the "surrenders" programming concerns are a data-reporting issue rather than a data-capturing issue. He said the companies have until May of the following year to report the data, so he said he was not sure why the "surrenders" data elements could not be reported in 2012. Ms. Ireland said that the companies do not treat these as two separate processes. If the reporting mechanism is built on the back-end of the capture mechanism, the reported number has to be reconciled to be sure the information was captured from the beginning of the data year. This could create data accuracy issues and slow down the time needed to complete an MCAS filing. She said that breaking out "the surrenders by policy year" and the "number of policies issued by age" each have the same issues.

Mr. Mealer said that doing an ad hoc report for data elements that are already captured is not a time-consuming activity for regulators. Ms. Baker said that, in past discussions, the industry has said that they needed to wait for the financial annual statement (FAS) to be released because the information for the MCAS is derived from the FAS systems. Ms. Baker asked Ms. Ireland if she was now telling the Task Force that there are other systems in place to capture MCAS data. Ms. Ireland said there are a large number of systems involved, especially if a group has a large number of companies or lines of business to be reported. She said the FAS has total surrender information, but not the breakout by policy year. She said that reconciling between systems can be time-consuming.

Mr. Nyhen said that not all of the ACLI companies pre-program these data elements. He said many of the companies do ad hoc querying of their data following year-end. Director Huff said that pre-programming adds to the company cost and that it is usually more efficient to do ad hoc querying, especially if the reports change over time.

Ms. Baker said that only fields that require programming to capture the data should be considered for a delay to the 2012 data year. Director Huff agreed, and said that was the basis of the discussions with the companies at the Summer National Meeting. Ms. Ireland agreed that was the industry's understanding. She said that, after the Summer National Meeting, the ACLI hosted a conference call to discuss the programming needs for the new data elements. She said that some of the data

elements the ACLI thought would be difficult to collect, such as the split between internal and external replacements, were not difficult, while others, such as the surrenders by policy year, were difficult. She said other data fields, such as "policies/contracts applied for" and "free looks" need to be defined more clearly before an opinion can be made about programming difficulties.

Several industry participants commented that they agreed with Ms. Ireland.

Ms. Ireland said that, even if companies do ad hoc queries of the data, there is the additional burden of 18 more states collecting the MCAS data that would make running ad hoc reports unwieldy.

Director Huff said that an option would be to have the companies provide a download of all transactional data and send the data to the NAIC. The ad hoc reporting responsibilities would then be with the state regulators. Mr. Mealer, Mr. Hooker and Ms. Szumkowski agreed that they would prefer transactional data that they could query against. Susan Bregman (Prudential) said that providing transactional data would possibly be easier to provide. Mr. Mealer said that the regulators would be asking for all of the data and the regulators would determine what information they needed from the data supplied by the companies. Craig Mason (Kansas City Life) said that the amount of data supplied would be unworkable, considering the number of companies that would be submitting the data. Mr. Mealer said that regulators had experience with large amounts of data. He said the volume is needed in order to determine what data elements might be useful in uncovering misconduct in the marketplace.

Mr. Mealer said that, at the interim meeting, Director Huff asked for suggestions concerning useful data elements and had not received any responses to his question. He reiterated that, by receiving transaction-level data, the regulators could determine which elements were useful for uncovering misconduct.

Ms. Ireland said that the idea of transactional data had been discussed last year and the regulators had agreed that they were unprepared to receive and analyze that quantity of data. She said this would require rebuilding the MCAS. She said that companies would need six months to develop the queries. Mr. Mealer said that the companies could do the ad hoc querying of the data as well as the regulators can, and the regulators would not need six months. If the regulators are going to do the querying, then the companies should be required to submit of all the data, so that regulators can use that information to protect consumers as best as possible. Ms. Narcini said transaction-level detail was an option, but she would be concerned for the new states who have not collected MCAS data before. She said she did not think they could handle the quantity of transactional data and, if the Task Force decided to request transactional data, it should be on a national level and not a state level.

Director Huff said that the regulators have not seen much movement from the industry in support of this year's MCAS initiatives. He said the industry raised a lot of concern about the due date for the data and the regulators were supportive of an incremental change of the due date over three years to give the industry time to adjust to the change. Time and resources were invested in an interim meeting and, when consensus was reached, the industry said that as much as three years were necessary to program systems to capture the data. When consensus was reached on which new data elements required programming for capture and which were already available, the regulators were told that even if the information is already captured, as much as a year is necessary to develop methods for reporting the data. Director Huff said it seems as though the regulators are being pushed off from collecting data that could be gathered quickly if a market conduct exam was scheduled.

Ms. Ireland said that the ACLI was not asking for a three-year delay. She said that only six months are required for programming the reporting of the data. She said the companies would be able to begin providing data with a beginning date of June 2011; that is, six months of 2011 data could be provided on the 2012 due date. Mr. Nyhen said that regulators would need a full year of data, not just six months. Mr. Rapp agreed that, for trending, a full year of data was necessary. Mr. Pennington said that six months of data would only be useful if companies provided the data every six months.

Director Huff asked Ms. Ireland to divide the data elements into those elements that were possible to begin capturing in January 2011 and those that needed programming to capture. Ms. Ireland said that the MCAS data elements that are of concern are "policies applied for," "free looks," surrenders by policy-year bands and policies issued by age bands. She said all of the other new data elements seemed to be immediately collectable. Ms. Ireland said the surrender bands also need to be better defined to make clear that it covers policies surrendered during policy years one and two in the first band; policy years three, four and five in the second band; and policy years six through 10 in the final band. Ms. Ireland said the calculation for internal and external replacements needs to be clearer to explain how to report one replacement that results from surrenders of multiple policies that include both internal and external policies.

Ms. Baker agreed that the "applied for" and "free looks" fields need system changes in order to collect. She said that the other fields should be able to be collected as of Jan. 1, 2011. Ms. Baker moved that the "polices/contracts applied for" and "free looks" fields begin to be collected Jan.1, 2012, to be reported by April 30, 2013, and that all other fields begin to be collected Jan. 1, 2011, to be reported in May 31, 2012. Ms. LeDuc seconded the motion. The motion was approved unanimously. Director Huff said that Ms. Baker would make the necessary changes to the Life and Annuity Data Call and Definitions and it will be forwarded to the Market Regulation and Consumer Affairs (D) Committee at the Fall National Meeting (Attachment One-A).

2. Discussion on Updating the MCAS Change Process

Director Huff said the revised procedures for MCAS changes were posted on the Task Force's Web page and sent to regulators and interested parties prior to the conference call. He said the primary change was that any revisions needed to be made by the Market Analysis Procedures (D) Working Group as of Aug. 1 and approved by the Market Regulation and Consumer Affairs (D) Committee by Oct. 1 in order to be effective by Jan.1 of the following year and reported by the due date in the year after the following year. If either the Working Group or the Committee do not adopt revisions by either date, the changes would be effective one year later. He said that a goal of the changes was to move away from using national meetings as the deadline for revisions, because national meetings do not necessarily fall on definite dates. Director Huff said the revision to the MCAS Change Process would be effective next year. He clarified that the MCAS data element changes adopted this year are made under the time guidelines of the current MCAS Change Process.

Ms. Ireland said the ACLI would support the dates if they allowed for one year and six months before data needs to be reported, to enable companies to program their systems. She said that companies need a minimum of six months to program for the changes. She suggested May 1 for the Working Group and July 1 for the Committee. Ms. Baker said that, because the chair of the Working Group changes in January, this would require the next year's Working Group members and chair to ratify the previous year's work. Ms. Krier said she would be more comfortable with the proposal if it was possible for working groups to do work after the final national meeting of the year.

Director Huff said the discussion would be continued on the next Task Force conference call.

Having no further business, the Market Information Systems (D) Task Force adjourned.

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Life & Annuities Data Call & Definitions

Lines of Business: Individual Life Cash Value Products
Individual Life Non-Cash Value Products
~~Group Life Products (Cash & Non-Cash Value)~~
Individual Fixed Annuities
Individual Variable Annuities

Reporting Period: January, ~~2010~~ 2011 through December 31, ~~2010~~ 2011

Filing Deadline: ~~June~~ May 3~~1~~0, ~~2011~~2012

Contact Information:
NAIC Code
NAIC Group Code
Federal Employers Identification Number (FEIN)
Contact Person
Contact Phone
Contact Email
Company Name
Address1
Address2
City
State
Zip Code
Company Comment (optional, maximum 255 characters)

Schedule Information

Schedule	Product Identifiers	Explanation of Product Identifiers
1	ICVP	Individual Life Cash Value Products (Includes Variable Life, Universal Life, Variable Universal Life, Term Life with Cash Value, Whole Life, & Equity Index Life)
2	INCVP	Individual Life Non-Cash Value Products (Any life insurance policy that does not contain a cash value element)
~~3~~	~~GRP~~	~~Group Life Products (Cash & Non-Cash Value products and includes Variable Life, Universal Life, Variable Universal Life, Whole Life, Equity Index Life & Term)~~
~~4~~ 3	IFA	Individual Fixed Annuities (Includes Equity Index Annuity Products)
~~5~~ 4	IVA	Individual Variable Annuities

Life & Annuities Data Call & Definitions

Interrogatories

	State Schedule 1 Comment (optional, maximum 255 characters) (Company comments on Individual Life Cash Value Products)
	State Schedule 1 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No
	Interrogatory Comment Field
	State Schedule 2 Comment (optional, maximum 255 characters) (Company comments on Individual Life Non-Cash Value Products)
	State Schedule 2 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No
	Interrogatory Comment Field
	State Schedule 3 Comment (optional, maximum 255 characters) (Company comments on Individual ~~Life Non-Cash Value~~Fixed Annuity Products)
	State Schedule 3 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No
	Interrogatory Comment Field
	State Schedule 4 Comment (optional, maximum 255 characters) (Company comments on Individual ~~Life Non-Cash Value~~Variable Annuity Products)
	State Schedule 4 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No
	Interrogatory Comment Field

Life & Annuities Data Call & Definitions

Schedule 1 – Individual Life Cash Value Products (ICVP)

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
ICVP	Product Identifier **Automatically loaded**
	~~Number Of New Replacement Policies Applied For During The Period (Include all replacements regardless of whether an insurance policy was actually issued.)~~
	Number Of New Replacement Policies Issued During The Period (Include only the number of replacement insurance policies issued)
	Number of Internal Replacements Issued
	Number of External Replacements Issued
	Number of Policies Replaced where age of insured at replacement was <65
	Number of Policies Replaced where age of insured at replacement was Age 65 and over
	~~Internal Replacement Indicator (Yes/No)~~
	~~Surrender Indicator (Yes/No)~~
	~~Loan Purchase Indicator (Yes/No)~~
	~~1035 Rollover Indicator (Yes/No)~~
	~~Replacement Register Indicator (Yes/No)~~
	~~Number of In force Policies With a Loan Balance Over 25% Of The Maximum Loan Value As of The End of The Reporting Period~~
	~~Number Of Policies Surrendered During The Period~~
	~~Number Of Partial Surrenders During The Period~~
	~~Number Of New 1035 Exchanges Coming Into The Company During The Period~~
	Number of Policies Surrendered Under 2 Years from Policy Issue
	Number of Policies Surrendered Between 2 Years and 5 Years of Policy Issue
	Number of Policies Surrendered Between 6 Years and 10 Years of Policy Issue
	Total Number of Policies Surrendered During the Period

Life & Annuities Data Call & Definitions

	~~Number of Policies Applied for During the Period~~
	~~Number of Policies Applied for, but not Issued, During the Period~~
	Number of Policies Issued During the Period where age of insured at issue was <65
	Number of Policies Issued During the Period where age of insured at issue was Age 65 and over
	Total Number Of New Policies Issued By The Company During The Period
	~~Number of Free Looks During the Period~~
	Number Of Policies In Force At The End Of The Period (The number of active policies that the company has outstanding at the end of the reporting period.)
	Dollar Amount Of Direct Premium During The Period
	Dollar Amount Of Insurance Issued During The Period (Face Amount)
	Dollar Amount Of Insurance In Force At The End Of The Period (Face Amount)
	Number Of Complaints Received Directly From Consumers
	~~Number Of Complaints Received Directly From The Corresponding Department Of Insurance~~
	~~Complaint Register Indicator (Yes/No)~~
	Number Of Death Claims Closed With Payment, During The Period, Within 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was made within 60 days from when the date of due proof of loss occurred.)
	Number Of Death Claims Closed With Payment, During The Period, Beyond 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was NOT made within 60 days from when the date of due proof of loss occurred.)
	Number Of Death Claims Denied, Resisted or Compromised During The Period ~~(A claim is considered resisted when it is in dispute and not resolved on the statement date.)~~
	Total Number Of Death Claims Received During The Period (Include any claim received during the period as determined by the first date the claim was opened on the company system.)
	State Schedule 1 Comment (optional, maximum 255 characters) (Company comments on Individual Life Cash Value Products)

Schedule 2 – Individual Life Non-Cash Value Products (INCVP)

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
INCVP	Product Identifier **Automatically loaded**
	~~Number Of New Replacement Policies Applied For During The Period (Include all replacements regardless of whether an insurance policy was actually issued.)~~

Life & Annuities Data Call & Definitions

	Number of New Replacement Policies Issued During The Period (Include only the number of replacement insurance policies issued)
	~~Internal Replacement Indicator (Yes/No)~~
	~~Replacement Register Indicator (Yes/No)~~
	Number of Internal Replacements Issued During the Period
	Numa~~a~~ber of External Replacements Issued During the Period
	Total Number Of New Policies Issued By the Company During The Period
	~~Number of Policies Applied for, but not Issued, During the Period~~
	~~Number of Free Looks During the Period~~
	Number Of Policies In Force At The End Of The Period (The number of active policies that the company has outstanding at the end of the reporting period.)
	Dollar Amount Of Direct Premium During The Period
	Dollar Amount Of Insurance Issued During The Period (Face Amount)
	Dollar Amount Of Insurance In Force At The End Of The Period (Face Amount)
	Number Of Complaints Received Directly From Consumers
	~~Number Of Complaints Received Directly From The Corresponding Department Of Insurance~~
	~~Complaint Register Indicator (Yes/No)~~
	Number Of Death Claims Closed With Payment, During The Period, Within 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was made within 60 days from when the date of due proof of loss occurred.)
	Number Of Death Claims Closed With Payment, During The Period, Beyond 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was NOT made within 60 days from when the date of due proof of loss occurred.)
	Number Of Death Claims Denied, Resisted or Compromised During The Period ~~(A~~
	Total Number Of Death Claims Received During The Period (Include any claim received during the period as determined by the first date the claim was opened on the company system.)
	~~State Schedule 2 Comment (optional, maximum 255 characters) (Company comments on Individual Life Non-Cash Value Products)~~
	~~State Schedule 2 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No~~
	~~Interrogatory Comment Field~~

Life & Annuities Data Call & Definitions

~~Schedule 3 – Group Life Products – Cash & Non-Cash (GRP)~~

~~ID~~	~~Description~~
	~~State Indicator (State for which data is being submitted)~~ ~~**Automatically loaded**~~
	~~NAIC Company Code~~ ~~**Automatically loaded after initial entry**~~
~~GRP~~	~~Product Identifier~~ ~~**Automatically loaded**~~
~~LS301~~	~~Number Of New Policies Issued By the Company During The Period~~
~~LS302~~	~~Number Of Policies In Force At The End Of The Period (The number of active policies that the company has outstanding at the end of the reporting period.)~~
~~LS303~~	~~Dollar Amount Of Direct Premium During The Period~~
~~LS304~~	~~Dollar Amount Of Insurance Issued During The Period (Face Amount)~~
~~LS305~~	~~Dollar Amount Of Insurance In Force At The End Of The Period (Face Amount)~~
~~LS306~~	~~Number Of Complaints Received Directly From Consumers~~
~~LS307~~	~~Number Of Complaints Received Directly From The Corresponding Department Of Insurance~~
~~LS308~~	~~Complaint Register Indicator (Yes/No)~~
~~LS309~~	~~Number Of Death Claims Closed With Payment, During The Period, Within 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was made within 60 days from when the date of due proof of loss occurred.)~~
~~LS310~~	~~Number Of Death Claims Closed With Payment, During The Period, Beyond 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was NOT made within 60 days from when the date of due proof of loss occurred.)~~
~~LS311~~	~~Number Of Death Claims Denied, Resisted or Compromised During The Period (A claim is considered resisted when it is in dispute and not resolved on the statement date.)~~
~~LS312~~	~~Total Number Of Death Claims Received During The Period (Include any claim received during the period as determined by the first date the claim was opened on the company system.)~~
~~LS3c~~	~~State Schedule 3 Comment (optional, maximum 255 characters) (Company comments on Group Life Products)~~

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Schedule ~~4~~ 3 – Individual Fixed Annuities (IFA)

