IN THE MATTER OF

THE LIFE INSURANCE COMPANIES OF AMERICO LIFE, INC.

Kansas City, Missouri

MULTI-STATE REGULATORY SETTLEMENT AGREEMENT

TEXAS DEPARTMENT OF INSURANCE
Lead Regulatory Negotiator

MULTI-STATE REGULATORY SETTLEMENT AGREEMENT
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IN THE MATTER OF

THE LIFE INSURANCE COMPANIES OF AMERICO LIFE, INC.

Kansas City, Missouri

MULTI-STATE REGULATORY SETTLEMENT AGREEMENT

This Multi-State Regulatory Settlement Agreement (the "Agreement") is entered into as of this ____ day of _____, 2007 (the "Effective Date"), by and between the life insurance companies of Americo Life, Inc., the Texas Department of Insurance (the "Lead Regulatory Negotiator"), the insurance regulators of the States of Georgia, Florida, California, and Ohio (the "Lead Regulators"), and the insurance regulators of each of the remaining states and of the District of Columbia that adopt, approve, and agree to this Agreement. Signatories to this Agreement hereinafter are "Participating Regulators."

I. BACKGROUND AND RECITALS

A. The named companies involved are listed below (the "Companies") and are all members of Americo Life, Inc. holding company group, a privately owned group that owns directly all the capital stock of United Fidelity Life Insurance Company, which itself owns directly or through wholly-owned subsidiaries all the capital stock of Great Southern Life Insurance Company, National Farmers Union Life Insurance Company, Americo Financial Life & Annuity Insurance Company (f.k.a. The College Life Insurance Company of America) and the Ohio State Life Insurance Company. At all relevant times herein, the Companies have been licensed insurers in the State of Texas. For purposes of this Agreement, the Companies shall be deemed to include their respective predecessors in interest, who were acquired by or merged into one of the Companies or one of their subsidiaries, or whose business was acquired by one of the Companies through reinsurance.

B. Pursuant to concerns raised by the National Association of Insurance Commissioners ("NAIC"), in 2000, Texas conducted a survey of race-based practices that asked if the Companies had ever charged race-based premiums, if they had discontinued issuing policies with race-based premiums, and if race-based premiums were currently being collected. The responses of the Companies to the survey in 2000 indicated that some of the Companies may have engaged in race-based pricing activities.

C. Commencing in 2002, the Texas Department of Insurance conducted a thorough market conduct examination of the Companies concerning the issues set forth herein. A copy of the Target Market Conduct Examination Report (the "Examination Report"), with selected attachments is attached to this Agreement as **Exhibit A**. The Examination Report indicated that while all race-based pricing activity related to new issues had ceased by 1960, documentation and/or statistical evidence supporting the conclusion that some of the Companies at some point in the past and for some period of time may have engaged in race-based pricing activities. *See* Exhibit A at 46-47. The Examination Report made no finding that current ownership of the Companies or management thereof had engaged in the alleged race-based pricing activities.

D. The Texas Department of Insurance alleges that the Companies or other insurance companies acquired by the Companies sold certain life insurance policies to non-white persons at higher premiums or with lesser benefits than policies sold to otherwise similarly situated white persons (the "Alleged Practices"). The Texas Department of Insurance contends that the Alleged Practices were discriminatory.

E. The Companies vigorously deny and do not admit to any wrongdoing or violation of any insurance or other law or regulation of any state, but are foregoing their rights to an administrative hearing under the applicable laws and regulations of any state whose insurance regulatory official signs the Regulatory Settlement Agreement and/or any Applicable Consent Order and is entering into this Agreement in exchange for the releases granted herein. The Companies also agree to accept the Examination Report and waive any and all rights to a hearing on the Examination Report.

F. The members of the NAIC, including the Participating Regulators, as the chief regulatory officials of their respective jurisdictions, have jointly agreed to designate

the Texas Department of Insurance as the Lead Regulatory Negotiator, in consultation with other regulators, in order to negotiate this Regulatory Settlement Agreement on behalf of and for the benefit of the Participating Regulators and the NAIC.

G. This Agreement was negotiated in an effort to conclude with finality all regulatory allegations involving the impact of race on life insurance underwriting, sales, pricing or policy benefits on policies that were issued, assumed, acquired or administered by the Companies prior to the Effective Date of this Agreement. By virtue of the terms and conditions set forth in this Regulatory Settlement Agreement, the Participating Regulators and the Companies desire to resolve and have resolved all regulatory issues arising from or in any way relating to the subject matter herein described on the terms and conditions set forth herein.

II. EXECUTION OF AGREEMENT

A. The Lead Regulatory Negotiator represents and warrants that he is authorized to negotiate this Regulatory Settlement Agreement on behalf of the State of Texas and on behalf of the insurance regulators of each of the other states of the United States and of the District of Columbia.

B. William T. Marden, President, Americo Life, Inc., warrants that he is authorized to agree to and execute this Regulatory Settlement Agreement on behalf of the Companies.

C. By their signature and delivery of this Regulatory Settlement Agreement, as described below, and by virtue of the execution of this Regulatory Settlement Agreement by the Lead Regulatory Negotiator on behalf of and for the benefit of the Participating Regulators, each Participating Regulator acknowledges and agrees that: (1) they have read and understand the terms and conditions of the Regulatory Settlement Agreement and (2) the Lead Regulatory Negotiator has been actively involved in the evaluation and discussion of each form of relief which is included within the Regulatory Settlement Agreement. By the signature and delivery of this Regulatory Settlement Agreement, each Participating Regulator further acknowledges the sufficiency and fairness of this Regulatory Settlement Agreement and agrees that the execution of said documents fairly, reasonably and adequately addresses the concerns of holders and

beneficiaries of Eligible Policies (as defined in the Regulatory Settlement Agreement), including the past, present and future Eligible Policy owners, and any holders, insureds, beneficiaries, payees and other parties in interest with respect to this Regulatory Settlement Agreement.

D. Each Participating Regulator by way of signature below gives his/her express assurance that under their applicable state laws, regulations and judicial rulings, they have the authority to enter into this Regulatory Settlement Agreement. Each Participating Regulator shall execute and deliver this Regulatory Settlement Agreement to the Lead Regulatory Negotiator within sixty (60) days following the receipt of this Regulatory Settlement Agreement from the Lead Regulatory Negotiator. If a Participating Regulator finds that, under state law, regulation or procedure, the preparation and execution of a consent order is necessary to carry out the terms of this Regulatory Settlement Agreement, such a consent order (the "Applicable Consent Order") shall be prepared by such Participating Regulator within **sixty (60) days** following the receipt of this Regulatory Settlement Agreement from the Lead Regulatory Negotiator.

E. For purposes of this Regulatory Settlement Agreement, an "Applicable Consent Order" shall be satisfactory to the Company if it: (1) acknowledges the authority of the Lead Regulatory Negotiator as described herein; (2) incorporates by reference and attaches via exhibit a copy of this Regulatory Settlement Agreement; (3) expressly adopts and agrees to the provisions of this Regulatory Settlement Agreement; and (4) includes other terms that may be required under law or regulations applicable to such consent orders generally in the state of the applicable Participating Regulator. However, nothing in this Regulatory Settlement Agreement shall be construed to require any state to execute and deliver an Applicable Consent Order if such State elects to sign this Regulatory Settlement Agreement and not prepare a consent order.

F. If any changes in the terms of this Agreement are required by any participating state to satisfy that state's particular statutory and/or regulatory requirements, such changes shall be incorporated into that state's State Amendment page and attached hereto and incorporated herein as to that state's requirements upon

acknowledgment and agreement thereto by the Companies. Those amendments shall have effect only for the amending state and shall have no effect on any other participating state.

G. This Agreement and its attachments and/or any applicable Consent Order constitute the entire agreement of the parties with respect to the matters referenced herein and, except for state-specific requirements as provided for in Section II.D., may not be amended or modified except by an amendment signed by all parties hereto; provided, however, that the Companies and the insurance departments of the states that are parties hereto may mutually agree to any reasonable extensions of time that might become necessary in order to carry out the provisions of this Agreement.

H. This Regulatory Settlement Agreement may be signed in multiple counterparts, each of which shall constitute a duplicate original, but which taken together shall constitute but one and the same instrument.

III. GENERAL MATTERS

A. In the event that any portion of this Regulatory Settlement Agreement is held invalid under any particular state's law as it is relevant to a Participating Regulator's state, such invalid portion shall be deemed to be severed only in that state and all remaining provisions of this Regulatory Settlement Agreement shall be given full force and effect and shall not in any way be affected thereby.

B. The Lead Regulatory Negotiator and the Companies may mutually agree to any reasonable extensions of time that might become necessary to carry out the provisions of this Regulatory Settlement Agreement.

C. Except for the provisions related to an order to enforce the terms of this Regulatory Settlement Agreement by any of the Participating Regulators or by the Lead Regulatory Negotiator, the terms of this Regulatory Settlement Agreement and/or any related Applicable Consent Orders with each of the states shall be governed by and interpreted according to the laws of the State of Texas, without regard to existing principles of conflicts of laws.

D. The Companies enter into this Regulatory Settlement Agreement with the Texas Department of Insurance acting as Lead Regulatory Negotiator. All of the terms of the Regulatory Settlement Agreement shall be binding upon, and shall inure to the benefit of, the Companies, each Participating Regulator, and the successors and assigns of each of the foregoing.

E. The Companies shall maintain records of their progress in completing the administrative acts required by this Agreement, and shall submit reports of such progress to the Lead Regulatory Negotiator on a quarterly basis. The first such report shall be due within 120 days after the Effective Date, and a Final Report shall be due within 60 days after the expiration of the Claims made period specified in Section IV.F.5. The Final Report, among other matters, will include: (1) the total amount of remediation paid; (2) the total amount of remediation paid by company; including by the state of the owner or beneficiary; (3) the total number of individuals who received remediation; (4) and the total number of individuals who received remediation by company, including by state of owner or beneficiary.

F. If the Companies default with any respect to any obligation under this Agreement and such default is not remedied within 30 business days following the Companies' receipt of written notice specifying such default (during which period the insurance regulator of the state in which such default occurred and the Companies shall make reasonable efforts to resolve any disputes involving the default), the Lead Regulatory Negotiator may seek judicial enforcement of this Agreement. Written notice of any alleged default shall be sent to the following address: 300 West 11th Street, Kansas City, MO 64105, Attn: William T. Marden, or may be faxed to him at (816) 391-2165.

IV. REMEDIATION RELIEF

A. *Definitions*

1. "Eligible Companies" – Attachments 14 and 19 to the Examination Report (**Exhibit A**) contain lists of the Companies identified with possible race-based pricing activities. Upon further research and explanation, Americo, Inc. was unable to confirm that either Maryland Life Insurance Company or National Masonic Life

Insurance Company was ever owned by Americo, Inc., or wrote policies that were acquired, directly or indirectly, by Americo, Inc. from any source. Thus, Maryland Life Insurance Company and National Masonic Insurance Company shall not be included in the "Eligible Companies." All other companies in Attachments 14 and 19 shall be "Eligible Companies."

2. "Eligible Policy" means a policy: (a) issued by one of the "Eligible Companies"; (b) with a "substandard" rating; (c) to a non-white individual; (d) which was issued during the date ranges identified in the Examination Report; (e) which has not been previously remediated by the Company, and (f) which was in-force at any time after December 31, 1959.

3. "Identifiable Person" means an individual holder or beneficiary of an Eligible Policy that the company can identify from its electronic records. Where a potential holder or beneficiary of an Eligible Policy is identified, but the race of such person is "unknown," the Companies will make a diligent inquiry to determine the race of the individual.

4. "Effective Date" means the date the Regulatory Settlement Agreement was executed by the Company and the Lead Regulatory Negotiator, the Texas Department of Insurance.

5. "Valid Claim" means any claim under an Eligible Policy by an Identifiable Person who has complied with the requirements of this Agreement and whose race is known to the Company, or whose race is unknown by the Company and has completed and filed the claim form attached to this Agreement as Exhibit F in the time frame established in Section IV.F.5.

B. *All Premium Paying Policies: Premium Reduction Relief*

There are no Eligible Policies in a premium paying status as of the Effective Date.

C. *Inforce Policies: Increased Death Benefit Relief*

1. For each Identifiable Person who is a holder of an in force Eligible Policy and whose race is known to the Companies, the appropriate Company shall, within

120 days after the Effective Date, calculate a 25% increase in the face amount of each such Eligible Policy for which the Companies have electronic records. The electronic records of the Companies shall be adjusted to reflect the increases in the face amounts of the adjusted in force Eligible Policies.

2. For each Identifiable Person who is a holder of a policy that may be an Eligible Policy but whose race is unknown to the Companies, the appropriate Company shall, within 120 days after the Effective Date, send a Claim form to such individual in the form of Exhibit F to this Agreement. Upon receipt of a Valid Claim the appropriate Company will calculate a 25% increase in the face amount of each in force Eligible Policy for which the Companies have electronic records. The electronic records of the Companies shall be adjusted to reflect the increases in the face amounts of the adjusted in force Eligible Policies.

3. The Companies shall provide written notice to each Identifiable Person, of any adjustment made to the face amount of any Eligible Policy within 120 days after the Effective Date (or within 30 days after the receipt of a Valid Claim in the case of any Identifiable Person whose race is unknown by the Companies), provided such person owns an in force Eligible Policy that was adjusted by the Companies pursuant to Section IV.C.1. or IV.C.2. The Notice, which has been approved by the Lead Regulatory Negotiator and is attached hereto as **Exhibit B**, will be mailed to the last known address of the Identifiable Person shown in the Companies' Home Office records. If a particular jurisdiction requires changes in policy face amounts to be evidenced by, among other things, a new certificate or endorsement, then the Companies, in addition to providing the Exhibit B Notice, shall provide to the policy owner the documentation required by that jurisdiction.

D. *Terminated Life Policies*

1. The Companies shall, within 180 days after the Effective Date, calculate an additional surrender benefit for each Eligible Policy that terminated by reason of cash surrender after December 31, 1959 for which the companies have electronic records, except for those Eligible Policies for which enhanced surrender benefits were previously paid. The additional surrender benefit shall be 25% of the

surrender benefit paid plus compound interest at the rate of 4% per annum calculated from the termination date to the Effective Date.

2. The Companies shall, within 180 days after the Effective Date, provide written notice to each Identifiable Person (or his or her beneficiary) who owned a terminated Eligible Policy for which an additional surrender benefit was calculated pursuant to Section IV.D.1 of the additional surrender benefit, together with a check for the payment of such additional benefit. The Notice, which has been approved by the Lead Regulatory Negotiator and is attached hereto as **Exhibit C**, and the check will be mailed to the last known address shown in the Companies' Home Office records.

3. Each person (or his or her beneficiary) with a Valid Claim who owned a life Eligible Policy which terminated by reason of surrender between January 1, 1960 and the Effective Date and for which an enhanced surrender benefit was not paid shall receive an additional surrender benefit.

4. The Companies shall pay the additional surrender benefit within 30 days of receipt of a Valid Claim.

E. *Estates and Matured Life Policies*

1. The Companies shall, within 180 days after the Effective Date, calculate the additional death or endowment benefit for each Eligible Policy that terminated by reason of death or endowment after December 31, 1959 for which the Companies have complete electronic records and for which an enhanced death or endowment benefit was not previously paid. The additional death or endowment benefits shall be 25% of the original face amount plus compound interest at the rate of 4% per annum calculated from the termination date to the Effective Date.

2. The Companies shall, within 180 days after the Effective Date, provide written notice to each Identifiable Person (or his or her beneficiary) who owned a terminated Eligible Policy for which an additional death or endowment benefit was calculated pursuant to Section IV.E.1 of the additional death or endowment benefit, together with a check for the payment of such benefit. The Notice, which has been approved by the Lead Regulatory Negotiator and is attached hereto as **Exhibit D**, will be

mailed to the Identifiable Person at the last known address shown in the Companies' Home Office records.

3. Each person (or his or her beneficiary) who owned an life Eligible Policy which terminated by reason of death or endowment between January 1, 1960 and the Effective Date and for which an enhanced death or endowment benefit was not previously paid and who timely files a Valid Claim pursuant to Section IV.F.5 of this Agreement shall receive an additional death or endowment benefit.

4. The Companies shall pay to the claimant within 30 days of receipt of proof of a Valid Claim an additional death or endowment benefit of 25% plus compound interest at the rate of 4% per annum calculated from the termination date to the Effective Date

5. Benefits payable under Section IV (E) will be paid to the last identified individual beneficiary or beneficiaries as their interests may appear without regard to whether the policy was subsequently assigned to a funeral home or other artificial entity.

F. *Companies' Undertaking Concerning Address Searches And Claims Process for Terminated, Estates and Matured Policies.*

1. *Delivery of Notices of Increased Face Value.* The Companies will make a thorough search of their Home Office records, and will mail notices to the last known valid address of the policyholder. If the Companies are unable to find what appears to be a valid address for a policyholder, or if a notice mailed to a policyholder is returned to the Companies as undeliverable, the Companies shall make a further effort to find a current valid address through the use of Accurint, a software search program made available to the Companies by an outside vendor, Lexis Nexis. If an apparent current address is located by the vendor, the notice will be mailed or, in the case of a returned notice, remailed to that address.

2. *Delivery of Checks for Additional Death, Endowment or Surrender Benefits.* The Companies will make a thorough search of their Home Office records in an effort to obtain a valid current address. Before checks are issued and mailed, the Companies shall attempt to verify addresses in the Companies' records through Accurint. If, despite a thorough review of its records and a search of Accurint's data base, the

Companies are unable to obtain a current valid address, no check will be issued but the details of the additional death or surrender benefit will be entered into a log of unclaimed benefits for use in future escheatment procedures. Similarly, if a check is issued and mailed but is returned as undeliverable, the check will be reversed and the details of the additional benefit will be entered into the log of unclaimed benefits for use in future escheatment procedures.

3. *Claims Made Procedure For Individuals Not Presently Identified.* The Companies acknowledge that they do not have complete records for many of the Eligible Policies, and the Companies may be unable to identify or locate all individuals that may be due monies based on their Home Office records. Therefore, the Companies have agreed to participate in the website project undertaken by Texas Department of Insurance, notifying individuals who may be due monies under the Eligible Policies of their potential right to an increased death or surrender benefit.

4. *Texas Department of Insurance, Race-Based Pricing Website.* On or about the Effective Date, the Texas Department of Insurance shall launch its Race-Based Pricing Website Project ("TDI Website Project"). Because the identity and location of persons with terminated Eligible policies is largely unknown, an extensive public notice campaign undertaken by the Companies would be inefficient and prohibitively expensive. For these reasons, the Texas Department of Insurance has created the Race-Based Pricing Website Project whose purpose is to provide notice to those persons who have Eligible Polices under this Settlement Agreement of their potential right to an increased death or surrender benefit. It is contemplated by the Department that this website feature will be expanded to include future settlements with other companies where the identity and location of persons with terminated Eligible policies is largely unknown. The Lead Regulatory Negotiator will furnish the Company with a copy of any text referring to Americo or any of the Companies prior to its being posted on the website in sufficient time for the Company to review it and provide comments or corrections of fact to the TDI.

The TDI Website Project shall contain general information regarding this Regulatory Settlement Agreement and Examination Report. In addition, the TDI Website Project shall contain a drop-down menu of the Eligible Companies of Americo, Inc. The drop-down menu will be an easy-to-understand way for potential claimants to associate the Eligible Companies with Americo, Inc. and this Regulatory Settlement. The TDI Website Project will also contain the following:

(a) Link to Americo, Inc. Website;

(b) Contact information for toll-free number at Americo, Inc.;

(c) Specific details on the definition of an Eligible Policy and what is required as proof. Such proof may include, but is not limited to a policy, policy number, a policy application, correspondence related to a policy, and/or debit payment books or receipts, and shall include a signed Claim form, a copy of which is attached hereto as **Exhibit F**, or other written statement which evidences that the claimant was the owner or beneficiary of an Eligible Policy.

(d) A copy of the Claim form, attached hereto as **Exhibit F.**

The Department agrees that it will use its best efforts to encourage the Lead Regulators to create appropriate links from their respective Websites to the TDI site so that the notice of this settlement can be disseminated as widely as possible, although their failure to do so shall not constitute a breach of this agreement.

5. *Claims Made Period.* For a period of 48 months from the Effective Date, the Companies shall honor all Valid Claims received, providing the appropriate level of additional death benefits or surrender benefits, for Eligible Policies terminated by reason of a death claim or surrender between January 1, 1960 and the Effective Date. The Companies shall pay all such legitimate claims within 30 days from the date of the receipt of proof satisfactory to the Companies.