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
IFA	Product Identifier **Automatically loaded**
	~~Number Of New Replacement Contracts Applied For During The Period (Include all replacements regardless of whether an annuity contract was actually issued.)~~
	Number of New Replacement Contracts Issued During The Period (Include only the number of replacement contracts issued.)
	~~Internal Replacement Indicator (Yes/No)~~
	~~Loan Purchase Indicator (Yes/No)~~
	~~1035 Rollover Indicator (Yes/No)~~
	~~Replacement Register Indicator (Yes/No)~~
	Number Of Internal Replacement Contracts Issued During The Period
	Number Of External Replacement Contracts Issued During The Period
	Number Of Contracts Replaced Where Age of Annuitant at Replacement was < 65
	Number Of Contracts Replaced where Age of Annuitant at Replacement was 65-80
	Number Of Contracts Replaced where Age of Annuitant at Replacement was > 80
	Number of New Immediate Contracts Issued During the Period
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was < 65
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was > 80
	Total Number Of New Deferred Contracts Issued By the Company During The Period
	Number of Contracts Surrendered Under 2 Years from Issuance
	Number of Contracts Surrendered Between 2 Years and 5 Years of Issuance
	Number of Contracts Surrendered Between 6 years and 10 Years of Issuance
	Total Number Of Contracts Surrendered During The Period
	~~Number Of New 1035 Exchanges Coming Into The Company During The Period~~
	~~Number of Contracts Applied for, but not Issued, During the Period~~
	~~Number of Free Looks During the Period~~
	Number Of Contracts In Force At The End Of The Period (The number of active contracts that the company has outstanding at the end of the reporting period.)
	Dollar Amount Of Annuity Considerations During The Period
	Number Of Complaints Received Directly From Consumers
	~~Number Of Complaints Received Directly From The Corresponding Department Of Insurance~~
	~~Complaint Register Indicator (Yes/No)~~
	~~State Schedule 4~~ 3 ~~Comment (optional, maximum 255 characters) Company comments on Individual Fixed Annuity Products~~

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	~~State Schedule 3 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No~~
	~~Interrogatory Comment Field~~

Schedule ~~5~~ 4 – Individual Variable Annuities (IVA)

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
IVA	Product Identifier **Automatically loaded**
	~~Number Of New Replacement Contracts Applied For During The Period (Include all replacements regardless of whether an annuity contract was actually issued.)~~
	Number of New Replacement Contracts Issued During The Period (Include only the number of replacement annuity contracts issued.)
	~~Loan Purchase Indicator (Yes/No)~~
	~~1035 Rollover Indicator (Yes/No)~~
	~~Replacement Register Indicator (Yes/No)~~
	Number Of Internal Replacement Contracts Issued During The Period
	Number Of External Replacement Contracts Issued During The Period
	Number Of Contracts Replaced Where Age of Annuitant at Replacement was < 65
	Number Of Contracts Replaced where Age of Annuitant at Replacement was 65-80
	Number Of Contracts Replaced where Age of Annuitant at Replacement was > 80
	Number of New Immediate Contracts Issued During the Period
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant

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	was < 65
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was > 80
	Total Number Of New Deferred Contracts Issued By The Company During The Period
	Number of Contracts Surrendered Under 2 Years from Issuance
	Number of Contracts Surrendered Between 2 Years and 5 Years of Issuance
	Number of Contracts Surrendered Between 6 years and 10 Years of Issuance
	Total Number Of Contracts Surrendered During The Period
	~~Number of Contracts Applied for During the Period~~ ~~Number Of New 1035 Exchanges Coming Into The Company During The Period~~
	~~Number of Free Looks During the Period~~
	Number Of Contracts In Force At The End Of The Period (The number of active contracts that the company has outstanding at the end of the reporting period.)
	Dollar Amount Of Annuity Considerations During The Period
	Number Of Complaints Received Directly From Consumers
	~~Number Of Complaints Received Directly From The Corresponding Department Of Insurance~~
	~~Complaint Register Indicator (Yes/No)~~
	~~State Schedule 5~~ 4 ~~Comment (optional, maximum 255 characters) Company comments on Individual Variable Annuity Products.~~
	~~State Schedule 4 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No~~
	~~Interrogatory Comment Field~~

In determining what business to report for a particular state, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages and in accordance with each applicable state's regulations.

Life & Annuities Data Call & Definitions

Definitions:

~~**1035 Exchange** – A provision in the tax code (IRC 1035), which allows for the direct transfer (Rollover) of accumulated funds in a life insurance policy, endowment policy or annuity contract to another life insurance policy, endowment policy or annuity policy, without creating a taxable event.~~

~~**1035 Rollover Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the 1035 Rollover Indicator whether the Replacement Counts provided include policies (for life products) or contracts (for annuity products) purchased through 1035 Exchanges (Rollovers).~~

Annuity – A contract under which an insurance company promises to make a series of periodic payments to a named individual in exchange for a premium or a series of premiums. Data is being requested for individual annuities only; data for group annuity contracts are not being requested.

Annuity Considerations – Funds deposited to or used to purchase annuity contracts issued by the company. For the purpose of this statement, annuity considerations should be determined in the same manner used for the state pages of the company's financial annual statement.

Cash Value Product – A life insurance policy that generates a cash value element. Term life policies with cash value are considered cash value products.

Claim – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Claims with multiple beneficiaries should be counted as one claim. If a single insured dies and has multiple policies (for individual life products)~~ and/or multiple certificates (for group life insurance products)~~, a claim should be reported for each of the insured's policies~~,~~ (for example, if an insured had 3 individual life policies (2 cash value products and one non-cash value product)~~ and 1 certificate~~, 3~~4~~ claims would be reported (2 claims under schedule 1 and 1 claim ~~each~~ under schedule~~s~~ 2~~ and 3~~).

It does not include events that were reported for "information only" or an inquiry of coverage since a claim has not actually been presented (opened) for payment.

Claim Closed with Payment – A claim where the final decision was payment of the claim.

Complaint – ~~–~~any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.~~Any written communication that expresses dissatisfaction with a specific insurance company, agent or other regulated entity. It does not include inquiries.~~

~~**Complaint Register Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the "Complaint Register Indicator" whether the company maintains a complaint register.~~

Life & Annuities Data Call & Definitions

~~**Consumer** – An individual who seeks to obtain, obtains or has obtained an insurance or annuity product either directly from an insurer or via an insurance producer.~~

Corporate Owned Life Insurance – Insurance on the life of an individual, paid for by the company, with the company being a beneficiary under the policy. Corporate Owned Life Insurance policies are included in the scope of this statement and should be reported in the applicable schedule.

Date Claim Received – The first date the claim is opened on the company system.

Date of Due Proof of Loss – The date the company received the necessary proof of loss on which to base a claim determination, including where necessary, proof of unencumbered interest of the beneficiary and documentation required to legally make payment (such as completed claim forms, W-9's, estate dispute settlements, proof of age, police investigation reports, etc.).

Denied Claim- A claim where a demand for payment was made but payment was not made under the contract.

Direct Written Premium – The actual amount of direct premiums written during the reporting period and should be determined in the same manner used for the financial annual statement. Data for subject business reported by the company on the financial annual statement should be reported for the purposes of this project regardless of any 1) reinsurance agreements or 2) arrangements to administer the business that may exist with another insurer.

External Replacement - An external replacement is when the policy and/or annuity to be replaced was issued by another company.

Face Amount – Sum of insurance provided by a policy at death or maturity. In determining the face amount to be reported, companies should follow the same methodology/definitions used to file the financial annual statement and its corresponding state pages. For example, the face amount would include the basic policy plus any riders or amounts for policies with increasing death benefits if these amounts in addition to the basic policy are reported on the company's financial annual statement.

Fixed Annuity – An annuity under which the insurer guarantees that at least a defined amount of monthly annuity benefit will be provided for each dollar applied to purchasing the annuity.

~~**Free Look** – *(this definition needs to be drafted)*~~

~~**Group Insurance Policy** – Single master policy that is issued to a party (usually a business or employer) under which individuals (such as employees of a business firm) and their dependents are provided insurance coverage. Members of the group receive a certificate of coverage rather than a policy. Companies should report group business using the same methodology used for the financial annual statement. If the company reports group business based on the situs of the~~

Life & Annuities Data Call & Definitions

~~policy for the financial annual statement, it should report the group business for the purposes of this statement based on the situs of the policy. If the company reports based on the residency of the insured for the financial annual statement for group business, for the purposes of this statement it should report group business based on the residency of the insured.~~

Immediate Annuity – An annuity (either fixed or variable) that begins its payment stream to the policyholder within 12 months after a single premium is paid. Immediate annuities are included within the scope of this statement and should be reported as a new immediate contract issued when issued during the reporting period. In addition, immediate annuities still in force at the end of the period should be included as well.

Internal Replacement - An internal replacement is when the policy and/or annuity to be replaced was also issued by your company.

~~**Internal Replacement Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the "Internal Replacement Indicator" whether the Replacement Counts provided include internal replacements.~~

Life Insurance Premiums – Funds used to purchase life insurance products issued by the company. For the purpose of this statement, life insurance premiums should be determined in the same manner used for the state pages of the company's financial annual statement.

~~**Loan Purchase Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the "Loan Purchase Indicator" whether the Replacement Counts provided include policies (for life policies) or contracts (for annuity products) purchased using loan proceeds from existing life insurance policies and/or annuity contracts.~~

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which file a Financial Annual Statement with the NAIC.

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of an insurance holding company.

Non-Cash Value Product – A life insurance policy that does not contain a cash value element. Do not include life insurance covering only Accidental Death and Dismemberment (AD&D).

~~**Policies/Contracts Applied For** – *(this definition still needs to be drafted; it will include a comment that it does not include business that was applied for through a Broker-Dealer but not forwarded to the company).*~~

~~**Partial Surrender** – A policy owner's request to obtain a partial amount of the cash value or surrender value, without using a policy loan option. It would include cashing in "paid-up additions."~~

Life & Annuities Data Call & Definitions

~~**Partial Surrenders Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the "Partial Surrenders Indicator" whether the Number of Policies Surrendered provided includes partial surrenders.~~

~~**Policy Loan** – A loan that an insurer makes to the owner of a permanent life insurance policy at the owner's request that is secured by the policy's cash value. Include only loans with an outstanding balance over 25% of the maximum loan value as of the end of the reporting period. In determining how many policies have an outstanding balance over 25% of the maximum loan value:~~

~~Identify which policies have policy loan balances as of the end of the reporting period. Note this is already done for the financial annual statement.~~

~~For each policy identified in the step above, multiple the policy's' cash value as of the end of the reporting period by 25%.~~

~~Compare the amount calculated in the step above to the BALANCE of the policy loan as of the end of the reporting period.~~

~~If the policy loan balance is greater than the calculated amount, count it. If the policy loan balance is less than the calculated amount, do not count it.~~

~~**Policies/Contracts Applied For But Not Issued** – policies/contracts that were declined, refused, postponed, not taken (including policies applied for that were rated up but not taken, but should not include policies returned under "Free Look" provisions). This should not include "policies applied for but not issued" in which no consideration was ever received and where consideration is required prior to issuance of the contract.~~

~~Note: for the Individual Fixed Annuity Schedule (IFA), denials for suitability reasons that occur at the broker dealer level should **not** be included.~~

Replacement Policy – A policy and/or annuity contract application received by your company that is intended to replace an existing policy and/or annuity contract according to each states definition of a replacement.~~.~~ This ~~would~~ may include both external and internal replacements according to each state's replacement law.

~~**Replacement Register Indicator** – For each applicable schedule, the company should select Yes or No in the "Replacement Register Indicator" field to indicate whether the company maintains a Replacement Register.~~

Resisted Claim – A claim is considered resisted when it is in dispute and not resolved on the financial statement date for the reporting period. Where the company is holding up payment for sufficient evidence or where a beneficiary has made a claim and then withdraws it, such items should be considered as in the course of settlement~~–~~.~~A claim that was denied or a claim that was resisted or compromised during the period, no matter the outcome.~~

~~**Separate Account** – An investment account that is maintained separately from an insurer's general investment account and that allows the insurer to manage the funds placed in variable life insurance policies and variable annuity contracts.~~

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~~**Surrender Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the "Surrender Indicator" whether the Replacement Counts provided include policies surrendered.~~

Surrendered Policy/Contract – A life insurance policy or annuity contract terminated at the request of the policy owner. It does not include life insurance policies or annuity contracts not taken or cancelled during the free look period. For annuities, systematic withdrawals (the withdrawal of a certain amount on a predetermined periodic basis for deferred annuities) and partial withdrawals should not be reported as "surrenders" for this statement.

~~**Systematic Withdrawal** – The withdrawal of a certain amount on a predetermined periodic basis for deferred annuities.~~

Term Life Insurance – Life insurance that provides a death benefit if the insured dies during the specified period. Term life insurance may or may not build cash value.

Universal Life Insurance – A form of whole life insurance that is characterized by flexible premiums, flexible face amounts and flexible death benefit amounts and its unbundling of the pricing factor.

Variable Annuity – An annuity under which the amount of the contract's accumulated value and the amount of the monthly annuity benefit payment fluctuate in accordance with the performance of a separate account.

Variable Life Insurance – A form of whole life insurance under which the death benefit and the cash value of the policy fluctuate according to the investment performance of a separate account.

Variable Universal Life Insurance – A form of whole life insurance that combines the premium and death benefit flexibility of universal life insurance with the investment flexibility and risk of variable life insurance.

Withdrawal –For annuity contracts, see Surrendered Policy/Contract ~~Count~~.

Whole Life Insurance – Life insurance that provides lifetime insurance coverage. Whole life insurance policies generally build cash value and cover a person for as long as he or she lives if premiums are paid as required. It would include life insurance policies that start accumulating cash value once the insured reaches a certain age as specified in the terms of the policy.

Life & Annuities Data Call & Definitions

Lines of Business: Individual Life Cash Value Products
Individual Life Non-Cash Value Products
~~Group Life Products (Cash & Non-Cash Value)~~
Individual Fixed Annuities
Individual Variable Annuities

Reporting Period: January, ~~2010~~ 2012 through December 31, ~~2010~~ 2012

Filing Deadline: ~~June~~ April 30, ~~2011~~2013

Contact Information:
NAIC Code
NAIC Group Code
Federal Employers Identification Number (FEIN)
Contact Person
Contact Phone
Contact Email
Company Name
Address1
Address2
City
State
Zip Code
Company Comment (optional, maximum 255 characters)

Schedule Information

Schedule	Product Identifiers	Explanation of Product Identifiers
1	ICVP	Individual Life Cash Value Products (Includes Variable Life, Universal Life, Variable Universal Life, Term Life with Cash Value, Whole Life, & Equity Index Life)
2	INCVP	Individual Life Non-Cash Value Products (Any life insurance policy that does not contain a cash value element)
~~3~~	~~GRP~~	~~Group Life Products (Cash & Non-Cash Value products and includes Variable Life, Universal Life, Variable Universal Life, Whole Life, Equity Index Life & Term)~~
~~4~~ 3	IFA	Individual Fixed Annuities (Includes Equity Index Annuity Products)
~~5~~ 4	IVA	Individual Variable Annuities

Life & Annuities Data Call & Definitions

Interrogatories

	State Schedule 1 Comment (optional, maximum 255 characters) (Company comments on Individual Life Cash Value Products)
	State Schedule 1 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No
	Interrogatory Comment Field
	State Schedule 2 Comment (optional, maximum 255 characters) (Company comments on Individual Life Non-Cash Value Products)
	State Schedule 2 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No
	Interrogatory Comment Field
	State Schedule 3 Comment (optional, maximum 255 characters) (Company comments on Individual ~~Life Non-Cash Value~~Fixed Annuity Products)
	State Schedule 3 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No
	Interrogatory Comment Field
	State Schedule 4 Comment (optional, maximum 255 characters) (Company comments on Individual ~~Life Non-Cash Value~~Variable Annuity Products)
	State Schedule 4 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No
	Interrogatory Comment Field

Life & Annuities Data Call & Definitions

Schedule 1 – Individual Life Cash Value Products (ICVP)

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
ICVP	Product Identifier **Automatically loaded**
	~~Number Of New Replacement Policies Applied For During The Period (Include all replacements regardless of whether an insurance policy was actually issued.)~~
	Number Of New Replacement Policies Issued During The Period (Include only the number of replacement insurance policies issued)
	Number of Internal Replacements Issued
	Number of External Replacements Issued
	Number of Policies Replaced where age of insured at replacement was <65
	Number of Policies Replaced where age of insured at replacement was Age 65 and over
	~~Internal Replacement Indicator (Yes/No)~~
	~~Surrender Indicator (Yes/No)~~
	~~Loan Purchase Indicator (Yes/No)~~
	~~1035 Rollover Indicator (Yes/No)~~
	~~Replacement Register Indicator (Yes/No)~~
	~~Number of In force Policies With a Loan Balance Over 25% Of The Maximum Loan Value As of The End of The Reporting Period~~
	~~Number Of Policies Surrendered During The Period~~
	~~Number Of Partial Surrenders During The Period~~
	~~Number Of New 1035 Exchanges Coming Into The Company During The Period~~
	Number of Policies Surrendered Under 2 Years from Policy Issue
	Number of Policies Surrendered Between 2 Years and 5 Years of Policy Issue
	Number of Policies Surrendered Between 6 Years and 10 Years of Policy Issue
	Total Number of Policies Surrendered During the Period
	Number of Policies Applied for During the Period
	~~Number of Policies Applied for, but not Issued, During the Period~~
	Number of Policies Issued During the Period where age of insured at issue was <65
	Number of Policies Issued During the Period where age of insured at issue was Age 65