6. *Escheat of Calculated Additional Surrender or Death Benefits.* Any additional surrender or death benefit calculated pursuant to Section IV (D) or (E) which remains undeliverable at the end of the Claims Made Period shall escheat to the

appropriate state (as determined by the Lead Regulatory Negotiator) or states in accordance with their escheat procedures.

7. *Handling of Telephone and/or Mail Inquiries.* In order to respond to telephone or mail inquiries generated by the TDI Website Project, the Companies will assign experienced Customer Service Representatives ("CSRs") within their Customer Service Center to handle calls coming in on the toll-free number contained on the TDI Website Project. The CSRs will be thoroughly versed in the terms of the settlement, and will be prepared to assist callers by gathering information that will assist in determining if the caller is eligible for additional death or surrender benefits.

8. *Ongoing Review.* Should the Companies in the normal course of business of paying claims, including those claims made pursuant to Section IV.F, identify additional policies where the race of the owner affected either premiums paid or benefits received, then the Companies will timely remediate such policies according to the terms of this Agreement.

9. *Evidence of Good Faith.* The use of the foregoing procedures will be deemed to represent a diligent good faith effort to locate policyholders and beneficiaries for the purpose of compliance with this Agreement.

V. UNCLAIMED BENEFIT SEARCH AND RELIEF

A. When a policy is identified under a claim submitted under the Claims Made provisions of this Regulatory Settlement Agreement, the Companies shall, within 30 days of receipt of a Valid Claim, conduct a search for other life insurance policies on the life of the insured under the policy so identified, utilizing the protocols described in **Exhibit G.**

B. If the Companies' search reveals that the deceased insured was covered by any other Eligible Companies' life insurance policy that, at the time of the death of the insured, was providing life insurance coverage (including without limitation pursuant to a contractual non-forfeiture option), and with respect to which a death benefit was not paid, the Companies shall use their best efforts to notify the beneficiary or beneficiaries of the life insurance policy and pay any death benefits due, plus any statutorily required interest,

regardless of whether such benefits have already escheated to a state governmental authority. If the benefits have escheated, the Lead Regulatory Negotiator will assist the Companies in their efforts to recover amounts paid to policyholders who by receiving such payments will be asked to subrogate to the appropriate Company their right to claim the escheated funds.

C. If the Companies' search reveals that the deceased insured was covered by any other Eligible Companies' life insurance policy that, at the time it reached endowment, was premium paying, fully paid-up or providing insurance coverage pursuant to a contractual non-forfeiture provision, and with respect to which maturity benefits became payable but have not been paid, the Companies shall use their best efforts to notify the person or entity to whom the policy's endowment benefits were payable (or, if such person is deceased, his or her estate) and pay the endowment benefits due, plus any statutorily required interest, regardless of whether such benefits have already escheated to a state governmental authority. If the benefits have escheated, the TDI will assist the Companies in their efforts to recover amounts paid to policyholders who by receiving such payments will be asked to subrogate to the appropriate Company their right to claim the escheated funds.

D. In addition, if the Companies' search reveals that the deceased insured was covered under any other Eligible Companies' life insurance policy that was also an Eligible Policy, then the Policy shall be eligible for the settlement benefits provided for the Policy under this Regulatory Settlement Agreement.

VI. GENERAL RELEASE AND RELEASE FROM FURTHER REGULATORY EXAMINATION OR SANCTION.

A. By the execution and delivery of this Regulatory Settlement Agreement and/or any Applicable Consent Order and except as necessary to enforce the terms hereof, each Participating Regulator does hereby release and forever discharge the Companies, and their past and present affiliated companies, and all past, present and future officers, directors, employees, shareholders, attorneys, agents and representatives, of and from all civil, administrative, criminal, or quasi-criminal causes, actions, claims, damages, fines, sanctions, losses, demands, or other liability that the States could pursue

or seek based upon: (1) the Alleged Practices described in Section I; (2) the Examination Report; or (3) distinctions in the terms or benefits of insurance policies based upon the race of the insured where such liability arises under the insurance and/or anti-discrimination laws and regulations of each state related or applicable to the marketing, solicitation, application, underwriting, benefit payment, acceptance, sale, purchase, operation, retention or administration of all life insurance policies sold, issued, assumed or administered by the Companies prior to the date that this Agreement is signed.

B. Each Participating Regulator on behalf of itself and its respective state of authority also agrees to discontinue any further questioning, examination or analysis of the Companies that relates to the subject matter of this Regulatory Settlement Agreement and that any examination, issue or information request posed by any state of a Participating Regulator to the Companies with respect to any other life insurance policy that is the subject of this Regulatory Settlement Agreement shall be deemed null, void, and withdrawn.

AGREED TO this 12th day of November, 2007.

LEAD REGULATORY NEGOTIATOR

By: _____
Mike Geeslin, as Insurance Commissioner for the State of Texas and Lead Regulatory Negotiator

AMERICO LIFE, INC.
FOR EACH OF THE COMPANIES (THE "COMPANIES")

By: _____
Willam T. Marden
President, Americo Life, Inc.

PARTICIPATING REGULATOR

By: _____
Steve Poizner
Commissioner for the State of California

PARTICIPATING REGULATOR

By: _____
Kevin M. McCarty
Commissioner for the State of Florida

PARTICIPATING REGULATOR

By: _____
John W. Oxendine
Commissioner for the State of Georgia

PARTICIPATING REGULATOR

By: _____
Mary Jo Hudson
Director for the State of Ohio

Exhibit A

Examination Report

with Selected Attachments

ACTUARIAL REPORT

RACE BASED PRICING ACTIVITIES
WITH RESPECT TO THE LIFE INSURANCE
BUSINESS OF THE LIFE INSURANCE COMPANIES
OF AMERICO LIFE, INC.

July 21, 2006

Prepared by:
Actuarial Resources Corporation
2753 State Road 580, Suite 101
Clearwater, FL 33761

Americo Life, Inc.'s Race Based Pricing (RPB) Exam Executive Summary

A. Reviewed 2000 NAIC RBP survey responses.

B. Developed history and acquisition activities of the five targeted Americo Life, Inc.'s life insurance holdings.

C. Performed a 5-Phase testing process to develop and substantiate findings with respect to the five targeted Americo Life, Inc.'s life insurance holdings.

Phase I - Review in-house boxed files and available rate books:
- Historical underwriting manuals
- Historical agents manuals
- Policy forms
- Board minutes
- Internal underwriting and marketing directives

Phase II - Based on Phase I findings, examiners sampled 643 of the 19,619 (about 3.25%) pre-1980 substandard issues still in force as of the late 1980's.
- Sample was reviewed to determine the company of issue, the race of the insured, occupation, rating, and the reason for the substandard rating.

Phase III - Based on companies targeted from the results of the Phase II analysis, a sample of 97 standard issue policies was drawn from the universe of pre-1980 issues still in force as of the late 1980's.
- Sample was analyzed to determine whether the proportion of non-whites in the standard class was consistent with that for the substandard class of policies.

Phase IV - Based on targeted (by company) additional sampling of pre-1966 sub- standard issues in force as of the late 1980's; 284 additional policy files were sampled.
- Process was intended to firm up tentative conclusions reached in the prior Phases of the examination with respect to the companies involved.

Phase V - Based on sampling the balance of the pre-1966 substandard issues in force as of the late 1980's.

Phase VI - Based on sampling of standard policies in force as of August 2002. Focused on companies not targeted in Phases I through V.

D. Conclusion Eighteen companies acquired by Americo Life, Inc., or one of its targeted insurance company holdings, engaged in some form of RBP activity, as defined, between the mid-1930's and 1960.

Introduction

The Texas Department of Insurance (TDI), under the authority of Article 1.15 of the Texas Insurance Code, has requested Actuarial Resources Corporation of Georgia ("the examiners") to perform a special multi-state market conduct examination with respect to the race based pricing activities of certain of the life insurance companies of Americo Life, Inc. Americo Life, Inc. is a Missouri holding company having a 100% ownership of United Fidelity Life Insurance Company which in turn owns the life insurance entities which, together with United Fidelity Life Insurance Company, are the subject of this exam. The companies involved ("the companies") are all members of the Americo Life, Inc. holding company group and directly include United Fidelity Life Insurance Company and it's subsidiary companies, Great Southern Life Insurance Company, National Farmers Union Life Insurance Company, Americo Financial Life & Annuity Insurance Company (f.k.a. The College Life Insurance Company of America) and the Ohio State Life Insurance Company. The companies also includes those companies, or their predecessors in interest, who were acquired by Americo, Inc. or one of its subsidiaries, or whose business was acquired by one of the subsidiary companies of Americo, Inc. through reinsurance. One of the life insurance companies in the Americo, Inc. group, Financial Assurance Life Insurance Company, a 100% subsidiary of the College Insurance Group, Inc. holding company (itself 100% owned by Americo Financial Life and Annuity Insurance Company) was not included for review in this exam. The Work Orders applicable to this examination are enclosed with this Report as Attachment 1.

The purpose of this exam is to determine whether the life insurance business of any of the companies reflected or reflect the use of race based pricing activities by any of the companies at any point in their history. Race based pricing activities are defined as any of the following for purposes of this exam:

1. Limiting the amount, extent, or type of coverage available by race.
2. Charging or collecting higher premiums for life insurance products based on race.
3. Assigning risk classifications based on race.
4. Creating or providing lower dividends, policy benefits, or nonforfeiture benefits based on race.
5. Utilizing distinct policy terms or conditions based on race.

The request by the TDI to perform a special market conduct examination in this area arose pursuant to concerns raised by the National Association of Insurance Commissioners (NAIC) that premium differentials in life insurance rates based on the race of the insured (in particular, African-Americans) existed in/or continued to exist in the marketplace. The concerns expressed by the NAIC were mainly in regard to blocks of business which had been issued many years in the past but also involved a desire to determine whether the practice of varying underwriting requirements or life insurance premiums by race continues to the present. Pursuant to the NAIC's concerns, in 2000 the TDI requested the companies response to an NAIC promulgated questionnaire directed to all life insurance companies to determine which, if any, were or are involved in the

underwriting or pricing of life insurance on a racially distinct basis. Based on the results of the NAIC questionnaire promulgated in 2000, included as Attachment 2, the special market conduct exam which is the subject of this Report was commissioned.

Although the terminology of the 2000 NAIC survey requested information on the companies' underwriting or pricing race based activities, for purposes of this examination the definition of race based activities has been expanded to include any differential in dividends, policy benefits, nonforfeiture benefits, or policy terms and conditions based on race.

Overview and Scope of Examination

The responses of the companies to the 2000 NAIC questionnaire referenced above indicated, at some point in their history, some of the companies had engaged in race based pricing activities. Accordingly, the examiners requested, and were provided with, any and all information in the companies' possession which might bear on the issue of whether any of the companies engaged in race based pricing activities as defined for purposes of this examination. To this end, the examiners were provided over 150 boxes of information collected by the companies as part of their effort to respond to the 2000 NAIC survey and specific requests by the examiners. This information included rate books, agent's manuals, underwriting manuals, policy forms, agency directives, application forms, internal company memos, pricing information, and minutes of board meetings and internal Company meetings relating to underwriting or pricing.

In addition to reviewing the paper files provided by the companies, the examiners also interviewed company personnel familiar with the administrative systems used by the companies and with the underwriting and pricing practices utilized by the companies in an effort to obtain a historical context for any race based pricing activities. It is important to note that the examiners relied on the personnel of the companies to provide them with all rate books, other rate documentation, and all of the information contained in those rate books and rate documentations.

Subsequent to their review of the paper files, the examiners utilized information collected from that review as the basis for the performance of various sampling and statistical analyses in an effort to
further solidify tentative conclusions reached from the review of the paper files. In this regard, an understanding of the administrative systems content and limitations was critical.

Affidavits, signed by an officer of the companies, attesting to the relevance and completeness of the information provided to the examiners are included as Attachment 3.

Reliances

As indicated previously in this Report, this examination covers the race based pricing activities of the companies as they relate to life insurance. The term "life insurance" is

not restrictive and refers to life insurance sold by companies under the labels "industrial life insurance", "monthly debit ordinary (MDO)", "burial insurance", "monthly intermediate ordinary (MIO)", "home service insurance", and "ordinary" insurance. The types of life insurance covered are also not restricted to the marketing methodology employed or to the particular type of insurance sales license under which the product was marketed.

In preparing this Report, we have relied on the accuracy and totality of the information requested, as provided by various personnel of the companies. The information provided included, but was not limited to, the following:

1. Rate book information on the life insurance products of the companies.
2. Other rate documentation information assembled by the companies.
3. Policy file information for any and all policies chosen by the examiners for sampling purposes.
4. Any premium rate methodology information.
5. Various extracts, provided on electronic media and in image format, of the companies' administrative data bases.
6. Various policy forms, including applications, used by the companies.
7. Underwriting manuals and internal company underwriting memos.
8. Agent's training manuals with respect to the business sold by the companies.

9. Internal company memos and documents relating to the pricing of the business of the companies.

10. Minutes of Board meetings and other meetings with respect to the pricing and underwriting practices of the companies.

Limitations

In certain situations limitations of one form or another precluded reaching a 100% accurate conclusion regarding the race based pricing activities of the companies with respect to their life insurance business. These include:

1. The passage of a number of years between the present and the period when the companies had, or potentially had, engaged in race based pricing activities with respect to their life insurance business. Personnel have changed and electronic data files are not readily available. The older historical files contain significantly less information compared to that regarding recently issued insureds.

2. The fact that the companies have, over the years, acquired numerous blocks of life insurance business, either through an assumption reinsurance arrangement or through acquisition of a company. Rate book and pricing information in respect of the business acquired in this fashion tended to be less than complete or unavailable, and lacking in information on the underwriting approach used for the products. Little pricing information

was available to provide insight into the mortality assumptions used in determining premiums, if any.

3. The fact that a number of the companies never explicitly requested information on the race of the applicant on the application forms used by them.

4. The fact that the companies have utilized numerous administrative systems for maintaining their life insurance policies. These systems included Vantage One and Life 70 (the latter being the more complete administrative and accounting system of the two systems used. Information on the companies' policies is contained on one or the other of these systems and sometimes both, making the retrieval of complete information on sampled policies difficult and time consuming.

5. The fact that, over the years, the companies had acquired a significant amount of business through assumption reinsurance or company acquisition and the maintenance of original company codes was incomplete. Attachment 4 summarizes in detail the blocks of business and acquisitions assembled over the years.

6. The legibility and readability of sampling information made available through the electronic imaging and microfiche process.

7. The fact that the various companies utilized different procedures and practices relating to the elimination of ratings on policies originally issued substandard. The mere fact that such ratings may have been eliminated at some point was also problematical.

8. Substandard ratings for paid up policies were, in the majority, non-existent. This is primarily due to the ratings being dropped after a certain number of years or upon the policy becoming paid up. As a result, the number of identifiable substandard (at issue) samples available to the examiners was limited.

9. The fact that most of the companies' issues were ordinary insurance, MDO, or MIO insurance, where adjustments for race were often in the nature of a tabular rating. In many cases, this rating for race may be in addition to ratings which would otherwise be assessed for medical or occupational purposes. For example, a person with medical impairments might be rated Table C, and it would not be possible to determine whether the rating might have been Table B in the absence of that individual being non-white.

Details of Examination

Phase I

As indicated above, a review of the information provided by the companies indicated that all direct business written as well as the business acquired through reinsurance or assumption was ordinary business, MIO business, or MDO business. None of the unsold business issued or acquired by the companies was industrial life business. The examiners' review of the documentation provided by the companies indicated that several companies

appeared to have engaged in race based pricing activities. Attachment 5 lists the companies and documentation obtained by the examiners, included in supporting Attachments 5.1-5.23, in support of this thesis.

The types of race based pricing activities referenced in the documents reviewed by the examiners were:

1. Assigning or increasing a substandard tabular rating solely based on race.
2. Establishing lower non-medical underwriting limits and/or maximum issue limits for non-white insureds.
3. Establishing separate higher premium rates for comparable products for white vs. non-white applicants.
4. Specifically declining to solicit non-white applicants for life insurance.
5. Declining to offer certain ancillary benefits (i.e. waiver of premium and double indemnity) to non-white applicants.
6. Declining to issue coverage to non-white female applicants.
7. Restricting beneficiary selections for non-white applicants.

In the course of the review, the examiners found no instances of policy language varying between policies issued to whites vs. non-whites, no variation in nonforfeiture benefits in respect of whites vs. non-whites, and no evidence of lower dividends or other policy benefits for whites vs. non-whites.

Phase II

In an effort to assemble statistical information to support certain of the documented race based pricing activities alleged above, and to attempt to ascertain a historical time frame during which these procedures were utilized, the examiners determined to extract a sample of substandard policy files on the companies' administrative systems as of 12/31/01. In addition, the examiners requested information from the companies as to the oldest historical date for which an electronic media in force data file of all policy records had been maintained. Although no historical electronic media in force data file was available for any period except the recent past, the companies were able to provide the examiners with information on transactions (deaths, maturities, surrenders) back through "the late 1980's". No information was available on the specific type of transaction (death, maturity, or surrender) and the examiners were informed that information from the Vantage One file transactions could not be made available without significant additional time and effort on the part of company personnel. The only information readily available on transactions for policies administered on Vantage One was from the current in force Vantage One file which retained transactions only for a period of six months from the current date (12/31/01).

As a result, it should be noted that the policies provided as part of this *Phase II* and other sampling efforts represented only a cross section of the companies included in Attachment 4. Not all companies that are either part of the holdings of Americo Life,

Inc. or which were acquired by an Americo Life, Inc. holding were represented in the policies provided by the company.[1]

Overall, over 50 companies, out of the 185 companies whose business was acquired either directly or indirectly by the Americo companies, were represented in the examiners' sampling efforts. It is the examiner's opinion that the substandard business of these companies represents a majority of the substandard business issued prior to 1966 and still in force with one of the Americo Life, Inc. holdings as of the late 1980's.

After reviewing the 12/31/01 in force substandard files, the examiners determined that the vast majority of pre-1966 issues on this file (about 90%) were policies that are being administered on the Life 70 system. Accordingly, it was decided by the examiners not to pursue retrieval of the Vantage One transaction files in respect of pre-1966 substandard issues since the effort would not justify the time and expense (in terms of refining the conclusions of this exam).

During this phase of the examination, the examiners also noted that, for one of the originally targeted companies in *Phase I*, Great Southern Life (GSL), no samples of policies originally issued by GSL prior to 1966 had been forthcoming from the file of transactions occurring between the late 1980's and 12/31/01. This seemed unusual to the examiners in light of the 23 substandard pre-1966 originally issued GSL policies still in

[1] The examiners performed extensive research on all historical rate books, agency directives, and underwriting material retained by the companies in an effort to extract any information with respect to current or acquired companies that may have indicated those companies engaged in race based pricing activities. All companies for which information obtained may have suggested race based pricing activities were included in the sampling process.

force as of 12/31/01. Accordingly, when the examiners requested all transaction files in respect of originally issued GSL policies issued prior to 1966 and in force as of the late 1980's, they were informed that no transaction file is created for policies on the Vantage One system, which included all originally issued GSL in force business (no originally issued GSL business was ever administered on the Life 70 system). Vantage One transactions are only maintained on the active data base for a period of six months and are not thereafter transferred to a separate media transaction for retention.

The information obtained by the examiners on the documentation of race based pricing activities indicated that the broad time frame during which the practices probably were in effect was between 1930 and 1960. Accordingly, the examiners asked the companies to extract and image all available information in respect of a sample of substandard policy files issued by any and all of the companies prior to 1979. The 1979 end point was utilized since the information obtained from the examiners' research appeared to indicate that all race based pricing activities referenced had ceased by 1960 and a few years were added for conservatism. The information imaged generally included the original application, underwriting data (including APS, credit report, underwriting worksheet), death certificate (if applicable), administrative system coding sheet, and general correspondence.

For this *Phase II* analysis, the data base from which samples were drawn included approximately 19,619 substandard policies in force at some time since the late 1980's. These were comprised of the substandard policies in force as of 12/31/01 and substandard

policies contained in the prior referenced transaction files. Attachment 6.1 provides information on the substandard samples drawn by the examiners for *Phase II* of the exam.

The examiners split the issues pre and post-1966 since no evidence was found that race based pricing activities existed beyond the mid-1960's. The examiner's sampled 80% of the pre-1966 substandard issues still in force as of 12/31/01 (483). In addition, 73 substandard issue transaction files for policies issued prior to 1966 were also sampled. For each policy selected, the examiners requested electronic image files of all information in the policy files, most of which had been previously microfiched by the companies.