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	and over
	Total Number Of New Policies Issued By The Company During The Period
	Number of Free Looks During the Period
	Number Of Policies In Force At The End Of The Period (The number of active policies that the company has outstanding at the end of the reporting period.)
	Dollar Amount Of Direct Premium During The Period
	Dollar Amount Of Insurance Issued During The Period (Face Amount)
	Dollar Amount Of Insurance In Force At The End Of The Period (Face Amount)
	Number Of Complaints Received Directly From Consumers
	~~Number Of Complaints Received Directly From The Corresponding Department Of Insurance~~
	~~Complaint Register Indicator (Yes/No)~~
	Number Of Death Claims Closed With Payment, During The Period, Within 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was made within 60 days from when the date of due proof of loss occurred.)
	Number Of Death Claims Closed With Payment, During The Period, Beyond 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was NOT made within 60 days from when the date of due proof of loss occurred.)
	Number Of Death Claims Denied, Resisted or Compromised During The Period ~~(A claim is considered resisted when it is in dispute and not resolved on the statement date.)~~
	Total Number Of Death Claims Received During The Period (Include any claim received during the period as determined by the first date the claim was opened on the company system.)
	State Schedule 1 Comment (optional, maximum 255 characters) (Company comments on Individual Life Cash Value Products)

Schedule 2 – Individual Life Non-Cash Value Products (INCVP)

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
INCVP	Product Identifier **Automatically loaded**
	~~Number Of New Replacement Policies Applied For During The Period (Include all replacements regardless of whether an insurance policy was actually issued.)~~
	Number of New Replacement Policies Issued During The Period (Include only the number of replacement insurance policies issued)
	~~Internal Replacement Indicator (Yes/No)~~
	~~Replacement Register Indicator (Yes/No)~~
	Number of Internal Replacements Issued During the Period
	Numaber of External Replacements Issued During the Period

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	Total Number Of New Policies Issued By the Company During The Period
	Number of Policies Applied for ~~, but not Issued,~~ During the Period
	Number of Free Looks During the Period
	Number Of Policies In Force At The End Of The Period (The number of active policies that the company has outstanding at the end of the reporting period.)
	Dollar Amount Of Direct Premium During The Period
	Dollar Amount Of Insurance Issued During The Period (Face Amount)
	Dollar Amount Of Insurance In Force At The End Of The Period (Face Amount)
	Number Of Complaints Received Directly From Consumers
	~~Number Of Complaints Received Directly From The Corresponding Department Of Insurance~~
	~~Complaint Register Indicator (Yes/No)~~
	Number Of Death Claims Closed With Payment, During The Period, Within 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was made within 60 days from when the date of due proof of loss occurred.)
	Number Of Death Claims Closed With Payment, During The Period, Beyond 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was NOT made within 60 days from when the date of due proof of loss occurred.)
	Number Of Death Claims Denied, Resisted or Compromised During The Period ~~(A~~
	Total Number Of Death Claims Received During The Period (Include any claim received during the period as determined by the first date the claim was opened on the company system.)
	~~State Schedule 2 Comment (optional, maximum 255 characters) (Company comments on Individual Life Non-Cash Value Products)~~
	~~State Schedule 2 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No~~
	~~Interrogatory Comment Field~~

Life & Annuities Data Call & Definitions

Schedule 3 – Group Life Products – Cash & Non-Cash (GRP)

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
GRP	Product Identifier **Automatically loaded**
LS301	Number Of New Policies Issued By the Company During The Period
LS302	Number Of Policies In Force At The End Of The Period (The number of active policies that the company has outstanding at the end of the reporting period.)
LS303	Dollar Amount Of Direct Premium During The Period
LS304	Dollar Amount Of Insurance Issued During The Period (Face Amount)
LS305	Dollar Amount Of Insurance In Force At The End Of The Period (Face Amount)
LS306	Number Of Complaints Received Directly From Consumers
LS307	Number Of Complaints Received Directly From The Corresponding Department Of Insurance
LS308	Complaint Register Indicator (Yes/No)
LS309	Number Of Death Claims Closed With Payment, During The Period, Within 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was made within 60 days from when the date of due proof of loss occurred.)
LS310	Number Of Death Claims Closed With Payment, During The Period, Beyond 60 Days From The Date Of Due Proof Of Loss (Include claims where the final decision was payment in full, and was NOT made within 60 days from when the date of due proof of loss occurred.)
LS311	Number Of Death Claims Denied, Resisted or Compromised During The Period (A claim is considered resisted when it is in dispute and not resolved on the statement date.)
LS312	Total Number Of Death Claims Received During The Period (Include any claim received during the period as determined by the first date the claim was opened on the company system.)
LS3c	State Schedule 3 Comment (optional, maximum 255 characters) (Company comments on Group Life Products)

Life & Annuities Data Call & Definitions

Schedule ~~4~~ 3 – Individual Fixed Annuities (IFA)

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
IFA	Product Identifier **Automatically loaded**
	~~Number Of New Replacement Contracts Applied For During The Period (Include all replacements regardless of whether an annuity contract was actually issued.)~~
	Number of New Replacement Contracts Issued During The Period (Include only the number of replacement contracts issued.)
	~~Internal Replacement Indicator (Yes/No)~~
	~~Loan Purchase Indicator (Yes/No)~~
	~~1035 Rollover Indicator (Yes/No)~~
	~~Replacement Register Indicator (Yes/No)~~
	Number Of Internal Replacement Contracts Issued During The Period
	Number Of External Replacement Contracts Issued During The Period
	Number Of Contracts Replaced Where Age of Annuitant at Replacement was < 65
	Number Of Contracts Replaced where Age of Annuitant at Replacement was 65-80
	Number Of Contracts Replaced where Age of Annuitant at Replacement was > 80
	Number of New Immediate Contracts Issued During the Period
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was < 65
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was > 80
	Total Number Of New Deferred Contracts Issued By the Company During The Period
	Number of Contracts Surrendered Under 2 Years from Issuance
	Number of Contracts Surrendered Between 2 Years and 5 Years of Issuance
	Number of Contracts Surrendered Between 6 years and 10 Years of Issuance
	Total Number Of Contracts Surrendered During The Period
	~~Number Of New 1035 Exchanges Coming Into The Company During The Period~~
	Number of Contracts Applied for D~~, but not Issued, D~~uring the Period
	Number of Free Looks During the Period
	Number Of Contracts In Force At The End Of The Period (The number of active contracts that the company has outstanding at the end of the reporting period.)
	Dollar Amount Of Annuity Considerations During The Period
	Number Of Complaints Received Directly From Consumers
	~~Number Of Complaints Received Directly From The Corresponding Department Of Insurance~~
	~~Complaint Register Indicator (Yes/No)~~
	~~State Schedule 4~~ 3 ~~Comment (optional, maximum 255 characters) Company comments on Individual Fixed Annuity Products~~

Life & Annuities Data Call & Definitions

	~~State Schedule 3 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No~~
	~~Interrogatory Comment Field~~

Schedule ~~5~~ 4 – Individual Variable Annuities (IVA)

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
IVA	Product Identifier **Automatically loaded**
	~~Number Of New Replacement Contracts Applied For During The Period (Include all replacements regardless of whether an annuity contract was actually issued.)~~
	Number of New Replacement Contracts Issued During The Period (Include only the number of replacement annuity contracts issued.)
	~~Loan Purchase Indicator (Yes/No)~~
	~~1035 Rollover Indicator (Yes/No)~~
	~~Replacement Register Indicator (Yes/No)~~
	Number Of Internal Replacement Contracts Issued During The Period
	Number Of External Replacement Contracts Issued During The Period
	Number Of Contracts Replaced Where Age of Annuitant at Replacement was < 65
	Number Of Contracts Replaced where Age of Annuitant at Replacement was 65-80
	Number Of Contracts Replaced where Age of Annuitant at Replacement was > 80
	Number of New Immediate Contracts Issued During the Period
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant

Life & Annuities Data Call & Definitions

	was < 65
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80
	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was > 80
	Total Number Of New Deferred Contracts Issued By The Company During The Period
	Number of Contracts Surrendered Under 2 Years from Issuance
	Number of Contracts Surrendered Between 2 Years and 5 Years of Issuance
	Number of Contracts Surrendered Between 6 years and 10 Years of Issuance
	Total Number Of Contracts Surrendered During The Period
	Number of Contracts Applied for During the Period ~~Number Of New 1035 Exchanges Coming Into The Company During The Period~~
	Number of Free Looks During the Period
	Number Of Contracts In Force At The End Of The Period (The number of active contracts that the company has outstanding at the end of the reporting period.)
	Dollar Amount Of Annuity Considerations During The Period
	Number Of Complaints Received Directly From Consumers
	~~Number Of Complaints Received Directly From The Corresponding Department Of Insurance~~
	~~Complaint Register Indicator (Yes/No)~~
	~~State Schedule 5 4 Comment (optional, maximum 255 characters) Company comments on Individual Variable Annuity Products.~~
	~~State Schedule 4 Interrogatory: Is there a reason that the reported information may identify the company as an outlier or be substantially different from previously reported data (such as assuming blocks of business; shifting market strategies; underwriting changes, etc) Yes/No~~
	~~Interrogatory Comment Field~~

In determining what business to report for a particular state, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages and in accordance with each applicable state's regulations.

Definitions:

~~**1035 Exchange** – A provision in the tax code (IRC 1035), which allows for the direct transfer (Rollover) of accumulated funds in a life insurance policy, endowment policy or annuity contract~~

Life & Annuities Data Call & Definitions

to another life insurance policy, endowment policy or annuity policy, without creating a taxable event.

1035 Rollover Indicator – For each applicable schedule, the company should indicate (Yes or No) in the 1035 Rollover Indicator whether the Replacement Counts provided include policies (for life products) or contracts (for annuity products) purchased through 1035 Exchanges (Rollovers).

Annuity – A contract under which an insurance company promises to make a series of periodic payments to a named individual in exchange for a premium or a series of premiums. Data is being requested for individual annuities only; data for group annuity contracts are not being requested.

Annuity Considerations – Funds deposited to or used to purchase annuity contracts issued by the company. For the purpose of this statement, annuity considerations should be determined in the same manner used for the state pages of the company's financial annual statement.

Cash Value Product – A life insurance policy that generates a cash value element. Term life policies with cash value are considered cash value products.

Claim – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Claims with multiple beneficiaries should be counted as one claim. If a single insured dies and has multiple policies (for individual life products) and/or multiple certificates (for group life insurance products), a claim should be reported for each of the insured's policies, (for example, if an insured had 3 individual life policies (2 cash value products and one non-cash value product) and 1 certificate, 34 claims would be reported (2 claims under schedule 1 and 1 claim each under schedules 2 and 3).

It does not include events that were reported for "information only" or an inquiry of coverage since a claim has not actually been presented (opened) for payment.

Claim Closed with Payment – A claim where the final decision was payment of the claim.

Complaint – —any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.Any written communication that expresses dissatisfaction with a specific insurance company, agent or other regulated entity. It does not include inquiries.

Complaint Register Indicator – For each applicable schedule, the company should indicate (Yes or No) in the "Complaint Register Indicator" whether the company maintains a complaint register.

Consumer – An individual who seeks to obtain, obtains or has obtained an insurance or annuity product either directly from an insurer or via an insurance producer.

Life & Annuities Data Call & Definitions

Corporate Owned Life Insurance – Insurance on the life of an individual, paid for by the company, with the company being a beneficiary under the policy. Corporate Owned Life Insurance policies are included in the scope of this statement and should be reported in the applicable schedule.

Date Claim Received – The first date the claim is opened on the company system.

Date of Due Proof of Loss – The date the company received the necessary proof of loss on which to base a claim determination, including where necessary, proof of unencumbered interest of the beneficiary and documentation required to legally make payment (such as completed claim forms, W-9's, estate dispute settlements, proof of age, police investigation reports, etc.).

Denied Claim- A claim where a demand for payment was made but payment was not made under the contract.

Direct Written Premium – The actual amount of direct premiums written during the reporting period and should be determined in the same manner used for the financial annual statement. Data for subject business reported by the company on the financial annual statement should be reported for the purposes of this project regardless of any 1) reinsurance agreements or 2) arrangements to administer the business that may exist with another insurer.

External Replacement - An external replacement is when the policy and/or annuity to be replaced was issued by another company.

Face Amount – Sum of insurance provided by a policy at death or maturity. In determining the face amount to be reported, companies should follow the same methodology/definitions used to file the financial annual statement and its corresponding state pages. For example, the face amount would include the basic policy plus any riders or amounts for policies with increasing death benefits if these amounts in addition to the basic policy are reported on the company's financial annual statement.

Fixed Annuity – An annuity under which the insurer guarantees that at least a defined amount of monthly annuity benefit will be provided for each dollar applied to purchasing the annuity.

Free Look – ***(this definition needs to be drafted.)***

~~**Group Insurance Policy** – Single master policy that is issued to a party (usually a business or employer) under which individuals (such as employees of a business firm) and their dependents are provided insurance coverage. Members of the group receive a certificate of coverage rather than a policy. Companies should report group business using the same methodology used for the financial annual statement. If the company reports group business based on the situs of the policy for the financial annual statement, it should report the group business for the purposes of this statement based on the situs of the policy. If the company reports based on the residency~~

Life & Annuities Data Call & Definitions

~~of the insured for the financial annual statement for group business, for the purposes of this statement it should report group business based on the residency of the insured.~~

Immediate Annuity – An annuity (either fixed or variable) that begins its payment stream to the policyholder within 12 months after a single premium is paid. Immediate annuities are included within the scope of this statement and should be reported as a new immediate contract issued when issued during the reporting period. In addition, immediate annuities still in force at the end of the period should be included as well.

Internal Replacement - An internal replacement is when the policy and/or annuity to be replaced was also issued by your company.

~~**Internal Replacement Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the "Internal Replacement Indicator" whether the Replacement Counts provided include internal replacements.~~

Life Insurance Premiums – Funds used to purchase life insurance products issued by the company. For the purpose of this statement, life insurance premiums should be determined in the same manner used for the state pages of the company's financial annual statement.

~~**Loan Purchase Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the "Loan Purchase Indicator" whether the Replacement Counts provided include policies (for life policies) or contracts (for annuity products) purchased using loan proceeds from existing life insurance policies and/or annuity contracts.~~

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which file a Financial Annual Statement with the NAIC.

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of an insurance holding company.

Non-Cash Value Product – A life insurance policy that does not contain a cash value element. Do not include life insurance covering only Accidental Death and Dismemberment (AD&D).

Policies/Contracts Applied For – ***(this definition still needs to be drafted; it will include a comment that it does not include business that was applied for through a Broker-Dealer but not forwarded to the company~~)~~.)***

~~**Partial Surrender** – A policy owner's request to obtain a partial amount of the cash value or surrender value, without using a policy loan option. It would include cashing in "paid-up additions."~~

Life & Annuities Data Call & Definitions

~~**Partial Surrenders Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the "Partial Surrenders Indicator" whether the Number of Policies Surrendered provided includes partial surrenders.~~

~~**Policy Loan** – A loan that an insurer makes to the owner of a permanent life insurance policy at the owner's request that is secured by the policy's cash value. Include only loans with an outstanding balance over 25% of the maximum loan value as of the end of the reporting period. In determining how many policies have an outstanding balance over 25% of the maximum loan value:~~

~~Identify which policies have policy loan balances as of the end of the reporting period. Note this is already done for the financial annual statement.~~

~~For each policy identified in the step above, multiple the policy's' cash value as of the end of the reporting period by 25%.~~

~~Compare the amount calculated in the step above to the BALANCE of the policy loan as of the end of the reporting period.~~

~~If the policy loan balance is greater than the calculated amount, count it. If the policy loan balance is less than the calculated amount, do not count it.~~

~~**Policies/Contracts Applied For But Not Issued** – policies/contracts that were declined, refused, postponed, not taken (including policies applied for that were rated up but not taken, but should not include policies returned under "Free Look" provisions). This should not include "policies applied for but not issued" in which no consideration was ever received and where consideration is required prior to issuance of the contract.~~

~~Note: for the Individual Fixed Annuity Schedule (IFA), denials for suitability reasons that occur at the broker dealer level should **not** be included.~~

Replacement Policy – A policy and/or annuity contract application received by your company that is intended to replace an existing policy and/or annuity contract according to each states definition of a replacement.~~.~~ This ~~would~~ may include both external and internal replacements according to each state's replacement law.

~~**Replacement Register Indicator** – For each applicable schedule, the company should select Yes or No in the "Replacement Register Indicator" field to indicate whether the company maintains a Replacement Register.~~

Resisted Claim – A claim is considered resisted when it is in dispute and not resolved on the financial statement date for the reporting period. Where the company is holding up payment for sufficient evidence or where a beneficiary has made a claim and then withdraws it, such items should be considered as in the course of settlement~~.~~.~~A claim that was denied or a claim that was resisted or compromised during the period, no matter the outcome.~~

~~**Separate Account** – An investment account that is maintained separately from an insurer's general investment account and that allows the insurer to manage the funds placed in variable life insurance policies and variable annuity contracts.~~

Life & Annuities Data Call & Definitions

~~**Surrender Indicator** – For each applicable schedule, the company should indicate (Yes or No) in the "Surrender Indicator" whether the Replacement Counts provided include policies surrendered.~~

Surrendered Policy/Contract – A life insurance policy or annuity contract terminated at the request of the policy owner. It does not include life insurance policies or annuity contracts not taken or cancelled during the free look period. For annuities, systematic withdrawals (the withdrawal of a certain amount on a predetermined periodic basis for deferred annuities) and partial withdrawals should not be reported as "surrenders" for this statement.

~~**Systematic Withdrawal** – The withdrawal of a certain amount on a predetermined periodic basis for deferred annuities.~~

Term Life Insurance – Life insurance that provides a death benefit if the insured dies during the specified period. Term life insurance may or may not build cash value.

Universal Life Insurance – A form of whole life insurance that is characterized by flexible premiums, flexible face amounts and flexible death benefit amounts and its unbundling of the pricing factor.

Variable Annuity – An annuity under which the amount of the contract's accumulated value and the amount of the monthly annuity benefit payment fluctuate in accordance with the performance of a separate account.

Variable Life Insurance – A form of whole life insurance under which the death benefit and the cash value of the policy fluctuate according to the investment performance of a separate account.

Variable Universal Life Insurance – A form of whole life insurance that combines the premium and death benefit flexibility of universal life insurance with the investment flexibility and risk of variable life insurance.

Withdrawal –For annuity contracts, see Surrendered Policy/Contract ~~Count~~.

Whole Life Insurance – Life insurance that provides lifetime insurance coverage. Whole life insurance policies generally build cash value and cover a person for as long as he or she lives if premiums are paid as required. It would include life insurance policies that start accumulating cash value once the insured reaches a certain age as specified in the terms of the policy.

Draft: 9/16/10

Market Information Systems (D) Task Force
Conference Call
September 8, 2010

The Market Information Systems (D) Task Force met via conference call Sept. 8, 2010. The following Task Force members participated: John M. Huff, Chair (MO); Gennet Purcell represented by Luther Ellis (DC); Michael T. McRaith represented by Robert Rapp (IL); Mike Chaney represented by Chad Bridges (MS); Thomas B. Considine represented by Anne Marie Narcini (NJ); Scott H. Richardson represented by Michael Bailes (SC); Mike Kreidler represented by Leslie Krier (WA); Sean Dilweg represented by Jo LeDuc (WI); and Jane L. Cline represented by Mark Hooker (WV). Also participating were: Brent Kabler and Jim Mealer (MO).

1. Timing for Collection of Adopted Market Conduct Annual Statement Property and Casualty Data Elements

Director Huff said this discussion began at the Summer National Meeting. The industry trade organizations agreed to provide information about which data elements could be collected in 2011 and reported in 2012, and which data elements required systems programming and should be delayed for collection until 2012 to be reported in 2013. He asked Deidre Manna (Property Casualty Insurers Association of America—PCI) to explain which data elements the industry believed should be delayed for collection until 2012.

Ms. Manna said the industry wants to provide accurate data and would need an implementation date of Jan. 1, 2012, for the "complaints" data elements and the new "lawsuits" reporting requirements. Cate Paolino (American Insurers Association—AIA) said the "loss of use" coverage part in the homeowners Market Conduct Annual Statement (MCAS) should also be delayed until 2012, because the industry does not currently capture the required level of detail for that coverage part. Richard Bates (State Farm) said that to change State Farm's reporting basis from "occurrence" to "claimant" would require 1,000 hours of programming, and additional time would be required to review the 2011 data that came in while the systems were being programmed. Ms. Paolino said that any programs that were not ready by Jan. 1, 2011, would require the companies to look back over the data from Jan. 1 to when the programming was finished. She said that time for programming has to be shared with other projects being pursued simultaneously.

Director Huff asked how many companies reported on an occurrence basis and how many companies reported on a claimant basis. Randy Helder (NAIC) said that, for 2009, about 67% of private passenger auto filings were reported on a claimant basis and that homeowners filings were split about evenly between occurrence basis and claimant basis. Director Huff said that was a significant amount of mixing of the two reporting types. He said it was necessary that all companies report in the same manner, so that accurate comparisons could be made. He said that a delay to 2012 for mandatory claimant-basis reporting was justified in order to be sure the reporting basis was accurately implemented.

Ms. Manna said the industry would like to have the reporting threshold moved to $100,000 in premium per state, because the changes to the MCAS reporting puts a heavy burden on smaller companies. Mr. Mealer said there was little difference in the number of companies reporting at $50,000 compared to $100,000 and, as such, the threshold should stay at $50,000. Ms. LeDuc agreed and said the information provided by the smaller companies is used by Wisconsin.

Ms. Krier moved to adopt the revised MCAS Property and Casualty Data Call and Definition revisions with all revisions to take effect on Jan. 1, 2011, to be reported by May 31, 2012, with the exception of the "complaints" fields, the "lawsuits" changes, the homeowners "loss of use" fields and the mandatory "claimant basis" reporting, which will be in effect Jan. 1, 2012, to be reported by April 30, 2013. Mr. Hooker seconded the motion. The revised MCAS Property and Casualty Data Call and Definitions were adopted (Attachment Two-A).

2. Discussion on Updating the MCAS Data Element Revision Process

Director Huff said the revised MCAS Data Element Change Process that is posted on the Market Information Systems (D) Task Force's Web page would be effective next year. He clarified that the MCAS data element changes adopted this year are made under the time guidelines of the current MCAS Change Process.

Ms. Manna said the adoption dates in the MCAS Data Element Revision Process should allow a six-month period for companies to prepare to collect any new data elements. She said any MCAS revisions should be adopted by the Market Regulation and Consumer Affairs (D) Committee by June 30 for data to be collected by Jan. 1 of the following year. Director Huff said that a June adoption date for the Working Group still allows companies six months, because the Committee would rarely make changes to what working Group adopts. He said the property/casualty insurers also were given an additional two months on the MCAS due date, which should help them prepare to report the MCAS data. Mr. Hooker said that, if an earlier date for the Working Group's adoption was required, it would be helpful to have continuity in the leadership of Working Group, to be sure the work of the previous year is consistent with the work in the following year.

Ms. Narcini moved to adopt the MCAS Data Element Revision Process, so that all MCAS data element changes must be adopted by the Working Group by June 1 and by the Committee by Aug. 1 in order for the changes to be effective Jan. 1 of the following year. Ms. LeDuc seconded the motion. The MCAS Data Element Revision Process was adopted (Attachment Two-B).

Having no further business, the Market Information Systems (D) Task Force adjourned.

w:\National Meetings\2010\Fall\TF\MIS\2010 09 08 call

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Line of Business: Homeowners

Reporting Period: January 1, 2011 ~~through December~~ 8/15/8/2010 31, 2011

Filing Deadline: May 31, 2012

Contact Information:
NAIC Code
NAIC Group Code
Federal Employers Identification Number (FEIN)
Contact Person
Contact Phone
Contact Email
Company Name
Address1
Address2
City
State
Zip Code
Company Comment (optional, maximum 255 characters)

Interrogatories
Has company had a significant event/business strategy that would affect data for this reporting period? Yes/No (If yes, add additional comments)
Significant Comment (if necessary) (optional, maximum 255 characters)
Was the Company still activity writing policies in the state at year end? Yes/No
Has this block of business or part of this block of business been sold, closed or moved to another company during the year? Yes/No If yes, please explain in the "State Underwriting Activity Comment" field.
How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim
Claims Comment (optional, maximum 255 characters)
Underwriting Comment (optional, maximum 255 characters)
~~Number Of Complaints Received Directly From Consumers~~

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

~~8/15~~9/8/2010

Coverage Identifier	Explanation of Coverage Identifier
A	Dwelling (includes – Other Structures)
~~B~~	~~Loss of Use~~
~~C~~B	Personal Property
~~D~~C	Liability
~~E~~D	Medical Payments
~~A~~	~~Dwelling (includes – Other Structures, Personal Property, Loss of Use and Medical Payments[1])~~
~~B~~	~~Liability and Medical Payments[1]~~

~~[1] The instructions in Schedule A and the definition in the existing HO Data Call are inconsistent. The changes are to clarify what the MCAS Subgroup intended. If the company was already reporting Medical Payments numbers on Schedule B, continue to do so. However, if the company had already programmed its system to put the Medical Payments numbers in Coverage Id A, continue to do so until the Subgroup can make the change officially. If the company reports these numbers in Schedule A, please make a note with the filing to indicate that the Medical Payments numbers are reported in Schedule A.~~

Schedule 1 – Homeowners Claims Activity~~, Counts Reported by Claimant~~

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (1) **Automatically loaded**
	Coverage Identifier (A ~~or~~, B, C, or D~~, or E~~) Automatically loaded
	Type of Claim Count Indicator (By Occurrence use “O”, by Claimant use “C”)
	Number of Claims open at the beginning of the period
	Number of Claims opened during the period
	Number of Claims closed during the period, with payment
	Number of Claims closed during the period, without payment
	Number of Claims open at the end of the period
	State Claims Activity Comment (optional, maximum 255 characters)

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

~~8/15~~9/8/2010

Schedule 2 – Homeowners Claims Closed ~~Settled~~ with Payment~~, Counts Reported by Claimant~~~~Report to Date of Final Payment~~

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (2) **Automatically loaded**
	Coverage Identifier (A, B, C, or D~~, or E~~~~A or B~~) **Automatically loaded**
	Median days to final payment
	Number of claims ~~settled~~ closed with payment within 0-30 days
	Number of claims closed~~settled~~ with payment within 31-60 days
	Number of claims closed~~settled~~ with payment within 61-90 days
	Number of claims closed~~settled~~ with payment within 91-180 days
	Number of claims closed~~settled~~ with payment within 181-365 days
	Number of claims closed~~settled~~ with payment beyond 365 days

Schedule 3 – Homeowners Claims Closed~~Settled~~ Without ~~Payment ,~~Payment~~, Counts Reported by Claimant~~ ~~Date of Loss to Date of Report~~

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

8/15/8/2010

	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (3) **Automatically loaded**
	Coverage Identifier (A, B, C, or D~~, or E~~~~A or B~~) **Automatically loaded**
	~~Median days to date of report final settlement without payment~~
	Number of claims closed~~settled~~ without payment within 0-30 days
	Number of claims closed~~settled~~ without payment within 31-60 days
	Number of claims closed~~settled~~ without payment within 61-90 days
	Number of claims closed~~settled~~ without payment within 91-180 days
	Number of claims closed~~settled~~ without payment within 181-365 days
	Number of claims closed~~settled~~ without payment beyond 365 days

Schedule 4 – Homeowners Claims in Suit~~, Counts Reported by Claimant~~

ID	Description
	State Indicator (State For Which Data Is Being Submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (4) **Automatically loaded**
	Coverage Identifier (A, B, C, or D~~, or E~~~~A or B~~) **Automatically loaded**
	Number of Suits open at beginning of the period
	Number of Suits opened during the period
	Number of Suits closed during the period
	Number of Suits open at end of period
	~~State Claims Activity Comment (optional, maximum 255 characters)~~

Schedule 5 – Homeowners Underwriting

Homeowners Underwriting, one record per company	
ID	**Description**

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

~~8/15~~9/8/2010

	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (5) **Automatically loaded**
	Number of dwellings which have policies in-force at the end of the period
	Number of policies in-force at the end of the period
	Number of new business policies written during the period
	Dollar amount of direct premium written during the period
	Number of Company-Initiated non-renewals during the period
	Number of cancellations for non-pay, non-sufficient funds or insured's request
	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company
	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to a related company
	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company
	~~Number Of Complaints Received Directly From Consumers~~

Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages.

Cancellations – Includes all ~~company-initiated~~ cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of locations/insureds under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium, non-sufficient funds or insured's request
  - These should be reported every time a policy cancels for the above reasons. (i.e. if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted)

- Policies cancelled for underwriting reasons

Exclude:

- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

~~Do not include:~~

- ~~Policies cancelled for non-payment of premium,~~
- ~~Policies cancelled at the insured's request, or~~
- ~~Policies cancelled for 're-write' purposes where there is no lapse in coverage.~~

~~**Cancellations 60 days or more** – Cancellations where the notice of cancellation was issued 60 days or more after the original effective date of the policy.~~

- ~~Policies that have been renewed and then cancelled at a later date are included.~~
- ~~The calculation of the number of days is from the original effective date of the policy, not the renewal date.~~
- ~~This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.~~

~~**Cancellations within the 1st 59 days** – Cancellations for new business where the notice of cancellation was issued within the 1st 59 days after the original effective date of the policy.~~

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.

Cancellations from 60 to 90 days - Cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.

Cancellations greater than 90 days - Cancellations where the notice of cancellation was issued 90 days or more after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.

Cancellations within the firs1st 59 days – Company-initiated cCancellations for new business where the notice of cancellation was issued within the fir1st 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' orthe 'underwriting' period for new business.

Cancellations from 60 to 90 days – Company-initiated Ccancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.

Cancellations greater than 90 days – Company-initiated Ccancellations where the notice of cancellation was issued more than 90 days or more after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' orto the 'underwriting' period for new business.

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy.

Include:
- Both first and third party claims.

A Claim is NOTExclude:
- An event reported for "information only".
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.
- A demand for payment for which it was determined that no relevant policy was in force at the time of the loss.

Claims Closed With Payment – Claims closed with payment where the date of the final payment to the claimant/insured was during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure is the difference between the date of the final payment and the date the claim was reported.

Exclude:
- It does not include cClaims where payment was made for company loss adjustment expenses however if no payment was made to an insured/claimant.

Include:
- Claims that are closed because the amount claimed is below the insured's deductible.

Clarification / Example:
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims. For example, if a claim is reopened for the sole purpose of refunding the insured's deductible, do not count it as a paid claim.

Calculation Clarification:
- For each coverage identifier, the sum of the claims closed with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment:

- A subsequent supplemental payment date should only be included if the original claim was re-opened and then closed with a payment during the reporting period.
- If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that supplemental payment from the time the request for supplemental payment was received and the date of the final payment was made.

~~Claims closed without payment where the date the claim was closed is during the reporting period regardless of the date of loss or when the claim was received.~~
~~• It includes claims where no payment was made to an insured/claimant however payment was made for company loss adjustment expenses.~~

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported.~~.~~

Include:

- ~~Include a~~All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- ~~Include c~~Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- ~~Includes a~~A demand for payment for which it was determined that no relevant policy was in force at the time of the loss if a claim file was set up and the loss was investigated.

Calculation Clarification:

- For each coverage identifier, the sum of the claims closed without payment across each closing time interval should equal the total number of claims closed without payment during the reporting period.

~~**Claims Settled With Payment** – Claims closed with payment during the reporting period where the number of days to settle closure is the difference between the date of the final payment and the date the claim was reported.~~

~~Calculation Clarification:~~

- ~~For each coverage identifier, the sum of the claims settled with payment across each closing time intervalduring the reporting period should equal the total number of claims closed with payment during the reporting period.~~

~~Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment:~~

~~8/15~~9/8/2010

- ~~A subsequent supplemental payment date should only be included if the original claim was re-opened and then closed with a payment during the reporting period.~~
- ~~If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that~~ supplement payment from the time the request for supplement payment was received and the date of the final payment was ~~made.claim.~~

~~**Complaint –** any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.~~

~~**Coverage** – Protection under an insurance policy.~~
~~**Coverage Identifier A** – Coverage for dwellings under Homeowners Policies and Dwelling Fire and Dwelling Liability Policies. It includes coverage for Other Structures, Personal Property, Loss of Use, and Medical Payments.~~
~~**Coverage Identifier B** – Liability insurance provided under Homeowners Policies.~~

Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions
10-6-2010

Coverage Identifier A – Coverage for dwellings under Homeowners Policies and Dwelling Fire and Dwelling Liability Policies. It includes coverage for Other Structures.

~~**Coverage Identifier B** – Loss of Use provided under Homeowners Policies.~~

Coverage Identifier BC – Personal Property provided under Homeowners Policies.

Coverage Identifier CD – Liability insurance provided under Homeowners Policies.

Coverage Identifier DE – Medical Payments provided under Homeowners Policies.

~~**Date Claim Opened** – This should be the earliest or first date the claim was reported to either the company or insurance agent.~~

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:

- If partial payments ~~are~~ were made on the claim, the claim would be considered closed with payment if the final payment date was made during the reporting period regardless of the date of loss or when the claims was received.

Date the Claim was Reported – The ~~earliest or first~~ date the claim was first reported to either the company or insurance agent.

Direct Written Premium - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period ~~and~~.

Calculation Clarifications:

- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an

explanation for the difference ~~(up or down)~~when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:

- A 2 or 3 family home covered under one policy would be considered 1 dwelling.

Dwelling Fire and Dwelling Liability Policies – ~~Provides property c~~Coverage for dwellings and their contents. It may also provide liability coverage and is usually written when a residential property does not qualify according to the minimum requirements of a homeowner's policy, or because of a requirement for the insured to select several different kinds of coverage and limits on this protection.

Include:
Dwelling Fire and Dwelling Liability policies should be included ONLY ~~if~~ IF the policies written under these programs are for personally occupied residential dwelling, not policies written under a commercial program and/or on a commercial lines policy form.

Homeowners Policies – Policies that combine liability insurance with one or more other types of insurance such as property damage, personal property damage, medical payments and additional living expenses that are reported on line 4 of the state page of the financial annual statement. ~~Note:~~

Include:

- Renters insurance, policies covering log homes, land homes, site built or mobile home are included unless the premium for these policies is not ~~being~~ reported as 'homeowners' insurance on line 4 of the state page of the financial annual statement.
- Inland Marine or Personal Articles endorsements.