The examiners noted that the percentage of substandard to total in force business as of 12/31/01 appeared somewhat low (2%) relative to industry standards (5%-6%). A couple of reasons were noted by the examiners for this anomaly. First, substandard policyholders tend to terminate by death or surrender at a faster rate than standard business. This would result in the ratio of substandard business to the total closed block of business declining over the years relative to that at issue for the block.

Second, even though a policy was originally issued on a substandard basis, the current in force record may not so indicate. There are a number of reasons this may be the case. First, the companies may delete the rating once the premium paying period has been completed (i.e. the policy has become paid up). Second, in the case where much of the

current companies' business is acquired either through assumption or acquisition of the company, ratings may be dropped in the course of transferring policy records to the new insurer. Third, a company could have a general administrative internal practice of deleting substandard ratings after a period of time for a policy (even if it is still in effect on a premium paying basis). In effect, the policyholder is deemed to have been standard after so many years. The companies indicate a number of times in letters attached to their 2000 NAIC survey response that "...it is our company policy to eliminate the impact of ratings assigned at the point of underwriting after a period of years". See Attachment 6.2 for a sample letter containing this language. Accordingly, the examiners queried companies' management numerous times as to whether a consistent practice in this regard existed and, if so, at what point in time the ratings were removed. As Attachment 7 indicates, no substantive documented procedure in this regard was made available to the examiners.

The examiners also noted that a substantial percentage (over 98%) of the 12/31/01 in force substandard policies issued before 1980 were still premium paying. This large percentage was most likely caused by the rating not being carried on the administrative system for paid up policies originally issued as a substandard basis. When the companies acquired paid up policies, it is likely that many of the system records acquired did not contain the original rating. It is also possible that the ratings for paid up policies may have been purged over time in the course of converting data from system to system.

In reviewing the imaged files, the examiners focused on, for each policy sample, two areas. The first area was the race of the insured, in an attempt to determine whether, proportionately, non-white insureds constituted a larger portion of substandard issues sampled than whites. Second, by reviewing the image file information on the occupation of the insured, the medical condition of the insured, and other underwriting data, the examiners attempted to determine whether any rating had been added or increased due solely to the race of the insured.

The examiners attempted to extract data on race for both the 87 substandard samples from post- 1966 issues and the 556 samples from the pre-1966 block of substandard issues. The results of that analysis are contained in Attachment 8.

It should be pointed out as part of this Report that race was not carried on the companies' administrative systems so the sampling involved reviewing all documents in the files to ascertain if possible, the race of the applicant. Statistically, about 10% of the sampled substandard files involved non-white insureds, 48% were white, and for the balance (42%) race could not be determined (see Attachment 8).

The results of the examiners' *Phase II* sampling indicated that one of the originally targeted companies from the examiners' *Phase I* analysis, Beneficial Standard Life Insurance Company (BSLIC), appeared to have in fact issued policies to non-whites with a substandard rating based solely on race, as their documented underwriting material

indicated. Attachments 9.1 and 9.2 provide examples of BSLIC's explicit use of race in assigning substandard ratings.

For all of the other originally targeted companies from *Phase I* of the exam, the sampling results were inconclusive for two reasons. First, the sample ended up including relatively few non-white substandard insureds. Second, as stated previously, where a substandard insured is non-white, in many cases the reason for the rating could not be conclusively attributed to race, based on the image file information.

The sampling also revealed concerns that race based rating procedures quite likely had been used by a number of the other companies. The examiners' initial *Phase I* investigation had turned up no documentation to suggest this was the case for these additional companies. The lack of documentation was deemed by the examiners not to have been surprising, given the multiplicity of acquisitions by the companies and the lack of information, outside of rate books, that accompanied these acquisitions. For these additional companies, information on the sample applications, underwriting worksheets, or notes in the file indicated that race based underwriting activities may have been the reason for the rating of the insured. Attachment 10 lists the companies involved and the information contained in the image files, in supporting Attachments 10.1 through 10.3, which lead the examiners to conclude that race based pricing practices were employed by each of the companies.

Phase III

In an effort to determine more definitively whether race based pricing activities actually occurred for companies where such activities were suspected, the examiners decided to extract a sample of standard policies from various companies. The purpose of this sampling process was to determine whether the proportion of non-whites in the standard class mirrored that proportion in the substandard class. The examiners are aware that this proportion may differ naturally if non-whites as a whole constituted a less healthy population than whites. The underwriting process would naturally reduce this variation but probably not completely. However, a drastic differential in these proportions between the standard and substandard classes would give credence to the theory that race was a factor in assigning individuals to the substandard class, especially if other documentation indicated this was the case.

In an effort to keep the additional sampling to a manageable level, this standard class sampling effort was restricted to those companies in the original *Phase II* sampling where the ratio of non-whites to the overall total sample was 50% or more, and there were at least eight samples where race was known. During the course of this sampling, it was determined that a number of standard class policyholders were in fact substandard at the time of original issue. These individuals were excluded from the analysis of this *Phase III* standard sample since they were considered substandard issues at the time of issue.

A total of 97 standard sample policies were drawn and image files requested from the companies. The results of this *Phase III* analysis of standard insureds (where race was

determined), together with a comparison to the *Phase II* analysis, are contained in Attachment 11. The analysis clearly indicates that, for two of the companies involved, BSLIC and Coastal States Life Insurance Company (CSLIC), even though non-whites as a percentage of total substandard insureds was greater than 50%, virtually no standard insureds were non-white.

Image files provided for samples of this *Phase III* analysis also indicated that race was listed as an underwriting factor on the underwriting data sheet for two companies, BSLIC and Victory Mutual Life Insurance Company of Chicago (VMLIC). See Attachments 12.1 – 12.2. For VMLIC, however, the use of race as an underwriting factor was apparently not utilized as VMLIC, based on *Phase II* and *Phase III* samples, appeared to issue only to African-Americans which included both standard and substandard issues.

Phase IV

After further review of the results of the sampling performed in *Phases II* and *III* of this exam, the examiners decided to expand the sampling of pre-1966 substandard issues still in force as of the late 1980's. Most of these additional samples came from the termination files associated with these issues since the *Phase II* sampling had previously sampled the vast majority (80%+) of the 12/31/01 in force pre-1966 substandard issues. This additional sampling was intended to focus on four companies and was driven by the tentative results reached as regards the race based pricing activities of these companies

pursuant to the *Phase I* and *II* activities. For the companies involved - BSLIC, National Investors Life Insurance company (NILIC), Coastal States Life Insurance Company (CSLIC), and VMLIC - the sampling included virtually all remaining pre-1966 substandard issues still in force as of the late 1980's.

The results of this *Phase IV* sampling are included as Attachment 12. For the 284 samples requested, image files were provided by the companies. Of the 284 imaged files, 213 of these files contained application and underwriting information. The remaining files consisted mainly of correspondence between the companies and the policyholder and included no application and underwriting information, and so were not of assistance to the examiners in the relevant aspects of this exam. In addition to the four primary companies intended to be sampled, the companies provided ten image files in respect of substandard policies issued originally by Fidelity Interstate Life Insurance Company (FILIC). This company was acquired by BSLIC and, due to the nature of how issuing companies are coded on the companies' administrative systems, these policies were still coded as BSLIC policies when in fact the policies were issued by FILIC.

As Attachment 12 indicates, about 40% of the BSLIC substandard samples (160 where race was determinable) were non-white. This result is fairly consistent with *Phase II* analysis in respect of BSLIC where about 57% of BSLIC substandard samples were non-white. Virtually no BSLIC policyholders in the *Phase III* standard sampling were non-white (1 out of 33). Accordingly, the results of this additional sampling further confirmed the thesis that BSLIC rated non-white applicants at least one table, Table A,

due to race. In many cases for BSLIC, the agent would submit the application on a Table A basis and indicate that the application being submitted was to be rated based on race. This practice occurred even though medical underwriting had not yet been performed on the applicant.

For FILIC, a company that was acquired by BSLIC, the additional samples (10) indicated five non-white substandard insureds. For all of these, the applicant was in good health (as per the subsequent underwriting) but the agent had submitted the application on a Table A basis and the insured was ultimately rated at the Table A rate. In effect, the procedure utilized was the same as that for BSLIC, the acquiring company, except that race was never explicitly indicated on the application or underwriting worksheet as the reason for the rating in the FILIC cases.

For another company, National Investors Life Insurance Company (NILIC), the additional sampling indicated that race continued to be listed as an underwriting factor on the underwriting worksheet. However, the additional 3 substandard samples were white, and constituted 100% of the additional sampling. This was consistent with the *Phase II* sampling for this company, where all of the substandard issues were white and also with the *Phase III* sample of standard insureds where all of the applicants were white. The examiners, therefore, could find no specific samples of race being used as an underwriting factor even though it is explicitly indicated as being such in NILIC's underwriting worksheet, a fact that indicated that the company engaged in race based pricing activities during the period the worksheet was utilized.

In the *Phase II* sampling, the examiners uncovered handwritten notes that CSLIC used race as a criteria for requesting additional medical information on an applicant. Specifically, this sampling tended to indicate that, although not explicitly indicated in the underwriting material, race was used to request certain additional medical information on the applicant and also that non-white applicants were rated at least one table for race. The *Phase IV* sampling tended to confirm further this theory in that three of the four samples, where sufficient data was provided to the examiners, were non-white. Two of the three non-whites were rated Table A as "Special Class Risks", even though each applicant was apparently healthy and employed in a non-hazardous occupation (see Attachment 12.1 for an example of this situation).

The final company for which substandard samples were drawn for *Phase IV* was VMLIC. Both the *Phase II* and *Phase III* sampling strongly indicated that this company issued exclusively to African-Americans. The *Phase IV* sample tended to confirm this theory in that all 36 samples, where race could be determined, the race was non-white (in this case, African-American).

Phase V

Upon further review of the substandard samplings performed in Phases II and IV of this exam, the examiners decided to sample the remainder of the pre-1966 substandard

policies provided by the companies. Out of the 1,206 substandard policies issued pre-1966 provided, 840 were sampled in Phases II and IV of the exam, which left the remaining 366 to be sampled in Phase V. Of these 366 samples, 20 were found to be non-white, but none were determined to be rated due to the race of the insured (see Attachment 13).