Exclude:

- Farmowners is not included as it is considered ~~as~~ to be Commercial Lines for purposes of this project.
- ~~Inland Marine or Personal Articles Floaters endorsements are included for the purposes of this project.~~
- Umbrella policies. ~~are not included for the purposes of this project~~excluded.

Inland Marine or Personal Articles ~~Floaters~~ Endorsements – Provides coverage via endorsement to a homeowners policy for direct physical loss to personal property as described in the endorsement.

Exclude:

- Stand-alone Inland Marine Policies ~~are not included~~.

Liability Insurance – Coverage for all sums that the insured becomes legally obligated to pay because of bodily injury or property damage, and sometimes other ~~wrongs~~ torts to which an insurance policy applies.

Loss Of Use – Coverage for additional living expenses incurred by the insured or fair rental value when the insured dwelling becomes uninhabitable as the result of an insured loss or when access to the dwelling is barred by civil authority.

~~**Median** - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.~~

Median Days to Final Payment – The median value for all claims closed with payment during the period and is calculated from the date the loss was reported to the company to the date of final payment. ~~**Note:**~~

Exclude:

- Subrogation payments ~~should not be included~~

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment: ~~-~~

- A subsequent supplemental payment date should only be used if the original claim was re-opened and then closed with a payment during the reporting period.
- If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that claim.

Calculation Clarifications / Examples:

- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company to the date of final

payment. The Median Days to Final Payment is the median value of the number of days it took to settle the claim for all claims during the period.

Median - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6	Nbr 7
Days to Settle	2	4	4	5	6	8	20

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6
Days to Settle	2	4	5	6	8	20

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

Closing Time	# of Claims
< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval "61-90 days." Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

~~**Median Days to Date of Report** – The median value for all claims closed with and without payment that were reported during the period, calculated from the date of the loss to the date the loss was reported to the company. To determine the Median Days to Date of Report you would follow the process outlined in the Median Days to Final Payment section, only the data set would be derived from the difference between the date of loss and the date the loss was reported to the company.~~

Medical Payments Coverage – Provides coverage for medical expenses resulting from injuries sustained by a claimant regardless of liability. ~~Note: If the medical payments are for a third party, it should be reported under Coverage Identifier B.~~

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

New Business Policy Written – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:

- ~~It does not include~~ '~~re~~Re-written' policies unless there was a lapse in coverage.

Non-Renewals – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the "non-renewal" clause of the policy.

Include:

- ~~It includes a~~All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period. ~~It does not include~~

Exclude: ~~policies~~

- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

Calculation Clarification:

- The number of nonrenewals should be reported on a policy basis regardless of the number of autos insured under the policy.

Other Structures – Structures on the residence premises (1) separated from the dwelling by a clear space or (2) connect to the dwelling by a fence, wall, wire, or other form of connection but not otherwise attached.

Personal Property Damage Coverage – Provides coverage for damage to dwelling contents or other covered personal property caused by an insured peril.

Personally Occupied – A dwelling in which the person owning the policy personally occupies the dwelling and lives there.

Property Damage Coverage – Provides coverage for damage to the dwelling and/or other insured structures caused by an insured peril.

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Reporting for direct business only – Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Suit – A court proceeding to recover a right to a claim, including suits for arbitration cases. It does not include subrogation claims where suit is filed by the company against the tortfeasor.

Note in counting the number of suits:

- One suit with two claimants would be reported as two suits as any awards/payments made would be made to the claimants individually.

- One suit filed, seeking damages under two policies, would be reported as one suit.

- One suit filed seeking damages for multiple coverages should be reported as one suit. If the suit is seeking damages for bodily injury and another coverage, the suit should be reported under bodily injury. If the suit seeks damages for two other coverages, the suit should be reported under the most applicable coverage.

- Suits should be reported in the state in which the policy was issued.

- If no suit is filed on an arbitration proceeding, then do not count the arbitration action in the count of suits.

Type of Claim Count Indicator – For each schedule, the company should indicate in the "Type of Claim Count Indicator" whether the claim information is being reported per occurrence (O) or claimant (C). Reporting should be consistent throughout regardless of which claim count indicator is used.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

Line of Business: Private Passenger Auto

Reporting Period: January 1, 2011 through December 31, 2011

Filing Deadline: May 31, 2012

Contact Information:
NAIC Code
NAIC Group Code
Federal Employers Identification Number (FEIN)
Contact Person
Contact Phone
Contact Email
Company Name
Address1
Address2
City
State
Zip Code
Company Comment (optional, maximum 255 characters)
Interrogatories
Has company had a significant event/business strategy that would affect data for this reporting period? Yes/No (If yes, add additional comments)
Significant Comment (if necessary) (optional, maximum 255 characters)
Was the Company still actively writing policies in the state at year end? Yes/No
Has this block of business or part of this block of business been sold, closed or moved to another company during the year? Yes/No. If yes, please explain in the "State Underwriting Activity Comment" field.
How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim
Claims Comment (optional, maximum 255 characters)
Underwriting Comment (optional, maximum 255 characters)
~~Number Of Complaints Received Directly From Consumers~~

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

Coverage Identifier	Explanation of Coverage Identifier
A A	Collision Comprehensive/ Other Than Collision, Collision and UMPD
BB	Comprehensive/Other Than CollisionBodily Injury
CC	Bodily Injury Property Damage
DD	Property Damage Uninsured Motorists and Underinsured Motorists (UMBI)
EE	Uninsured Motorists and Underinsured Motorists (UMBI) Combined Single Limits
F F	Uninsured Motorists and Underinsured Motorists (UMPD)Personal Injury Protection
G A	Med Pay Collision
HB	Combined Single LimitsComprehensive/Other Than Collision
IC	Personal Injury ProtectionBodily Injury
D	Property Damage
E	Uninsured Motorists and Underinsured Motorists (UMBI)
F	Uninsured Motorists and Underinsured Motorists (UMPD)
G	Med Pay
H	Combined Single Limits
I	Personal Injury Protection

Schedule 1 – Private Passenger Auto Claims Activity, Counts Reported by Claimant

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (1) **Automatically loaded**
	Coverage Identifier (A, B, C, D, E, F, G, H or I or F) Automatically loaded
	Type of Claim Count Indicator (By Occurrence use “O”, by Claimant use “C”)

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

	Number of Claims open at the beginning of the period
	Number of Claims opened during the period
	Number of Claims closed during the period, with payment
	Number of Claims closed during the period, without payment
	Number of Claims remaining open at the end of the period

Schedule 2 – Private Passenger Auto Claims ClosSettled with Payment, Counts Reported by Claimant Report to Date of Final Payment

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (2) **Automatically loaded**
	Coverage Identifier (A, B, C, D, E, F, G, H or Ior F) **Automatically loaded**
	1st or 3rd Party Claims **Automatically loaded**
	Median days to final payment
	Number of claims settled closed with payment within 0-30 days
	Number of claims clossettled with payment within 31-60 days
	Number of claims clossettled with payment within 61-90 days
	Number of claims clossettled with payment within 91-180 days
	Number of claims clossettled with payment within 181-365 days
	Number of claims clossettled with payment beyond 365 days

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

Schedule 3 – Private Passenger Auto Claims ~~Settled~~Closed WithoOut ~~Payment ,~~Payment~~, Counts Reported by Claimant Date of Loss to Date of Report~~

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (3) **Automatically loaded**
	Coverage Identifier (A, B, C, D, E, F, G, H or I~~or F~~) **Automatically loaded**
	~~Median days to date of report~~final settlement without payment
	Number of claims closs~~ettl~~ed without payment within 0-30 days
	Number of claims closs~~ettl~~ed without payment within 31-60 days
	Number of claims closs~~ettl~~ed without payment within 61-90 days
	Number of claims closs~~ettl~~ed without payment within 91-180 days
	Number of claims closs~~ettl~~ed without payment within 181-365 days
	Number of claims closs~~ettl~~ed without payment beyond 365 days

Schedule 4 – Private Passenger Auto Claims in Suit~~, Counts Reported by Claimant~~

ID	Description
	State Indicator (State For Which Data Is Being Submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (4) **Automatically loaded**
	Coverage Identifier (A, B, C, D, E, F, G, H or I~~or F~~) **Automatically loaded**
	Number of Suits open at beginning of the period
	Number of Suits opened during the period
	Number of Suits closed during the period
	Number of Suits open at end of period

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

Schedule 5 – Private Passenger Auto Underwriting

Private Passenger Auto Underwriting, one record per company	
ID	**Description**
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (5) **Automatically loaded**
	Number of autos which have policies in-force at the end of the period
	Number of policies in-force at the end of the period
	Number of new business policies written during the period
	Dollar amount of direct premium written during the period
	Number of Company-Initiated non-renewals during the period
	Number of cancellations for non-pay, non-sufficient funds or insured's request
	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
	Number of Company-Initiated cancellations that occur ~~60~~ greater than 90 days ~~or more~~ after effective date, excluding rewrites to an affiliated company~~excluding those for either non-pay or at the insured's request~~

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages.

Data should be reported for both private passenger automobiles and motorcycles. Exclude antique vehicles and primarily off-road vehiclesroad vehicles such as dune buggies or three-wheel ATVs.

Cancellations – Includes all company initiated cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of automobiles insured under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium, non-sufficient funds or insured's request
    - These should be reported every time a policy cancels for the above reasons. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted).

- Policies cancelled for underwriting reasons.

Exclude:

- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

Do not include:

- Policies cancelled for non-payment of premium,
- Policies cancelled at the insured's request, or
- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

~~**Cancellations 60 days or more** – Cancellations where the notice of cancellation was issued 60 days or more after the original effective date of the policy.~~

- ~~Policies that have been renewed and then cancelled at a later date are included.~~
- ~~The calculation of the number of days is from the original effective date of the policy, not the renewal date.~~
- ~~This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.~~

Cancellations within the fir~~1~~st 59 days – Company-initiated ~~C~~cancellations for new business where the notice of cancellation was issued within the fir~~1~~st 59 days after the original effective date of the policy.

- ~~Policies that have been renewed and then cancelled at a later date are not included.~~
- The calculation of the number of days is from the original inception ~~effective~~ date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ~~'free look' or~~ 'underwriting' period for new business.

Cancellations from 60 to 90 days ~~–~~ Company-initiated ~~C~~cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ~~'free look' or~~ 'underwriting' period for new business.

Cancellations greater than 90 days ~~–~~ Company-initiated ~~C~~cancellations where the notice of cancellation was issued more than 90 days ~~or more~~ after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ~~'free look' or~~ 'underwriting' period for new business.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy.

Include:

- ~~and includes both~~ Both first and third party claims.

~~A Claim is NOT~~Exclude:

- An event reported for "information only".
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.
- ~~A demand for payment for which it was determined that no relevant policy was in force at the time of the loss.~~

Claims Closed With Payment – Claims closed with payment where the date of the final payment to the claimant/insured was during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure is the difference between the date of the final payment and the date the claim was reported.

Exclude:

- ~~It does not include claims~~ Claims where payment was made for company loss adjustment expenses ~~however~~ if no payment was made to an insured/claimant.

Include:

- Claims that are closed because the amount claimed is below the insured's deductible.

Clarification / Example:

- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims. For example, if a claim is reopened for the sole purpose of refunding the insured's deductible, do not count it as a paid claim.

Calculation Clarification:

- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment:

- A subsequent supplemental payment date should only be included if the original claim was re-opened and then closed with a payment during the reporting period.
- If a new claim was opened for a subsequent supplemental payment, calculate a separate aging on that supplemental payment from the time the request for supplemental payment was received and the date the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported.
~~Claims closed without payment where the date the claim was closed is during the reporting period regardless of the date of loss or when the claim was received.~~

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy was in force at the time of the loss if a claim file was set up and the loss was investigated.
- ~~It includes claims where no payment was made to an insured/claimant however payment was made for company loss adjustment expenses.~~

~~**Claims Settled with Payment** – Claims closed with payment during the reporting period where the number of days to closure settle is the difference between the date of the final payment and the date the claim was reported.~~

~~Calculation Clarification:~~
~~For each coverage identifier, the sum of the claims settled with payment across each closing time interval during the reporting period should equal the total number of claims closed with payment during the reporting period.~~

~~Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment:~~

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

- ~~A subsequent supplemental payment date should only be included if the original claim was re-opened and then closed with a payment during the reporting period.~~

~~If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that supplement payment from the time the request for supplement payment was received and the date of the final payment was made. claim.~~

~~**Complaint –** – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.~~

Coverage Identifier A - Collision Insurance – Coverage to provide protection against physical contact of an automobile with another inanimate object resulting in damage to the insured automobile.

Include:
Rental/transportation cost claims as a result of a collision claim are also considered as a collision claim.

-

Coverage Identifier B - Comprehensive/Other than Collision Insurance – Coverage providing protection in the event of physical damage (other than collision), including theft of the insured automobile.

Include:

- Rental/transportation cost claims as a result of a comprehensive/other than collision claim should be included in the count of the comprehensive/other than collision claims.

Coverage Identifier C - –Bodily Injury – Physical damage to one's person. The purpose of liability (casualty) insurance is to cover bodily injury to a third party resulting from the negligent acts and omissions of an insured.

Coverage Identifier D - –Property Damage Liability Insurance – Coverage in the event that the negligent acts or omissions of an insured result in damage or destruction to another's property.

Include:

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

- 'Property Damage Rental' coverage (i.e. amounts paid for a third party claimant's rental car).

Coverage Identifier E – UMBI – Includes both Uninsured Motorist Coverage and Underinsured Motorists Coverage for bodily injury claims.

- **Underinsured Motorist Coverage (UIM)** – Provides coverage for bodily injury sustained by an insured who is involved in an accident caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- **Uninsured Motorist Coverage (UM)** – Provides coverage for bodily injury sustained by an insured involved in an accident caused by an at-fault driver who does not have liability insurance.

Coverage Identifier ~~F UMPDF~~ - UMPD – Includes both Uninsured Motorist Property Damage Coverage and Underinsured Motorist Property Damage Coverage.

- **Underinsured Motorist Property Damage Coverage –** Provides coverage for property damage to covered property caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- **Uninsured Motorist Property Damage Coverage** – Provides coverage for property damage to covered property caused by an at-fault driver who does not have liability insurance.

Coverage Identifier G - Medical Payments Coverage – First party coverage for injuries incurred in a motor vehicle accident.

Coverage Identifier H - Combined Single Limit – Bodily injury liability and property damage liability expressed as a single sum of coverage.

Coverage Identifier I - Personal Injury Protection (PIP) – A first party benefit. c~~C~~overage to pay basic expenses for an insured and his/her family in states with no fault automobile insurance laws. No-fault laws generally require drivers to carry personal injury protection coverage to pay for basic medical needs of the insured, such as medical expenses, in the event of an accident. For the purposes of this project, all PIP coverages (wage, funeral, death, medical, etc) that would correspond to first party coverages in the applicable participating states should be included.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

10-68-154-2010

~~**Date Claim Opened** – This should be the earliest or first date the claim was reported to either the company or insurance agent.~~

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:

- If partial payments ~~are~~ were made on the claim, the claim would be considered closed with payment if the final payment ~~date~~ was made during the reporting period regardless of the date of loss or when the claims was received.

Date the Claim was Reported – The ~~earliest or first~~ date the claim was first reported to either the company or insurance agent.

Direct Written Premium - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarifications:

- Premium amounts ~~and~~ should be determined in the same manner as used for the financial annual statement. If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported. If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference ~~(up or down)~~ when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.

~~**Median** - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.~~

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Median Days to Final Payment – The median value for all claims closed with payment during the period and is calculated from the date the loss was reported to the company to the date of final payment. **Note:**

Exclude:

- Subrogation payments should not be included.

Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment:

- A subsequent supplemental payment date should only be used if the original claim was re-opened and then closed with a payment during the reporting period.

- If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that claim.

Calculation Clarifications / Examples:

- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle the claim for all claims during the period.

Median - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

- Consider the following simple example of the number of days it took to settle each of the following seven claims:

	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6	Nbr 7
Days to Settle	2	4	4	5	6	8	20

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In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6
Days to Settle	2	4	5	6	8	20

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

Closing Time	**# of Claims**
< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval "61-90 days." Any reported median that falls outside of this range (i.e., less than 61 or greater than 90) will indicate a data error.

~~**Median Days to Date of Report** – The median value for all claims closed with and without payment that were reported during the period, calculated from the date of the loss to the date the loss was reported to the company. To determine the Median Days to Date of Report you would follow the process outlined in the Median Days to Final Payment section, only the data set would be derived from the difference between the date of loss and the date the loss was reported to the company.~~

~~**Medical Payments Coverage** –Medical Payments Coverage is not included in this request.~~

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NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

New Business Policy Written – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:

- It does not include Renewals or 're-written' policies unless there was a lapse in coverage.

Non-Renewals – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the "non-renewal" clause of the policy. It includes all company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

- It does not include

Include:
All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

-

Exclude:

- policies Policies where a renewal offer was made and the policyholder did not accept the offer.
- It does not include instances Instances where the policyholder requested that the policy not be renewed.
- Non-renewals for non-payment of premium.

Calculation Clarification:

- The number of non-renewals should be reported on a policy basis regardless of the number of autos insured under the policy.