A summary of the racial distribution for all of the substandard samples reviewed in Phases II, IV, and V of this exam is included as Attachment 14. As this Attachment indicates, 152 (17% of the samples where race was found) of the samples were found to be non-white. Of these 152 non-white samples, 14 were determined by the examiners to be rated due to the race of the insured (see Attachments 15 and 15.1). Of the 14 policies determined by the examiners to be rated because of race, 6 (all of the in force policies contained in the 14) policies were premium paying.

Phase VI

In an effort to determine whether additional companies, other than those identified in the prior Phases of this examination, had engaged in race based pricing activities and whether policies originally issued substandard had been initially rated based on race and were now classified as standard, the examiners decided to draw 500 samples of August 2002 in force standard policies issued pre-1950 by companies not previously identified as having engaged in race based pricing activities. Because of the difficulty in extracting specific companies from the August 2002 in-force data base, it was possible that some of the

companies included in this sample would overlap with some of the prior target companies, but such overlap was not felt to be significant.

The 500 samples were drawn from the ordinary standard policy in-force data base as of August 2002. The examiners were provided electronic copies of the available information in the Company's files with respect to the requested samples. Applications were available in this format for 298 of the samples requested and race was identifiable in respect of 272 of the samples, through the applications, underwriting worksheets, death certificates, or other information contained in the electronic data files. A breakdown of the 500 samples, including a breakdown by race for the 272 situations where it is identifiable, is contained in Attachment 16.

For five of the samples where the policy was classified as standard as of August 2002, the examiners found the policies were originally issued on a substandard basis. See Attachment 16. A review of these files indicated that, except in one situation, the policy was not issued substandard based on the race of the insured. For the situation where the policy was apparently rated due to race, the issuing company was National Educators Life Insurance Company, a company not identified in any of the prior Phases of this examination as having engaged in race based pricing activities. See Attachment 17.1.

In addition to identifying those policy samples that had been issued substandard, the examiners reviewed the electronic files for the remaining samples to determine whether

there was any indication that race may have been a consideration in the issue or rating of the policies involved. As a result of this analysis, the application or underwriting worksheets of five additional companies appeared to indicate that race was potentially a significant underwriting consideration. See Attachments 17.2 to 17.6.

One of the five companies, Pyramid Life Insurance Company, had been identified as having engaged in race based pricing activities as a result of documents reviewed in an earlier Phase of this examination. It should be noted that none of the current samples drawn in respect of this company had been indicated as being issued to non-whites, although race was identifiable in virtually all of the sample files drawn. See Attachment 17.2.

For College Life Insurance Company and University Life Insurance Company (part of the same holding company), both companies from which substandard samples had been drawn in the prior Phases of the examination, the electronic files provided in this Phase of the examination indicated, as had the previous samples, that race was treated as an "Irregularity" in the underwriting process. See Attachments 17.3 and 17.4. The examiners had concluded from the previous sampling that the presence of this information on the underwriting worksheet did not imply that the information was used as a basis for race based underwriting activities. However, to confirm or refute this conclusion, the examiners went back to the prior samples drawn for these companies and reviewed the underwriting information in respect of the one substandard non-white insured contained in that sampling. It was confirmed that this non-white insured had

been rated substandard for a medical condition and not because of race. Accordingly, the examiners concluded that these companies should not be included as having engaged in the practice of race based pricing.[2]

For the remaining companies for which questions arose as to potential race based pricing activities as a result of this Phase VI sampling activity (Oklahoma Life Insurance Company and Texas State Life Insurance Company), the examiners' review of the applications and underwriting worksheets in respect of the samples drawn indicated that race was used in the underwriting process. See Attachments 17.5 and 17.6. These companies had not been identified as having engaged in any race based pricing activities in the prior Phases of this examination since no substandard issues remained in force in respect of these companies as of August 2002 and no rate book or other underwriting material had been located during the course of the on site examination.

During the course of this Phase of the examination, the examiners also noted that the August 2002 pre-1966 issues in force data base provided, contained a number of situations where the issue age and date of birth of the insured indicated the possibility that policies may have been issued substandard using a rated up age at issue. Accordingly, it was decided to examine 56 policies whose data base record contained this apparent anomaly. This particular sampling excluded prior companies targeted as having

[2] The fact that race was deemed an "Irregularity" on the underwriting worksheet of the companies was not, in the absence of additional supporting evidence, deemed by the examiners strong enough "prima facie" evidence that the companies engaged in race based pricing activities.

performed race based pricing activities and also policies with an issue age of 10 or 15, which was likely to have been the minimum issue age available for premium rates.

This analysis indicated that the vast majority of these 56 policies were issued on either a joint basis or were family policies, explaining why the date of birth was not consistent with the issue age shown on the data base. However, this additional sampling did reveal one currently standard policy that had been issued substandard to an African-American insured who had been rated based on race. See Attachment 18. The company involved was General Life Insurance Company of America, a company which had not been previously identified as having engaged in any race based pricing activities since no rate books or underwriting material had been previously made available and prior sampling had not included this company.

In summary, this Phase of the examination produced data that indicated four companies in addition to those identified in previous Phases of this examination had engaged in race based pricing activities or underwriting practices.

Conclusions/Summary of Findings

As stated previously in this Report, the purpose of this special examination is to make a determination of whether the life insurance business of any of the companies, which are the subject of this Report, reflected the use of race based pricing activities by the

companies at any point in their history. This section of the Report attempts to document the conclusions the examiners have reached in this regard and the rationale for those conclusions. The findings of this examination are as follows:

1. The examiners analysis indicated documentation and/or statistical evidence supporting the theory that a number of the companies at some point in the past and for some period of time engaged in the race based pricing activities described in items 1., 2., and 3. of the Introduction section of this Report. Support for this conclusion is provided in Attachments 5, 9.1-9.2, 10, 11, 11.1-11.2, 12.1, 17.1-17.6, and 18 of this Report.

2. The period of time during which a particular company engaged in the race based pricing activities alluded to varied with the company but all such activities appeared to have ceased with respect to new issues by approximately 1960. A summary of the companies involved, the race based pricing activity in which each company engaged, and the estimated period of time the examiners determined these activities occurred with respect to each company are shown in Attachment 19.

3. The specific race based pricing activities involved were:

i. Assigning or increasing a substandard tabular rating solely based on race.

ii. Establishing lower non-medical underwriting limits for non-white insureds.

iii. Establishing separate higher premium rates for comparable products for white vs. non-white applicants.

iv. Specifically declining to solicit non-white applicants for life insurance.

v. Declining to offer certain ancillary benefits (i.e. waiver of premium and double indemnity) to non-white applicants.

vi. Declining to issue coverage to non-white female applicants.

vii. Restricting beneficiary selections for non-white applicants.

4. Attachments 5, 9.1-9.2, 10, 11, 11.1-11.2, 12.1, 17.1-17.6, and 18 of this Report illustrate the various procedures used by the companies involved.

5. The race based pricing activities typically involved all life insurance plan types issued by the companies affected during the period the activities were in effect.

6. The examiners found no evidence that any of the companies engaged in the race based pricing activities described in items 4. and 5. of the Introduction section of this Report.

Recommendations

Pursuant to the Conclusions/Summary of Findings section of this Report, the examiners recommend the following program of remediation.

The program would apply to all substandard policies issued prior to 1961 and in force as of 12/31/59 by the companies referred to in Attachment 19 where the insured was or is non-white. Upon production of the policy, or equivalent, and confirmation of eligible status, remediation would be set in an amount equal to 25% of the face amount of the policy, accumulated with interest from the date of death, maturity, or surrender to 6/30/05. For insureds in force as of 6/30/05, remediation would be in the form of an increase in face amount of the policy of 25%.[3]

This exam has been performed in accordance with any guidelines and procedures established for such exams by the NAIC Race Based Premium Working Group. Pursuant to those guidelines and procedures, the exam was a multi-state exam conducted on behalf of all states but with particular co-ordination between the TDI and the 2000 top four premium income states (plus Florida) of the targeted Americo, Inc. life insurance holdings. The 2000 top four premium income states with respect to each of the targeted companies are shown in Attachment 20.

Attachment 21, provided and based upon an analysis performed by TDI personnel, indicates the top premium states based on a review of historical annual statements for the companies listed in both Attachment 19 and Attachment 20. The count indicates the number of times a state was included in the top of 5 states based on premium. For companies listed in Attachment 19, the earliest available annual statement for each company was reviewed. For companies listed in Attachment 20, the 2000 annual statement for each company was reviewed.

Respectfully submitted,

John A. MacBain, FSA, MAAA
Actuarial Resources Corporation
2753 State Road 580, Suite 101
Clearwater, FL 33761
Phone: 727-726-318
Fax: 727-791-4707
E-mail: john.macbain@arcga.com

[3] The recommendation of a 25% face amount increase is consistent with a Table A substandard rating, a rating in prevalent use as a rating for race by the companies identified by the examiners as having engaged in race based pricing activities.

Americo Life, Inc.
TDI Race Based Premium Exam
Summary of Race Distribution Based on Phase II, IV & V Samples

Attachment 14

Issuing Company	Sample Policies					
	Race: White		Race: Non-white		Race: Unknown	TOTAL
	Number	% [1]	Number	% [1]	Number	Number
American Pacific Life	0	--	0	--	1	1
American Preferred LIC	0	0%	1	100%	0	1
American Republic Life	0	--	0	--	1	1
Beneficial Standard LIC	132	58%	97	42%	6	235
Carolina Home	1	100%	0	0%	0	1
Central National LIC of Omaha	4	100%	0	0%	1	5
Charter National LIC	0	--	0	--	1	1
Coastal States LIC	5	42%	7	58%	0	12
College LIC of America	249	97%	8	3%	13	270
Empire LIC	1	100%	0	0%	5	6
Farm and Ranch Life	1	100%	0	0%	0	1
Fidelity Interstate LIC	7	50%	7	50%	2	16
Fidelity Standard	2	67%	1	33%	0	3
Financial Assurance	1	100%	0	0%	0	1
First Equity Life	1	100%	0	0%	0	1
First Pyramid LIC of America	11	100%	0	0%	0	11
FL State Life and Health	0	0%	1	100%	0	1
Great Plains LIC	3	100%	0	0%	0	3
Great Western LIC	3	100%	0	0%	0	3
GSL	20	87%	3	13%	0	23
Guardian	2	100%	0	0%	0	2
Guardsman LIC	6	100%	0	0%	34	40
Integrated Resources LIC	0	--	0	--	1	1
Investors Guaranty	0	--	0	--	1	1
Kennesaw Life & Accident IC	7	88%	1	13%	0	8
Lee National LIC	1	25%	3	75%	0	4
Life of Mid-American IC	9	100%	0	0%	0	9
Lincoln National LIC (BSLIC)	1	100%	0	0%	0	1
Loyalty LIC	0	--	0	--	1	1
National College & University LIC	1	100%	0	0%	0	1
National Educators LIC	15	75%	5	25%	2	22
National Executive LIC	2	100%	0	0%	0	2
National Investors LIC	58	100%	0	0%	9	67