Personal Injury Protection (PIP) – Coverage to pay basic expenses for an insured and his/her family in states with no fault automobile insurance laws. No-fault laws generally require drivers to carry both liability insurance and personal injury protection coverage to pay for basic needs of the insured, such as medical expenses, in the event of an accident. For the purposes of this project, all PIP

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~~coverages (wage, funeral, death, medical, etc) that would correspond to first party coverages in the applicable participating states should be included.~~

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Private Passenger Auto Insurance – Those policies issued on automobiles owned or leased by an individual or by husband and wife resident in the same household that are reported on lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement. ~~This covers four wheel vehicles including station wagons, vans, or pick-up trucks with a gross vehicle weight up to 10,000 pounds or less and not customarily used in the occupation, profession, or business of the insured.~~

~~Note:~~

Include:

- ~~•~~ This covers four wheel vehicles including station wagons, vans, or pick-up trucks with a gross vehicle weight up to 10,000 pounds or less and not customarily used in the occupation, profession, or business of the insured.
- Vehicles as defined above that are reported on Lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement which meet the definition of private passenger automobiles.
- ~~•~~ Motorcycles
- ~~•~~ Policies where the insured's vehicle is titled privately to the insured but is used by the insured for work should be included, unless the coverage is written on a commercial auto form.
- ~~•~~ Policies written on a volunteer basis and those written through a residual market mechanism such as assigned risk pools should be included.
- ~~•~~ Policies written on ~~RV's,~~RV's and motor homes are included as they are licensed vehicles that fall under the various states' Motor Vehicle Responsibility laws.
-

Exclude~~s~~:

- ~~•~~ Policies written on antiques, collectibles, ~~motorcycles,~~ all terrain vehicles, snowmobiles, trailers, dune buggies. ~~are not included.~~
- ~~•~~ Miscellaneous vehicles written on Inland Marine policies.

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Private Passenger Auto Data Call & Definitions

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~~are not included. .~~

- ~~•~~ Other vehicles classified by ISO as miscellaneous that do not fall under the various states' Motor Vehicle Responsibility laws.

~~are not included for the purposes of this project.~~

- ~~•~~ 'Fleet' policies are generally considered to be a commercial policy and would not be included unless the premium for these policies is being reported as 'private passenger auto' insurance on lines 19.1, 19.2 or 21.1 of the state page of the financial annual statement.

~~**Property Damage Liability Insurance** – Coverage in the event that the negligent acts or omissions of an insured result in damage or destruction to another's property. This would include 'Property Damage Rental' coverage (i.e. amounts paid for a third party claimant's rental car).~~

Reporting for direct business only – Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Schedule – Policy permitting an insured to choose desired coverage. These policies are important for items with relatively low limits of coverage under standard property insurance forms. For example, an insured would have to specifically schedule expensive stereos and custom equipment in order to receive full value for a loss.

Suit – A court proceeding to recover a right to a claim, including suits for arbitration cases. It does not include subrogation claims where suit is filed by the company against the tortfeasor.

Note in counting the number of suits:

- One suit with two claimants would be reported as two suits as any awards/payments made would be made to the claimants individually.

- One suit filed, seeking damages under two policies, would be reported as one suit.

- One suit filed seeking damages for multiple coverages should be reported as one suit. If the suit is seeking damages for bodily injury and another coverage, the suit should be reported under bodily injury. If the suit seeks damages for two other coverages, the suit should be reported under the most applicable coverage.

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Private Passenger Auto Data Call & Definitions

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- Suits should be reported in the state in which the policy was issued.

Type of Claim Count Indicator – For each schedule, the company should indicate in the "Type of Claim Count Indicator" whether the claim information is being reported per occurrence (O) or claimant (C). Reporting should be consistent throughout regardless of which claim count indicator is used.

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Homeowner Data Call & Definitions

~~8/15~~10-6-~~/~~2010

Line of Business: Homeowners

Reporting Period: January 1, 2012 through December 31, 2012

Filing Deadline: April 30, 2013

Contact Information:
NAIC Code
NAIC Group Code
Federal Employers Identification Number (FEIN)
Contact Person
Contact Phone
Contact Email
Company Name
Address1
Address2
City
State
Zip Code
Company Comment (optional, maximum 255 characters)

Interrogatories
Has company had a significant event/business strategy that would affect data for this reporting period? Yes/No (If yes, add additional comments)
Significant Comment (if necessary) (optional, maximum 255 characters)
Was the Company still activity writing policies in the state at year end? Yes/No
Has this block of business or part of this block of business been sold, closed or moved to another company during the year? Yes/No If yes, please explain in the "State Underwriting Activity Comment" field.
How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

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claim/open new claim
Claims Comment (optional, maximum 255 characters)
Underwriting Comment (optional, maximum 255 characters)
Number Of Complaints Received Directly From Consumers

Coverage Identifier	Explanation of Coverage Identifier
A	Dwelling (includes – Other Structures)
B	Loss of Use
C	Personal Property
D	Liability
E	Medical Payments
~~A~~	~~Dwelling (includes – Other Structures, Personal Property, Loss of Use and Medical Payments[1])~~
~~B~~	~~Liability and Medical Payments[1]~~

~~[1] The instructions in Schedule A and the definition in the existing HO Data Call are inconsistent. The changes are to clarify what the MCAS Subgroup intended. If the company was already reporting Medical Payments numbers on Schedule B, continue to do so. However, if the company had already programmed its system to put the Medical Payments numbers in Coverage Id A, continue to do so until the Subgroup can make the change officially. If the company reports these numbers in Schedule A, please make a note with the filing to indicate that the Medical Payments numbers are reported in Schedule A.~~

Schedule 1 – Homeowners Claims Activity, Counts Reported by Claimant

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**

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Homeowner Data Call & Definitions

~~8/15~~10-6-~~/~~2010

	Schedule Identifier (1) **Automatically loaded**
	Coverage Identifier (A ~~or~~, B, C, D, or E) Automatically loaded
	~~Type of Claim Count Indicator (By Occurrence use "O", by Claimant use "C")~~
	Number of Claims open at the beginning of the period
	Number of Claims opened during the period
	Number of Claims closed during the period, with payment
	Number of Claims closed during the period, without payment
	Number of Claims open at the end of the period
	State Claims Activity Comment (optional, maximum 255 characters)

Schedule 2 – Homeowners Claims Closed ~~Settled~~ with Payment, Counts Reported by Claimant~~Report to Date of Final Payment~~

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (2) **Automatically loaded**
	Coverage Identifier (A, B, C, D, or E~~A or B~~) **Automatically loaded**
	Median days to final payment
	Number of claims ~~settled~~ closed with payment within 0-30 days
	Number of claims closed~~settled~~ with payment within 31-60 days
	Number of claims closed~~settled~~ with payment within 61-90 days
	Number of claims closed~~settled~~ with payment within 91-180 days
	Number of claims closed~~settled~~ with payment within 181-365 days

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

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	Number of claims closed~~settled~~ with payment beyond 365 days

Schedule 3 – Homeowners Claims Closed~~Settled~~ With~~O~~out ~~Payment ,~~Payment, Counts Reported by Claimant ~~Date of Loss to Date of Report~~

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (3) **Automatically loaded**
	Coverage Identifier (A, B, C, D, or E~~A or B~~) **Automatically loaded**
	~~Median days to date of report final settlement without payment~~
	Number of claims closed~~settled~~ without payment within 0-30 days
	Number of claims closed~~settled~~ without payment within 31-60 days
	Number of claims closed~~settled~~ without payment within 61-90 days
	Number of claims closed~~settled~~ without payment within 91-180 days
	Number of claims closed~~settled~~ without payment within 181-365 days
	Number of claims closed~~settled~~ without payment beyond 365 days

Schedule 4 – Homeowners Claims in Suit, Counts Reported by Claimant

ID	Description
	State Indicator (State For Which Data Is Being Submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (4) **Automatically loaded**
	Coverage Identifier (A, B, C, D, or E~~A or B~~) **Automatically loaded**
	Number of Suits open at beginning of the period
	Number of Suits opened during the period
	Number of Suits closed during the period

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Homeowner Data Call & Definitions

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	Number of Suits open at end of period
	~~State Claims Activity Comment (optional, maximum 255 characters)~~

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Homeowner Data Call & Definitions

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Schedule 5 – Homeowners Underwriting

Homeowners Underwriting, one record per company	
ID	**Description**
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (5) **Automatically loaded**
	Number of dwellings which have policies in-force at the end of the period
	Number of policies in-force at the end of the period
	Number of new business policies written during the period
	Dollar amount of direct premium written during the period
	Number of Company-Initiated non-renewals during the period
	Number of cancellations for non-pay, non-sufficient funds or insured's request
	~~Number of cancellations that occur 60 days or more after effective date, excluding those for either non-pay or at the insured's request~~
	~~Number of cancellations that occur in the first 59 days after effective date, excluding those for either non-pay or at insured's request~~
	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company
	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to a related company
	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company
	~~Number Of Complaints Received Directly From Consumers~~

Homeowner Data Call & Definitions

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Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages.

~~Definitions:~~

Cancellations – Includes all ~~company-initiated~~ cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of ~~automobiles~~ dwellings insured under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium, non-sufficient funds or insured's request.
    - These should be reported every time a policy cancels for the above reasons. (i.e. if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.)

- Policies cancelled for underwriting reasons.

Exclude:

- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

~~Do not include:~~

- ~~Policies cancelled for non-payment of premium,~~
- ~~Policies cancelled at the insured's request, or~~
- ~~Policies cancelled for 're-write' purposes where there is no lapse in coverage.~~

~~**Cancellations 60 days or more** – Cancellations where the notice of cancellation was issued 60 days or more after the original effective date of the policy.~~

~~• Policies that have been renewed and then cancelled at a later date are included.~~

~~• The calculation of the number of days is from the original effective date of the policy, not the renewal date.~~

~~• This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.~~

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Cancellations within the 1st 59 days – Cancellations for new business where the notice of cancellation was issued within the 1st 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.

Cancellations from 60 to 90 days - Cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.

Cancellations greater than 90 days - Cancellations where the notice of cancellation was issued 90 days or more after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.

Cancellations within the fir1st 59 days – Company-initiated cCancellations for new business where the notice of cancellation was issued within the fir1st 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' orthe 'underwriting' period for new business.

Cancellations from 60 to 90 days — Company-initiated Ccancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.

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Cancellations greater than 90 days — Company-initiated Ccancellations where the notice of cancellation was issued more than 90 days or more after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'free look' orto the 'underwriting' period for new business.

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy.

Include:

- bothBoth first and third party claims.

A Claim is NOTExclude:

- An event reported for "information only".
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.
- A demand for payment for which it was determined that no relevant policy was in force at the time of the loss.

Claims Closed With Payment – Claims closed with payment where the date of the final payment to the claimant/insured was during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure is the difference between the date of the final payment and the date the claim was reported.

Exclude:

- It does not include cClaims where payment was made for company loss adjustment expenses however if no payment was made to an insured/claimant.

Include:

- Claims that are closed because the amount claimed is below the insured's deductible.

Clarification / Example:

- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims. For example, if a claim is reopened for the sole purpose of refunding the insured's deductible, do not count it as a paid claim.

Calculation Clarification:

- For each coverage identifier, the sum of the claims closed with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment:

- A subsequent supplemental payment date should only be included if the original claim was re-opened and then closed with a payment during the reporting period.
- If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that supplemental payment from the time the request for supplemental payment was received and the date of the final payment was made.

~~Claims closed without payment where the date the claim was closed is during the reporting period regardless of the date of loss or when the claim was received.~~
~~• It includes claims where no payment was made to an insured/claimant however payment was made for company loss adjustment expenses.~~

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported.~~.~~

Include:

- ~~Include a~~All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- ~~Include c~~Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- ~~Includes a~~A demand for payment for which it was determined that no relevant policy was in force at the time of the loss if a claim file was set up and the loss was investigated.

Calculation Clarification:

- For each coverage identifier, the sum of the claims closed without payment across each closing time interval should equal the total number of claims closed without payment during the reporting period.

~~**Claims Settled With Payment** – Claims closed with payment during the reporting period where the number of days to settle closure is the difference between the date of the final payment and the date the claim was reported.~~

Homeowner Data Call & Definitions

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Calculation Clarification:

- For each coverage identifier, the sum of the claims settled with payment across each closing time intervalduring the reporting period should equal the total number of claims closed with payment during the reporting period.

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment:

- A subsequent supplemental payment date should only be included if the original claim was re-opened and then closed with a payment during the reporting period.
- If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that supplement payment from the time the request for supplement payment was received and the date of the final payment was made.claim.

Complaint – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.

Coverage – Protection under an insurance policy.
Coverage Identifier A – Coverage for dwellings under Homeowners Policies and Dwelling Fire and Dwelling Liability Policies. It includes coverage for Other Structures, Personal Property, Loss of Use, and Medical Payments.
Coverage Identifier B – Liability insurance provided under Homeowners Policies.

Coverage Identifier A – Coverage for dwellings under Homeowners Policies and Dwelling Fire and Dwelling Liability Policies. It includes coverage for Other Structures.

Coverage Identifier B – Loss of Use provided under Homeowners Policies.

Coverage Identifier C – Personal Property provided under Homeowners Policies.

Coverage Identifier D – Liability insurance provided under Homeowners Policies.

Coverage Identifier E – Medical Payments provided under Homeowners Policies.

~~**Date Claim Opened** – This should be the earliest or first date the claim was reported to either the company or insurance agent.~~

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:

- If partial payments ~~are~~ were made on the claim, the claim would be considered closed with payment if the final payment date was made during the reporting period regardless of the date of loss or when the claims was received.

Date the Claim was Reported – The ~~earliest or first~~ date the claim was first reported to either the company or insurance agent.

Direct Written Premium - ~~-~~The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period ~~and~~.

Calculation Clarifications:

- ~~-~~Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference ~~(up or down)~~ when filing the market conduct

annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:

- A 2 or 3 family home covered under one policy would be considered 1 dwelling.

Dwelling Fire and Dwelling Liability Policies – ~~Provides property c~~Coverage for dwellings and their contents. It may also provide liability coverage and is usually written when a residential property does not qualify according to the minimum requirements of a homeowner's policy, or because of a requirement for the insured to select several different kinds of coverage and limits on this protection.

Include:

- Dwelling Fire and Dwelling Liability policies should be included ONLY ~~if~~ IF the policies written under these programs are for personally occupied residential dwellings, not policies written under a commercial program and/or on a commercial lines policy form.

Homeowners Policies – Policies that combine liability insurance with one or more other types of insurance such as property damage, personal property damage, medical payments and additional living expenses that are reported on line 4 of the state page of the financial annual statement. ~~Note:~~

Include:

- Renters insurance, policies covering log homes, land homes, site built or mobile home are included unless the premium for these policies is not ~~being~~ reported as 'homeowners' insurance on line 4 of the state page of the financial annual statement.
- Inland Marine or Personal Articles endorsements.
-

Exclude:

- Farmowners is not included as it is considered ~~as~~ to be Commercial Lines for purposes of this project.
- ~~Inland Marine or Personal Articles Floaters endorsements are included for the purposes of this project.~~
- Umbrella policies. ~~are not included for the purposes of this project~~excluded.

Inland Marine or Personal Articles ~~Floaters~~ Endorsements – Provides coverage via endorsement to a homeowners policy for direct physical loss to personal property as described in the endorsement.

Exclude:

- Stand-alone Inland Marine Policies ~~are not included~~.

Liability Insurance – Coverage for all sums that the insured becomes legally obligated to pay because of bodily injury or property damage, and sometimes other ~~wrongs~~ torts to which an insurance policy applies.

Loss Of Use – Coverage for additional living expenses incurred by the insured or fair rental value when the insured dwelling becomes uninhabitable as the result of an insured loss or when access to the dwelling is barred by civil authority.

~~**Median** – A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.~~

Median Days to Final Payment – The median value for all claims closed with payment during the period and is calculated from the date the loss was reported to the company to the date of final payment. ~~**Note:**~~

Exclude:

- Subrogation payments. ~~should not be included~~

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment: ~~-~~

- A subsequent supplemental payment date should only be used if the original claim was re-opened and then closed with a payment during the reporting period.
- If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that claim.

Calculation Clarifications / Examples:

- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle the claim for all claims during the period.

Median - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6	Nbr 7
Days to Settle	2	4	4	5	6	8	20

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6
Days to Settle	2	4	5	6	8	20

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

Closing Time	**# of Claims**
< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval "61-90

days." Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

~~**Median Days to Date of Report** – The median value for all claims closed with and without payment that were reported during the period, calculated from the date of the loss to the date the loss was reported to the company. To determine the Median Days to Date of Report you would follow the process outlined in the Median Days to Final Payment section, only the data set would be derived from the difference between the date of loss and the date the loss was reported to the company.~~

Medical Payments Coverage – Provides coverage for medical expenses resulting from injuries sustained by a claimant regardless of liability. ~~Note: If the medical payments are for a third party, it should be reported under Coverage Identifier B.~~

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

New Business Policy Written – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:

- ~~It does not include~~ 'reRe-written' policies unless there was a lapse in coverage.

Non-Renewals – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the "non-renewal" clause of the policy.

Include:

- ~~It includes a~~All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.
- ~~It does not include~~

Exclude: ~~policies~~

- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

Calculation Clarification:

- The number of nonrenewals should be reported on a policy basis regardless of the number of dwellings~~autos~~ insured under the policy.

Other Structures – Structures on the residence premises (1) separated from the dwelling by a clear space or (2) connect to the dwelling by a fence, wall, wire, or other form of connection but not otherwise attached.

Personal Property Damage Coverage – Provides coverage for damage to dwelling contents or other covered personal property caused by an insured peril.

Personally Occupied – A dwelling in which the person owning the policy personally occupies the dwelling and lives there.

Property Damage Coverage – Provides coverage for damage to the dwelling and/or other insured structures caused by an insured peril.

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Reporting for direct business only – Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Suit – A court proceeding to recover a right to a claim, including suits for arbitration cases.

Exclude:

- ~~It does not include s~~Subrogation claims where suit is filed by the company against the tortfeasor.
- Non-suit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, and declaratory judgement actions filed by an insurer.

Calculation Clarification:~~Note in counting the number of suits:~~

- Suits should be reported on the same basis as claims. One suit should be reported for ~~each /~~each / claimant / coverage combination, regardless of the number of actual suits filed.
- One suit with two claimants would be reported as two suits as any awards/payments made would be made to the claimants individually.
- ~~One suit filed, seeking damages under two policies, would be reported as one suit.~~

- One suit filed seeking damages for multiple coverages should be reported as one suit for each applicable coverage. ~~If the suit is seeking damages for bodily injury and another coverage, the suit should be reported under bodily injury. If the suit seeks damages for two other coverages, the suit should be reported under the most applicable coverage.~~
- Suits should be reported in the state in which the ~~policy was issued~~claim was reported on this statement.

~~**Type of Claim Count Indicator** – For each schedule, the company should indicate in the "Type of Claim Count Indicator" whether the claim information is being reported per occurrence (O) or claimant (C). Reporting should be consistent throughout regardless of which claim count indicator is used.~~

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

108-6154-2010

Line of Business: Private Passenger Auto

Reporting Period: January 1, 2012 through December 31, 2012

Filing Deadline: April 30, 2013

Contact Information:
NAIC Code
NAIC Group Code
Federal Employers Identification Number (FEIN)
Contact Person
Contact Phone
Contact Email
Company Name
Address1
Address2
City
State
Zip Code
Company Comment (optional, maximum 255 characters)
Interrogatories
Has company had a significant event/business strategy that would affect data for this reporting period? Yes/No (If yes, add additional comments)
Significant Comment (if necessary) (optional, maximum 255 characters)
Was the Company still actively writing policies in the state at year end? Yes/No
Has this block of business or part of this block of business been sold, closed or moved to another company during the year? Yes/No. If yes, please explain in the "State Underwriting Activity Comment" field.
How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim
Claims Comment (optional, maximum 255 characters)
Underwriting Comment (optional, maximum 255 characters)
Number Of Complaints Received Directly From Consumers

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

108-6154-2010

Coverage Identifier	Explanation of Coverage Identifier
A A	Collision Comprehensive/ Other Than Collision, Collision and UMPD
BB	Comprehensive/Other Than CollisionBodily Injury
CC	Bodily Injury Property Damage
DD	Property Damage Uninsured Motorists and Underinsured Motorists (UMBI)
EE	Uninsured Motorists and Underinsured Motorists (UMBI) Combined Single Limits
F F	Uninsured Motorists and Underinsured Motorists (UMPD)Personal Injury Protection
G A	Med Pay Collision
HB	Combined Single LimitsComprehensive/Other Than Collision
IC	Personal Injury ProtectionBodily Injury
D	Property Damage
E	Uninsured Motorists and Underinsured Motorists (UMBI)
F	Uninsured Motorists and Underinsured Motorists (UMPD)
G	Med Pay
H	Combined Single Limits
I	Personal Injury Protection

Schedule 1 – Private Passenger Auto Claims Activity, Counts Reported by Claimant

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (1) **Automatically loaded**
	Coverage Identifier (A, B, C, D, E, F, G, H or Ior F) Automatically loaded
	Type of Claim Count Indicator (By Occurrence use "O", by Claimant use "C")
	Number of Claims open at the beginning of the period
	Number of Claims opened during the period
	Number of Claims closed during the period, with payment
	Number of Claims closed during the period, without payment

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

108-6154-2010

	Number of Claims remaining open at the end of the period

Schedule 2 – Private Passenger Auto Claims ClosSettled with Payment, Counts Reported by Claimant ~~Report to Date of Final Payment~~

ID	Description
	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (2) **Automatically loaded**
	Coverage Identifier (A, B, C, D, E, F, G, H or I~~or F~~) **Automatically loaded**
	~~1st or 3rd Party Claims **Automatically loaded**~~
	Median days to final payment
	Number of claims ~~settled~~ closed with payment within 0-30 days
	Number of claims clossettled with payment within 31-60 days
	Number of claims clossettled with payment within 61-90 days
	Number of claims clossettled with payment within 91-180 days
	Number of claims clossettled with payment within 181-365 days
	Number of claims clossettled with payment beyond 365 days

Schedule 3 – Private Passenger Auto Claims ~~Settled~~Closed WithoOut ~~Payment~~ ,Payment, Counts Reported by Claimant ~~Date of Loss to Date of Report~~

ID	Description

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

108-6154-2010

	State Indicator (State for which data is being submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (3) **Automatically loaded**
	Coverage Identifier (A, B, C, D, E, F, G, H or I~~or F~~) **Automatically loaded**
	~~Median days to date of report~~final settlement without payment
	Number of claims closs~~ettl~~ed without payment within 0-30 days
	Number of claims closs~~ettl~~ed without payment within 31-60 days
	Number of claims closs~~ettl~~ed without payment within 61-90 days
	Number of claims closs~~ettl~~ed without payment within 91-180 days
	Number of claims closs~~ettl~~ed without payment within 181-365 days
	Number of claims closs~~ettl~~ed without payment beyond 365 days

Schedule 4 – Private Passenger Auto Claims in Suit, Counts Reported by Claimant

ID	Description
	State Indicator (State For Which Data Is Being Submitted) **Automatically loaded**
	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (4) **Automatically loaded**
	Coverage Identifier (A, B, C, D, E, F, G, H or I~~or F~~) **Automatically loaded**
	Number of Suits open at beginning of the period
	Number of Suits opened during the period
	Number of Suits closed during the period
	Number of Suits open at end of period

Schedule 5 – Private Passenger Auto Underwriting

Private Passenger Auto Underwriting, one record per company	
ID	**Description**
	State Indicator (State for which data is being submitted) **Automatically loaded**

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

108-6154-2010

	NAIC Company Code **Automatically loaded after initial entry**
	NAIC Group Code **Automatically loaded after initial entry**
	Schedule Identifier (5) **Automatically loaded**
	Number of autos which have policies in-force at the end of the period
	Number of policies in-force at the end of the period
	Number of new business policies written during the period
	Dollar amount of direct premium written during the period
	Number of Company-Initiated non-renewals during the period
	Number of cancellations for non-pay, non-sufficient funds or insured's request
	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
	Number of Company-Initiated cancellations that occur ~~60~~ greater than 90 days ~~or more~~ after effective date, excluding rewrites to an affiliated company~~excluding those for either non-pay or at the insured's request~~

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

108-6154-2010

Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages.

Data should be reported for both private passenger automobiles and motorcycles. Exclude antique vehicles and primarily off-road vehiclesroad vehicles such as dune buggies or three-wheel ATVs.

Cancellations – Includes all company initiated cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of automobiles insured under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium, non-sufficient funds or insured's request
    - These should be reported every time a policy cancels for the above reasons. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted).

- Policies cancelled for underwriting reasons.

Exclude:

- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

Do not include:

- Policies cancelled for non-payment of premium,
- Policies cancelled at the insured's request, or
- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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~~**Cancellations 60 days or more** – Cancellations where the notice of cancellation was issued 60 days or more after the original effective date of the policy.~~

- ~~Policies that have been renewed and then cancelled at a later date are included.~~
- ~~The calculation of the number of days is from the original effective date of the policy, not the renewal date.~~
- ~~This time frame should be used regardless of individual state requirements related to the 'free look' or 'underwriting' period for new business.~~

Cancellations within the fir~~1~~st 59 days – Company-initiated ~~C~~cancellations for new business where the notice of cancellation was issued within the fir~~1~~st 59 days after the original effective date of the policy.

- ~~Policies that have been renewed and then cancelled at a later date are not included.~~
- The calculation of the number of days is from the original inception ~~effective~~ date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ~~'free look' or~~ 'underwriting' period for new business.

Cancellations from 60 to 90 days ~~–~~ Company-initiated ~~C~~cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ~~'free look' or~~ 'underwriting' period for new business.

Cancellations greater than 90 days ~~–~~ Company-initiated ~~C~~cancellations where the notice of cancellation was issued more than 90 days ~~or more~~ after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the ~~'free look' or~~ 'underwriting' period for new business.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

108-6154-2010

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy.

Include:

- and includes both Both first and third party claims.

A Claim is NOTExclude:

- An event reported for "information only".
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.
- A demand for payment for which it was determined that no relevant policy was in force at the time of the loss.

Claims Closed With Payment – Claims closed with payment where the date of the final payment to the claimant/insured was during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure is the difference between the date of the final payment and the date the claim was reported.

Exclude:

- It does not include claims Claims where payment was made for company loss adjustment expenses however if no payment was made to an insured/claimant.

Include:

- Claims that are closed because the amount claimed is below the insured's deductible.

Clarification / Example:

- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims. For example, if a claim is reopened for the sole purpose of refunding the insured's deductible, do not count it as a paid claim.

Calculation Clarification:

- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment:

- A subsequent supplemental payment date should only be included if the original claim was re-opened and then closed with a payment during the reporting period.
- If a new claim was opened for a subsequent supplemental payment, calculate a separate aging on that supplemental payment from the time the request for supplemental payment was received and the date the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported.
~~Claims closed without payment where the date the claim was closed is during the reporting period regardless of the date of loss or when the claim was received.~~

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy was in force at the time of the loss if a claim file was set up and the loss was investigated.
- ~~It includes claims where no payment was made to an insured/claimant however payment was made for company loss adjustment expenses.~~

~~**Claims Settled with Payment** – Claims closed with payment during the reporting period where the number of days to closure settle is the difference between the date of the final payment and the date the claim was reported.~~

~~Calculation Clarification:~~
~~For each coverage identifier, the sum of the claims settled with payment across each closing time interval during the reporting period should equal the total number of claims closed with payment during the reporting period.~~

~~Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment:~~

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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- ~~A subsequent supplemental payment date should only be included if the original claim was re-opened and then closed with a payment during the reporting period.~~

~~If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that supplement payment from the time the request for supplement payment was received and the date of the final payment was made. claim.~~

Complaint – – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.

Coverage Identifier A – Collision Insurance – Coverage to provide protection against physical contact of an automobile with another inanimate object resulting in damage to the insured automobile.

Include:
Rental/transportation cost claims as a result of a collision claim are also considered as a collision claim.

-

Coverage Identifier B - Comprehensive/Other than Collision Insurance – Coverage providing protection in the event of physical damage (other than collision), including theft of the insured automobile.

Include:

- Rental/transportation cost claims as a result of a comprehensive/other than collision claim should be included in the count of the comprehensive/other than collision claims.

Coverage Identifier C - Bodily Injury – Physical damage to one's person. The purpose of liability (casualty) insurance is to cover bodily injury to a third party resulting from the negligent acts and omissions of an insured.

Coverage Identifier D - Property Damage Liability Insurance – Coverage in the event that the negligent acts or omissions of an insured result in damage or destruction to another's property.

Include:

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- 'Property Damage Rental' coverage (i.e. amounts paid for a third party claimant's rental car).

Coverage Identifier E - UMBI – Includes both Uninsured Motorist Coverage and Underinsured Motorists Coverage for bodily injury claims.

- **Underinsured Motorist Coverage (UIM)** – Provides coverage for bodily injury sustained by an insured who is involved in an accident caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- **Uninsured Motorist Coverage (UM)** – Provides coverage for bodily injury sustained by an insured involved in an accident caused by an at-fault driver who does not have liability insurance.

Coverage Identifier ~~F UMPDF~~ - UMPD – Includes both Uninsured Motorist Property Damage Coverage and Underinsured Motorist Property Damage Coverage.

- **Underinsured Motorist Property Damage Coverage –** Provides coverage for property damage to covered property caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- **Uninsured Motorist Property Damage Coverage** – Provides coverage for property damage to covered property caused by an at-fault driver who does not have liability insurance.

Coverage Identifier G - Medical Payments Coverage – First party coverage for injuries incurred in a motor vehicle accident.

Coverage Identifier H - Combined Single Limit – Bodily injury liability and property damage liability expressed as a single sum of coverage.

Coverage Identifier I - Personal Injury Protection (PIP) – A first party benefit. c~~C~~overage to pay basic expenses for an insured and his/her family in states with no fault automobile insurance laws. No-fault laws generally require drivers to carry personal injury protection coverage to pay for basic medical needs of the insured, such as medical expenses, in the event of an accident. For the purposes of this project, all PIP coverages (wage, funeral, death, medical, etc) that would correspond to first party coverages in the applicable participating states should be included.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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~~**Date Claim Opened** – This should be the earliest or first date the claim was reported to either the company or insurance agent.~~

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:

- If partial payments ~~are~~ were made on the claim, the claim would be considered closed with payment if the final payment ~~date~~ was made during the reporting period regardless of the date of loss or when the claims was received.

Date the Claim was Reported – The ~~earliest or first~~ date the claim was first reported to either the company or insurance agent.

Direct Written Premium - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarifications:

- Premium amounts ~~and~~ should be determined in the same manner as used for the financial annual statement. If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported. If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference ~~(up or down)~~ when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.

~~**Median** – A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.~~

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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Median Days to Final Payment – The median value for all claims closed with payment during the period and is calculated from the date the loss was reported to the company to the date of final payment. **Note:**

Exclude:

- Subrogation payments should not be included.

Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment:

- A subsequent supplemental payment date should only be used if the original claim was re-opened and then closed with a payment during the reporting period.

- If a new claim was opened for a subsequent supplemental payment, then, calculate a separate aging on that claim.

Calculation Clarifications / Examples:

- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle the claim for all claims during the period.

Median - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

- Consider the following simple example of the number of days it took to settle each of the following seven claims:

	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6	Nbr 7
Days to Settle	2	4	4	5	6	8	20

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, &

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6
Days to Settle	2	4	5	6	8	20

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

Closing Time	**# of Claims**
< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval "61-90 days." Any reported median that falls outside of this range (i.e., less than 61 or greater than 90) will indicate a data error.

~~**Median Days to Date of Report** – The median value for all claims closed with and without payment that were reported during the period, calculated from the date of the loss to the date the loss was reported to the company. To determine the Median Days to Date of Report you would follow the process outlined in the Median Days to Final Payment section, only the data set would be derived from the difference between the date of loss and the date the loss was reported to the company.~~

~~**Medical Payments Coverage** –Medical Payments Coverage is not included in this request.~~

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

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Private Passenger Auto Data Call & Definitions

108-6154-2010

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

New Business Policy Written – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:

- It does not include Renewals or 're-written' policies unless there was a lapse in coverage.

Non-Renewals – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the "non-renewal" clause of the policy. It includes all company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

• It does not include

Include:

All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

•

Exclude:

- policies Policies where a renewal offer was made and the policyholder did not accept the offer.
- It does not include instances Instances where the policyholder requested that the policy not be renewed.
- Non-renewals for non-payment of premium.

Calculation Clarification:

- The number of non-renewals should be reported on a policy basis regardless of the number of autos insured under the policy.

Personal Injury Protection (PIP) – Coverage to pay basic expenses for an insured and his/her family in states with no fault automobile insurance laws. No-fault laws generally require drivers to carry both liability insurance and personal injury protection coverage to pay for basic needs of the insured, such as medical expenses, in the event of an accident. For the purposes of this project, all PIP coverages (wage, funeral, death, medical, etc) that would correspond to first party coverages in the applicable participating states should be included.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Private Passenger Auto Insurance – Those policies issued on automobiles owned or leased by an individual or by husband and wife resident in the same household that are reported on lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement. ~~This covers four wheel vehicles including station wagons, vans, or pick-up trucks with a gross vehicle weight up to 10,000 pounds or less and not customarily used in the occupation, profession, or business of the insured.~~

~~Note:~~

Include:

- ~~•~~ This covers four wheel vehicles including station wagons, vans, or pick-up trucks with a gross vehicle weight up to 10,000 pounds or less and not customarily used in the occupation, profession, or business of the insured.
- Vehicles as defined above that are reported on Lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement which meet the definition of private passenger automobiles.
- ~~•~~ Motorcycles
- ~~•~~ Policies where the insured's vehicle is titled privately to the insured but is used by the insured for work should be included, unless the coverage is written on a commercial auto form.
- ~~•~~ Policies written on a volunteer basis and those written through a residual market mechanism such as assigned risk pools should be included.
- ~~•~~ Policies written on ~~RV's,~~RV's and motor homes are included as they are licensed vehicles that fall under the various states' Motor Vehicle Responsibility laws.
-

Exclude~~s~~:

- ~~•~~ Policies written on antiques, collectibles, ~~motorcycles,~~ all terrain vehicles, snowmobiles, trailers, dune buggies. ~~are not included.~~
- ~~•~~ Miscellaneous vehicles written on Inland Marine policies. ~~are not included.~~
- ~~•~~ Other vehicles classified by ISO as miscellaneous that do not fall under the various states' Motor Vehicle Responsibility laws.