Americo Life, Inc.
TDI Race Based Premium Exam
Summary of Race Distribution Based on Phase II, IV & V Samples

Attachment 14

Issuing Company	Sample Policies					
	Race: White		Race: Non-white		Race: Unknown	TOTAL
	Number	% [1]	Number	% [1]	Number	Number
National Life Assurance Co. of Ca	5	100%	0	0%	0	5
National Underwriters LIC	1	100%	0	0%	0	1
NFU	27	96%	1	4%	7	35
Ohio LIC	2	100%	0	0%	0	2
OSL	40	100%	0	0%	95	135
Presidential	0	--	0	--	1	1
Puritan LIC	17	94%	1	6%	11	29
Pyramid LIC	21	100%	0	0%	2	23
Security Benefit	0	--	0	--	1	1
Southern Christian LIC	1	100%	0	0%	0	1
Southern Equitable	1	100%	0	0%	0	1
Southern States LIC	5	83%	1	17%	0	6
State Life and Health IC	2	100%	0	0%	0	2
UFL	7	88%	1	13%	6	14
University LIC of America	11	100%	0	0%	11	22
Valley Forge LIC	0	--	0	--	2	2
Victory LIC	35	100%	0	0%	4	39
Victory Mutual LIC of Chicago	0	0%	51	100%	6	57
Unknown [2]	2	67%	1	33%	159	162
Total	720	79%	190	21%	383	1,293

(1) Percentages based on the samples where race had been identified.
(2) Insufficient data provided for requested samples.

Americo Life, Inc.
TDI Race Based Premium Exam
Summary of Potential Race Based Pricing Activities

Attachment 19

Issuing Company	Estimated Date/Era	Race Based Pricing (RBP) Activity [1]	Phase(s) RBP Activity Identified
Acme	1935 - 1954	B, C	1
Beneficial Standard LIC	3/1/1949-1960	A, B, C	1, 2, 4
Carolina Home Life	1945	B	1
Coastal States LIC	1954	B	2, 4
Fidelity Interstate LIC	1959	B	4
General LIC of America	1954	B	6
Great Southern Life	1936 - 1955	A, B	1
Lee National LIC	5/1/1929	A	1
Maryland LIC	1939 - 1948	A	1
National Educators LIC	1942	B	6
National Investors LIC	1963	B	2
Nat'l Masonic Provident	1934	B	1
Ohio State Life	1932 - 1948	B	1
Oklahoma LIC	1928	B	6
Pyramid	1931 - 1939	B, C	1, 6
Texas State LIC	1938 - 1947	B	6
United Fidelity Life	1933 - 1956	A, B, C	1
Victory LIC	1948	A	1

(1) Race based pricing activities utilized by the companies include the following:

A. Limiting the amount, extent, or type of coverage available by race.
B. Charging or collecting higher premiums for life insurance products based on race.
C. Assigning risk classifications based on race.

EXHIBIT B

(Notice to In-Force Policyholders)

[Date]

John W. Doe
123 Fourth St.
Anytown, Anystate 12345

Re: Policy No. 1234567
"Eligible Company," part of the The Life Insurance Companies of Americo Life, Inc.
Increased Death Benefit $ _____

Dear Mr. Doe:

As part of a multi-state regulatory settlement with insurance regulators, **"Eligible Company," part of the The Life Insurance Companies of Americo Life, Inc.** has adjusted the death benefits and surrender benefits of certain in-force life insurance policies. As a result of this review, the death benefit under your policy has been increased to the amount shown above. The increase in your death benefit also results in an increase in the surrender value under your policy. More information about your enhanced surrender value is available by calling [Number]. If you call, please be sure you have the policy number shown above available.

No action on your part is required at this time. Please keep this letter with your policy.

Sincerely,

[Name]
[Title]

Exhibit B

EXHIBIT C

(Notice to Policyholders of Additional Surrender Benefits)

John W. Doe
123 Fourth St.
Anytown, Anystate 12345

[Date]

Re: Policy No. 1234567
"Eligible Company," part of the The Life Insurance Companies of Americo Life, Inc.
Increased Death Benefit $ _____

Dear Mr. Doe:

As part of a multi-state regulatory settlement with insurance regulators, **"Eligible Company," part of the The Life Insurance Companies of Americo Life, Inc.** has increased the surrender benefits under certain life insurance policies that were terminated by cash surrender between January 1, 1960 and **Effective Date**.

According to our records, you were the owner of the above numbered policy at the time it was terminated by cash surrender and as such, you are entitled to receive an additional surrender benefit in the amount shown above. A check for the additional surrender benefit is enclosed.

Sincerely,

[Name]
[Title]

Enclosures

Exhibit C

EXHIBIT D

(Notice to Beneficiaries of Additional Death Benefits)

[Date]

John W. Doe
123 Fourth St.
Anytown, Anystate 12345

Re: Policy No. 1234567
"Eligible Company," part of the The Life Insurance Companies of Americo Life, Inc.
Increased Death Benefit $ _____

Dear Mr. Doe:

As part of a multi-state regulatory settlement with insurance regulators, **"Eligible Company," part of the The Life Insurance Companies of Americo Life, Inc.** has increased the death benefits under certain life insurance policies that were terminated by the death of the insured between January 1, 1960 and **Effective Date**.

According to our records, you were a beneficiary of a claim filed under the above numbered policy and as such, you are entitled to receive an additional death benefit in the amount shown above. A check for the additional death benefit is enclosed.

Sincerely,

[Name]
[Title]

Enclosures

Exhibit D

Exhibit E

Claims Made Website

Texas Department of Insurance

Race-based Pricing Web Resource Page

List of settlements

[forthcoming]

Summary statistics and claims figures

[forthcoming]

FAQs

[forthcoming]

TDI negotiating race-based pricing settlements

Since 2000, the Texas Department of Insurance and a number of other state insurance departments have been investigating a large number of life insurance companies to determine whether any of them historically have charged non-white individuals more in premium than similarly situated white individuals, a practice known as race-based pricing. While the TDI has determined that the race-based pricing ceased altogether regarding the sale of new policies in the early 1970s, premiums currently being collected or death benefits paid on old policies issued before the early 1970s may not have been adjusted to eliminate the effects of this practice.

As a result of these investigations, the TDI along with several other states are the lead negotiators in a multi-state effort to settle claims against insurers who they believe may have historically engaged in race-based pricing. The policies involved are commonly known as industrial premium policies, small-amount life policies, industrial life and burial policies, or penny policies. Typically, these policies provide life insurance coverage. However, they might also provide accident and health or disability coverage.

The TDI has established this website in order to assist individuals who believe that they may be eligible for additional benefits pursuant to one of the settlements negotiated by the TDI. If you have one of these policies or are the beneficiary of such a policy, you might be entitled to refunds, additional free insurance, or a cash payment, even if the policy has already been terminated. To determine whether your

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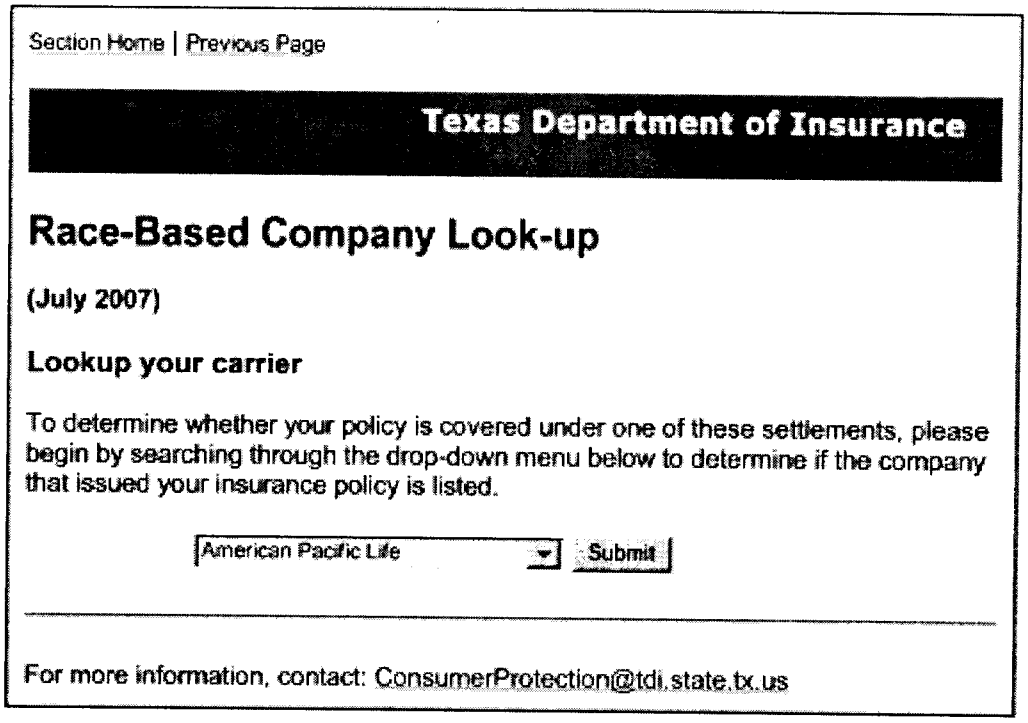
- Online Fraud Reporting for Insurance Companies

policy is covered under one of these settlements, please begin by searching through the drop-down menu below to determine if the company that issued your insurance policy is listed. If so, simply click on the company's name, and click the go button next to the drop-down menu.

Lookup your carrier

For more information, contact: ConsumerProtection@tdi.state.tx.us



Section Home | Previous Page

Texas Department of Insurance

Race-Based Company Look-up

(July 2007)

Lookup your carrier

To determine whether your policy is covered under one of these settlements, please begin by searching through the drop-down menu below to determine if the company that issued your insurance policy is listed.

American Pacific Life Submit

For more information, contact: ConsumerProtection@tdi.state.tx.us

Previous Page | Consumer Protection Home

Texas Department of Insurance

American Pacific Life Resource Page

General Information | Eligibility Provisions | Additional Benefits | Claim Instructions | Contact Information

General Information

In 2000, the Texas Department of Insurance (TDI) conducted a survey of a number of life insurance companies inquiring whether any of them had ever engaged in race-based pricing. Neither the survey nor a multi-state examination report conducted by the TDI after reviewing the survey found that the companies in question had engaged in any race-based pricing since 1960. However, the examination concluded that some of the companies may have engaged in race-based pricing prior to 1960.

The companies maintain that they have never violated any insurance or other law or regulation of any state related to race-based pricing, but have agreed to provide certain additional benefits to non-white policyholders or their beneficiaries with regard to certain policies issued prior to 1960 in an effort to conclude with finality all regulatory allegations involving the impact of race on life insurance underwriting, sales, pricing or policy benefits. In order to memorialize this commitment, the companies in question have entered into a multi-state settlement agreement with the TDI and the insurance departments from a number of other states.

The TDI has established this website in order to assist individuals who believe that they may be eligible to receive additional benefits pursuant to the terms of the settlement. Here you will find a variety of information related to the settlement, including:

- **Am I eligible?** For a detailed description of which insurance policies are eligible for increased benefits under the settlement, click here: Eligibility Provisions.
- **If I am eligible, what benefits will I receive?** For a description of the additional benefits offered by the participating companies with regard to the eligible policies, click here: Additional Benefits
- **If I am eligible, how do I make a claim?** For step-by-step instructions regarding what you will need to do if you believe you are eligible for such benefits, click here: Claim Instructions
- **Who do I contact for more information?** If you need contact information to contact the companies directly with additional questions, click here: Contact Information.

Eligibility Provisions

In order to be eligible for additional benefits under the settlement agreement, an "eligible policy" must meet ALL of the following six (6) criteria:

1. The policy was issued by American Pacific Life.

2. The policy was issued with a "substandard" rating. "Substandard" means that the insured policyholder was charged an extra premium for anticipated higher than standard mortality.
3. The policy was issued to an individual who was not white.
4. The policy was issued prior to 1960 and remained in force during or after 1960.
5. The issuing company has not previously provided additional benefits to the policyholder or beneficiary related to the pricing of the policy.
6. The policy was either issued in a state that is a party to the settlement or was issued to a person who either currently resides in a participating state or was living in a participating state at the time the policy was terminated for any reason, including death.

If you have additional questions about the eligibility requirements, please call **1-888-386-0106**.

Additional Benefits

The benefits provided by the companies vary depending on whether a particular eligible policy is currently in force (meaning that the person whose life is insured by the policy is still living and someone is still being charged annual premiums for the policies), or whether the eligible policy has already terminated as a result of the death of the insured person or any other surrender of the policy, including discontinuation of premium or endowment payments.

Benefits for In-Force Eligible Policies

If an eligible policy is still in force the company issuing the policy will increase the face value of the policy by 25% upon submission of a properly completed and signed claim form. To fill out a claim form, click here for the PDF version of the claim form.

Benefits for Terminated Eligible Policies

If an eligible policy has terminated as a result of the death of the insured person or any other surrender of the policy, including discontinuation of premium payments or endowment, the company issuing the policy will make a cash payment equal to 25% of the amount paid upon the termination of the policy. This cash payment will be made to the policy owner (if living) or to the appropriate beneficiary or beneficiaries of the policy upon receipt of a properly completed and signed claim form. To fill out a claim form, click here for the PDF version of the claim form.

ANY CLAIM FOR BENEFITS MUST BE FILED WITH THE APPROPRIATE COMPANY BY **[INSERT DATE 48 MONTHS FROM THE EFFECTIVE DATE]**.

If you have additional questions about the benefits paid for eligible policies, please call **1-888-386-0106**

If you would like more information about the TDI, or the insurance department of any other state participating in the settlement, please select the appropriate state from the following list.

- California
- Florida
- Georgia
- Ohio
- Texas

Claim Instructions

If you believe that you either own or are the legal beneficiary of a policy that is eligible for benefits under the settlement (click here for a description of eligibility requirements), you will need to complete the claim form available here. Once you have printed, completed, and signed the claim form, please mail it to the address indicated on the bottom of the claim form.

If you have any questions about how to complete a claim form, or if you have already submitted a claim form and have additional questions, please call **1-888-386-0106**.

Contact Information

To contact the company directly, please call **1-888-386-0106** or write:

American Pacific Life
RE: Multi-state Race-based Pricing Settlement
P.O. Box 410288
Kansas City, MO 64141-0288

Exhibit F

Claims Made Form

CLAIM FORM

To claim "Additional Benefits" hereunder the claimant must certify that the insured was not a white person. If the insured was white you are not entitled to any benefits and you may not submit this application.

Name of Insurance Company:

1. Claim for Additional Benefits under Regulatory Settlement

Name of Claimant	Home Phone: ( )	Work Phone: ( )
Address (include City, State, and ZIP)		

2. Claim for Increased Death Benefits

If you are claiming increased death benefits as a policyholder of a policy which is in force please provide as much of the following information as possible:

Name of Policyholder	Policy Number	Social Security # of Policyholder
Name of Insured (if different from Policyholder)		Date of Birth of Insured
Address of Policyholder (include City, State, and ZIP)		
Date on which Policy was issued	Face amount of Policy	Relationship of Claimant to Policyholder (if different)

Please attach any supporting documents you may have, such as correspondence with the Company, check vouchers, premium receipt books, etc.

3. Claim for Additional Death Benefits

If you are claiming additional death benefits as a beneficiary (or the heir of a deceased beneficiary) of a policy under which a death claim has already been filed and a death benefit has already been paid, please provide as much of the following information as possible:

Name of Insured	Date of Birth of Insured	Policy Number	Social Security # of Insured
Address of Insured at time of death (include City, State, and ZIP)			
Name of Beneficiary	Relationship of Claimant to Beneficiary		Social Security # of Beneficiary
Amount of Death Benefit	Claim No.		Date on which original death benefits were received

Please attach any supporting documents you may have, such as premium receipt books, correspondence with the Company, check vouchers, copies of insured's death certificate, etc.

4. Claim for Additional Surrender Benefits

If you are claiming additional surrender benefits as a policyholder (or the beneficiary of a deceased policyholder) of a policy which has already been surrendered and a surrender benefit has already been paid, please provide as much of the following information as possible:

Name of Policyholder	Policy Number	Social Security # of Policyholder
Address of Policyholder at time of surrender (include City, State, and ZIP)		
Name of Insured (if different from Policyholder)	Date of Birth of Insured	Relationship of Claimant to Policyholder
Date on which Policy was surrendered	Amount of Surrender Benefit received	Date received

Please attach any supporting documents you may have, such as correspondence with the Company, check vouchers, premium receipt books, etc.

5. Certification *(This section must always be completed)*

The Claimant hereby certifies that the person whose life is/was insured under the policy described above is/was (check one):

☐ **African-American** ☐ **Native American** ☐ **Other non-white: (Describe)** _____

Our ability to identify the policy under which you are claiming benefits is dependent upon the amount of information we have. It is therefore in your best interest to supply as much of the information requested in this form as possible, and to furnish as much supporting documentation as possible.

Fraud Warning: In many states, presenting a false or fraudulent claim for the payment of benefits is a crime, subject to civil and/or criminal penalties. See the attached list for the required fraud warning for your state.

I hereby represent that the above information is true and correct to the best of my knowledge and belief.

_____ _____

Date Signature of Claimant

Be sure to sign this form. We cannot process this form without your signature. Send the completed, signed form, together with all supporting documentation to the following address: [Insert Name of Insurer], Attn: Operational Compliance Dept., PO Box 410288, Kansas City, MO 64141-0288.

07-221-1

ADDITIONAL FRAUD STATEMENTS

The following is required to appear on this form by several states other than those listed below. It is a crime to complete this form so as to knowingly omit important facts or to include answers which I know are false. Each state may provide different penalties for violation of its laws.

The following is required to appear on this form by Alaska. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The following is required to appear on this form by Arkansas. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The following is required to appear on this form by Arizona. For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

The following is required to appear on this form by California. For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The following is required to appear on this form by Colorado. "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies."

The following is required to appear on this form by District of Columbia. Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The following is required to appear on this form by Delaware. Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

The following is required to appear on this form by Florida. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

The following is required to appear on this form by Idaho. Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

The following is required to appear on this form by Indiana. A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

The following is required to appear on this form by Kentucky. Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

The following is required to appear on this form by Louisiana. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The following is required to appear on this form by Maine. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

The following is required to appear on this form by Minnesota. A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

The following is required to appear on this form by New Hampshire. Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

The following is required to appear on this form by New Jersey. "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

The following is required to appear on this form by New Mexico. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

The following is required to appear on this form by New York. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The following is required to appear on this form by Ohio. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The following is required to appear on this form by Oklahoma. "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

The following is required to appear on this form by Pennsylvania. "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

The following is required to appear on this form by Tennessee. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The following is required to appear on this form by Texas. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The following is required to appear on this form by Virginia. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The following is required to appear on this form by West Virginia. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Exhibit G

Unclaimed Benefit Search Protocol

1. Upon receipt of notification of the death of an insured, the Companies shall compile the most complete information available on the deceased insured, utilizing the documentation submitted with the death claim, such as the death certificate, premium receipt books, etc., together with information available from the application and other related sources, to include, to the extent available:

a) Name;
b) Date of Birth;
c) Sex;
d) Social Security Number; and
e) Address, including Zip Code.

2. With the accumulated information about the deceased insured, the Companies shall then perform a search of their files and records in an effort to locate additional policies that may cover the deceased insured. The name of the deceased insured, including nicknames, aliases, maiden names or first name initials, all of which are requested on the Companies' claim forms, is searched as follows:

a. If the first, middle and last names are full names (e.g., Robert Louis Stevenson), or if the first last names are full names and the middle name is an initial (e.g., Robert L. Stevenson), the first and last names are searched with no limitation as to address, date of birth, gender, etc. For example, if the Companies are searching for policies on a deceased insured Robert Louis Stevenson, the initial search would identify all policies on which Robert Stevenson, Robert L. Stevenson or Robert Louis Stevenson is listed as the insured, i.e., all middle names or initials would be included.

b. For the policies identified under 2(a), comparisons are then made of the dates of birth, social security numbers (if available) and sex indicators. If, using the foregoing indicators potential matches are found, those policies are subject to further review.

c. For the policies identified as potential matches under 2(b), addresses with Zip Codes, if available, are used to further verify matches.

Exhibit G