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~~are not included for the purposes of this project.~~

- ~~•~~ 'Fleet' policies are generally considered to be a commercial policy and would not be included unless the premium for these policies is being reported as 'private passenger auto' insurance on lines 19.1, 19.2 or 21.1 of the state page of the financial annual statement.

~~**Property Damage Liability Insurance** – Coverage in the event that the negligent acts or omissions of an insured result in damage or destruction to another's property. This would include 'Property Damage Rental' coverage (i.e. amounts paid for a third party claimant's rental car).~~

Reporting for direct business only – Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Schedule – Policy permitting an insured to choose desired coverage. These policies are important for items with relatively low limits of coverage under standard property insurance forms. For example, an insured would have to specifically schedule expensive stereos and custom equipment in order to receive full value for a loss.

Suit – A court proceeding to recover a right to a claim, including suits for arbitration cases.

Exclude:

- ~~It does not include subrogation~~ Subrogation claims where suit is filed by the company against the tortfeasor.
- Non-suit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, and declaratory ~~judgement~~judgment actions filed by an insurer.

~~Note in counting the number of suits~~
Calculation Clarification~~:~~

- ~~-~~Suits should be reported on the same basis as claims. One suit should be reported for each claimant / coverage combination, regardless of the number of actual suits filed.
- One suit with two claimants would be reported as two suits as any awards/payments made would be made to the claimants individually.
- ~~One suit filed, seeking damages under two policies, would be reported as one suit.~~

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- One suit filed seeking damages for multiple coverages should be reported as one suit for each applicable coverage. If the suit is seeking damages for bodily injury and another coverageproperty damage, theone suit should be reported for each of the two coverages.
under bodily injury. If the suit seeks damages for two other coverages, the suit should be reported under the most applicable coverage.
- Suits should be reported in the state in which the policy was issued the claim is reported on this statement.

Type of Claim Count Indicator – For each schedule, the company should indicate in the "Type of Claim Count Indicator" whether the claim information is being reported per occurrence (O) or claimant (C). Reporting should be consistent throughout regardless of which claim count indicator is used.

Market Conduct Annual Statement Data Element Revision Process

**Adopted by the
Market Information Systems (D) Task Force on
September 8, 2010**

The following establishes the procedures of the Market Regulation and Consumer Affairs Committee's Market Analysis Procedures (D) Working Group (hereinafter "MAP") with respect to proposed changes to the Market Conduct Annual Statement data elements. The procedures are for substantive changes only—such as the addition of data elements or significant (non-technical) changes to their definitions.

1. MAP may consider relevant changes to the annual statement blank and instructions at any scheduled working group conference call or meeting. The MAP chair will determine which suggested changes are considered.

2. Suggested changes and amendments to the Market Conduct Annual Statement data elements or definitions may be submitted to the NAIC support staff for MAP at any time during the year.

3. All recommended changes shall include:

- a concise statement of the proposed change;
- the statement type of the suggested change (Life and Annuity, Property and Casualty, etc.);
- the reason for the change; and
- any supporting information relating to the change.

4. Only changes that have been adopted by the MAP Working Group by June 1 and the Market Regulation and Consumer Affairs (D) Committee by August 1 will be added to the blank for the data collected in the following calendar year. (For example, if MAP adopts a change during May 2011 and the D Committee adopts it in July 2011, the change will be effective January 1, 2012 and would be reported in the data filed in 2013.)

5. If the MAP Working Group or the D Committee do not adopt a recommended change by their respective date (June 1 or August 1), any adopted change will be effective the second calendar year after the adoption of the change. (For example, if MAP adopts a change during July 2011 and the D Committee adopts it in September 2011, the change will be effective January 1, 2013 and would be reported in the data filed in 2014).

6. All suggested changes will be made available for comment at least 30 days prior to adoption by the Market Regulation and Consumer Affairs D Committee.

Draft: 10/26/10

Market Analysis Procedures (D) Working Group
Orlando, FL
October 18, 2010

The Market Analysis Procedures (D) Working Group of the Market Information Systems (D) Task Force met in Orlando, FL, Oct. 18, 2010. The following Working Group members participated: Lynette Baker, Chair (OH); Peter Camacci, Vice Chair (PA); Maria Chavira (AZ); Barb Szumowski (FL); James Morris (IL); Ron Musser (LA); Nancy Grodin (MD); Eric Cioppa and Robert Wake (ME); Regan Johnson (MI); Jim Mealer (MO); Carol Roy (MT); Ernest Nickerson (NC); Holly Blanchard and Bruce Ramge (NE); Chuck Vanasdalan (NH); Anne Marie Narcini (NJ); Gail Keren (NY); Gayle Woods (OR); Carla Griffin (SC); Suzette Green-Wright (UT); Jackie Cunningham (VA); Charles Piasecki (VT); Leslie Krier (WA); Sue Ezalarab and Jo LeDuc (WI); and Mark Hooker (WV).

1. Adoption of Sept. 14 Minutes

Mr. Ramge moved to adopt the Sept. 14 conference call minutes (Attachment Three-A). Ms. Krier seconded the motion. The minutes were adopted.

2. Adoption of Market Analyst Core Competencies

Ms. Baker said the Market Analyst Core Competencies have been posted on the MAP Web page and no comments were received. Ms. Krier moved to adopt the Core Competencies. Ms. Narcini seconded. Mr. Hooker said the list of designations that market analysts are encouraged to obtain seemed too lengthy. Ms. LeDuc agreed and specifically mentioned that the MCM designation is primarily focused on examinations. Mr. Hooker suggested changing the list to only cite a few major designations and inserting a statement referencing designations from other major insurance organizations. Mr. Hooker also requested that the Working Group develop an addendum to the *Market Regulation Handbook* that addresses the required training for market analysts. The Working Group adopted the Market Analyst Core Competencies as amended (Attachment Three-B).

3. Discussion on Continuing Unfinished Tasks into Next Year

Ms. Baker said the Working Group completed two of its four tasks for 2010. She said the two unfinished tasks were the revisions to the *Market Regulation Handbook* and development of the Best Practices Guide for market analysis. She said it would be better to move these unfinished tasks to next year because of the changes to the Market Conduct Annual Statement (MCAS) and the possible changes to the market systems that the Market Information Systems (D) Task Force is considering. She said she discussed this with Director John M. Huff (MO) and he agreed. Ms. Baker said she would like the Working Group to contact states individually to discuss each state's market analysis processes. These different methods could be added to the *Market Regulation Handbook* as possible alternatives or included as an addendum available in StateNet to regulators only. Ms. Narcini said the Working Group should begin with market analysis best practices because of new states collecting MCAS data in 2011. Ms. Baker said she would schedule regular conference calls for the second Wednesday of each month to keep the Working Group on track to complete these tasks.

4. Market Conduct Annual Statement Lines of Business

Ms. Baker noted that one of the data element changes made by the Working Group was to eliminate the group life schedule from the life line of business in MCAS for the 2011 data year. She suggested that the group life line of business be removed for the 2010 data year also. Mr. Ramge asked how this would be communicated to companies at this late date. Ms. Narcini said that if it is not possible to take the group life schedule out of the programming for the new reporting application, the companies could be instructed that it does not need to be included. Kelly Ireland (American Council of Life Insurers—ACLI) suggested that the companies be advised in the data call letter. Ms. LeDuc moved to eliminate the group life schedule for the 2010 MCAS data year. Ms. Narcini seconded. The Working Group voted to remove the group life schedule.

Ms. Baker said that based on the new change procedures for MCAS that were adopted by Market Information Systems (D) Task Force, all changes to be effective in the 2012 data year must be adopted by the Working Group by June 1, 2011, and by the D Committee by Aug. 1. Because of the new deadline, she said it was important to begin consideration of changes to MCAS. Ms. LeDuc suggested reviewing the results of a 2006 survey of state data calls that was conducted by the subgroup

led by Ms. Narcini. Ms. Narcini said the Insurance Data Management Association (IDMA) has a database of special state data calls and may have current information that can be used in conjunction with the older survey done by the subgroup.

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

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Draft: 9/30/10

Market Analysis Procedures (D) Working Group
Conference Call
September 14, 2010

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Sept. 14, 2010. The following Working Group members participated: Lynette Baker, Chair (OH); Peter Camacci, Vice Chair (PA); Maria Chavira (AZ); Don McKinley (CA); Jeff Olson (CO); Kurt Swan (CT); Luther Ellis (DC); Amy Groszos (FL); Rob Rapp (IL); Stacy Rinehart (KS); Larry Hawkins (LA); Tom Marshall (MD); Kendra Godbout (ME); Win Nickens and Jim Mealer (MO); Kerry Banks (MN); Tracy Biehn (NC); Reva Vandevoorde (NE); Sylvia Lawson (NY); Mike Lyden (OR); Rusty Shropshire (VA); Doug Pennington (WA); Jo LeDuc (WI); and Mark Hooker (WV).

1. Market Conduct Annual Statement Update

Ms. Baker provided a brief Market Conduct Annual Statement (MCAS) update. She reported that the Working Group's proposed MCAS changes were approved at the Summer National Meeting. However, some changes were made at the Market Information Systems (D) Task Force level regarding the implementation timeline for the approved changes. The implementation timeline for the MCAS changes will be documented.

2. Discuss Proposed Revisions to the Market Analysis Chapters of the *Market Regulation Handbook* (MAP Charge 1)

Ms. LeDuc provided an outline of possible changes to the Market Analysis chapters of the *Market Regulation Handbook* that have been posted on the NAIC website for review and comment. Ms. Baker would like to see documentation and instruction for using the information available in I-SITE to be included in the proposed draft. She requested that state regulators provide examples showing how their states use the I-SITE tools, and how they conduct Baseline, Level 1 and Level 2 market analysis. Mr. Mealer said it would be helpful to also share how different states conduct analysis with their own internal tools or systems outside of I-SITE, such as SERFF. Mr. Stroup suggested a section on the use of Quicklink to query large amounts of financial and market data. Ms. Baker said the contributions should be sent to Randy Helder (NAIC) by Sept. 24. Ms. Baker asked for state volunteers to work together to prepare a rough draft for the Fall National Meeting. Mr. Ellis and Mr. Mealer volunteered to assist Ms. LeDuc with the draft.

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

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2. Market Analysis Core Competencies	
Data Collection	Ability to gather and evaluate data as demonstrated by: 1) utilization of the Market Analysis Review System; 2) collection of data as required by the Commissioner, Director or Superintendent; and 3) for participating Departments of Insurance, collection of data for the Market Conduct Annual Statement; 4) use of the standardized data calls when there is a need for the collection of relevant data prior to the initiation of an investigation of market regulatory action.
Analysis	Departments of Insurance shall gather information from data currently available to the Department of Insurance, as well as surveys and required reporting requirements, information collected by the NAIC and a variety of other sources in both the public and private sectors, and information from within and outside the insurance industry. The information shall be analyzed in order to develop a baseline understanding of the marketplace and to identify for further review regulated entities or practices that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.
Market Analysis Chief	The Market Analysis Chief (MAC) is the principal liaison with the NAIC Market Analysis team~~Division~~, ~~–~~the Market Analysis Procedures (MAP) (D) Working Group and the Market Information Systems (D) Task Force. The MAC is responsible for all market analysis-related communications with other work units within the Department of Insurance. The MAC and CAD may be two individuals or the same person. The Department of Insurance should have the appropriate staff member assigned as the MAC to ensure an effective market analysis program.
Market Analyst	Market Analysis is a process where data and information is collected and analyzed for an insurance market and particular companies to determine both what are standard practices and when companies or general market trends are outside of those standards. The purpose is to provide both general understanding and specific company identification for further analysis, audit, investigation or examination. The Market Analyst works under the supervision of the MAC to assure a systematic approach to Market Analysis. The Market Analysis process typically includes baseline analysis on the various lines of insurance utilizing a variety of standardized and state based tools and data, as well as the Market Conduct Annual Statement (MCAS) submissions by companies. The Market Analyst combines the findings of baseline analysis and MCAS to identify outliers for Level 1 and Level 2 reviews. The Market Analysis process should include working closely with various program areas in their respective Insurance Department as well as other states'~~'s~~ Insurance Departments and the NAIC. Working closely may also include providing regular or even formal reports to a variety of internal and external stakeholders, at the direction and supervision of the MAC or CAD.

Competency: Market Analysis

SubSection: Market Analyst

Market Analysis is a process where data and information is collected and analyzed for an insurance market and particular companies to determine both what are standard practices and when companies or general market trends are outside of those standards. The purpose is to provide both general understanding and specific company

identification for further analysis, audit, investigation or examination. The Market Analyst works under the supervision of the MAC to assure a systematic approach to Market Analysis. The Market Analysis process typically includes baseline analysis on the various lines of insurance utilizing a variety of standardized and state based tools and data, as well as the Market Conduct Annual Statement (MCAS) submissions by companies. The Market Analyst combines the findings of baseline analysis and MCAS to identify outliers for Level 1 and Level 2 reviews. The Market Analysis process should include working closely with various program areas in their respective Insurance Department as well as other state~~'~~s' Insurance Departments and the NAIC. Working closely may also include providing regular or even formal reports to a variety of internal and external stakeholders, at the direction and supervision of the MAC or CAD.

The following standards apply to this competency:

Standard One: Analysts should possess skills and abilities necessary to access and navigate a variety of databases utilizing several formats (e.g., online, Access, CSV, Excel, etc.).

Standard Two: Analysts should have or be able to gain an understanding of insurance markets, products and coverages in at least one line of insurance, but preferably multiple lines.

Standard Three: Analysts must be capable of interpreting applicable laws, regulations, and standards to ensure analyses are appropriately conducted.

Standard Four: Analysts should have the skill and aptitude to discuss complex compliance and regulatory issues with other regulators and company representatives.

Standard Five: Analysts should have the experience, training or aptitude to adequately review and understand financial statements with specific focus and understanding on how the information in those statements may impact company operations or result from company operations (e.g. claims, underwriting, rating, reinsurance, sales, marketing, etc.)

Standard Six: Analysts should have the skills and abilities necessary for the analysis of abstract data from a variety of resources (MAPT, MCAS, I-Site, s~~S~~tate s~~S~~ystems, i~~I~~nternet d~~D~~atabases, etc.) in order to identify issues and companies for further analysis (baseline analysis) and then utilize that data, and additional data, in completion of appropriate company analyses (MARS Level 1 & Level 2 analyses.)

Standard Seven: Analysts should be competent in the writing of management reports (for inside the agency) and formal finding reports (to companies or for enforcement actions.)

Standard Eight: Analysts should be skilled in working independently and with other regulators within their state, regionally and nationally.

Standard Nine: Analysts are encouraged to attend seminars or attain education that regularly supports and updates their knowledge of insurance and insurance regulatory and compliance areas (E-Reg, IRES CDS, AICP National Conference, NAIC Meetings, etc.) as well as encouraged to attain advanced education or certification in areas related to insurance and insurance compliance or regulations (e.g., CIE, ~~AIE, MCM,~~ SPIR, ~~PIR, APIR,~~ CPCU, ~~CLU,~~ FLMI, CFE, and other designations by

major insurance organizations ~~AIRC, ARC, MBA, JD, etc.)~~, etc.) as allowed or supported by the rules and regulations of each state.

~~DRAFT~~

Market Information Systems (D) Task Force
2011 CHARGES

For 2011, the Task Force is charged to:

1. Using the NAIC Market Regulation Handbook, "Voice of the Customer" Report, and Market Analysis Framework as references, finalize an overall strategy and program plan, which takes into consideration existing NAIC staffing and resource levels. This would consist of identifying the "best practices" for Market Regulators' processes; defining the overall strategy for the role of Market Information Systems in support of these processes; comparing the existing systems to the automation needs associated with those processes; evaluating the gaps; and identifying and prioritizing projects to close those gaps. The Market Information Systems include: 1) Market Analysis Prioritization Tool (MAPT); 2) Market Analysis Review System (MARS); 3) Complaint Database System (CDS); 4) Examination Tracking System (ETS); 5) Regulatory Information Retrieval System (RIRS); ~~and~~ 6) Market Initiatives Tracking System (MITS); 7) Special Activities Database (SAD) (in conjunction with the Anti-Fraud (D) Task Force); and 8) Market Conduct Annual Statement (MCAS)—Essential

2. Appoint a Market Analysis Procedures Working Group to (1) develop a Market Conduct Annual Statement Blank to be used for the collection of data for additional lines of business~~Workers' Compensation data~~; (2) develop a Best Practices Guide to be used by state insurance regulators to analyze the Market Conduct Annual Statement data on a company specific, group, and national basis; (3) provide recommendations regarding the refinements and expansions to the data elements of the Market Conduct Annual Statement; (4) make recommendations for the enhancement and improvement of the Market Regulation Handbook market analysis chapters —Essential

3. Develop data reporting standards and data editing protocols to ensure consistent collection and storage of market regulation data that are accurate, complete, and conform to all NAIC standards—Essential

4. Serve as the business partner to receive reports from the internal NAIC Advisory Committee overseeing the development of a system for the automation and collection of the Market Conduct Annual Statement and provide direction to the Advisory Committee to ensure business objectives are being met—Essential