Attachment A

Draft: 6/3/25

Market Regulation and Consumer Affairs (D) Committee
Virtual Meeting
April 30, 2025

The Market Regulation and Consumer Affairs (D) Committee met April 30, 2025. The following Committee members participated: Dean L. Cameron, Chair (ID); Trinidad Navarro, Co-Vice Chair (DE); Scott Kipper, Co-Vice Chair (NV); Alan McClain represented by Teri Ann Mecca (AR); Peter M. Fuimaono represented by Elizabeth Perri (AS); Holly W. Lambert (IN); Sharon P. Clark (KY); Robert L. Carey (ME); Angela L. Nelson represented by Jo A. LeDuc (MO); Mike Causey represented by Robert Croom (NC); D.J. Bettencourt represented by Joan Lacourse (NH); Carter Lawrence (TN); Cassie Brown represented by Leah Gillum (TX); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted Its Spring National Meeting Minutes

Commissioner Kipper made a motion, seconded by Commissioner Clark, to adopt the Committee's March 27 minutes (*see NAIC Proceedings – Spring 2025, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Heard a Presentation on Consumers' Need for Help Finding Insurance Agents/Brokers

Director Cameron said the concept of an NAIC consumer-facing agent/broker search tool arose from an Improper Marketing of Health Insurance (D) Working Group discussion. The development of the tool became part of the NAIC's Marketing of Insurance Strategic Regulatory Priority in 2023 and 2024. Director Cameron said an initial prototype was provided to the Working Group's parent group, the Antifraud (D) Task Force, at the 2024 Summer National Meeting.

Harry Ting (Health Care Consumer Advocate) said it is important for consumers to find ethical, knowledgeable insurance producers and advisors for all lines of insurance. Dr. Ting said there are no good tools to help consumers find appropriate insurance producers, and consumers can be harmed if they begin working with a producer that is misrepresenting products. He said some producers misrepresent health insurance products to consumers, and some consumers purchase the wrong policy for their needs. Dr. Ting said some producers fail to provide consumers with the proper guidance to understand what coverage they need.

Dr. Ting said state insurance regulators should help consumers be informed, and an important step in achieving this goal is to provide information on producers' credentials and company appointments. This would provide consumers with information about the companies a producer represents. Dr. Ting said it is important to disclose serious disciplinary actions to consumers. He said it is difficult to find information on state insurance department websites.

Dr. Ting said the Financial Industry Regulatory Authority's (FINRA's) BrokerCheck provides similar information on investment advisors and brokers. He said BrokerCheck is a good model of an online search tool and information sharing that is helpful to consumers. Dr. Ting said the NAIC could produce a similar tool for consumers to find information on insurance producers. He said the tool could include background information on producers and certain producer certifications, such as the ability to sell Medicare products. The tool could also allow consumers to search for producers if they do not have a specific producer for which to search. Dr. Ting said the tool could provide information on producers who have had serious disciplinary actions taken against them in any state and provide consumers with links to State Health Insurance Assistance Program (SHIP) counseling programs.

Dr. Ting said the NAIC is the correct organization to provide this service to consumers. He said that the NAIC directing consumers back to individual state websites is not the best solution because the NAIC can provide: 1) consistent, consumer friendly terminology; 2) information on serious disciplinary actions taken across the U.S.; 3) the ability to search producers even if consumers do not have a producer's name; and 4) links to SHIP counseling programs.

Dr. Ting said that the NAIC would not violate state-based regulations by providing this tool. Regarding liability concerns that have been raised, Dr. Ting said the NAIC Uniform Producer Licensing Application includes an attestation through which a producer applicant gives permission for information to be shared and releases organizations receiving the application from any liability related to sharing information from the producer's application.

Dr. Ting said the NAIC prototype does not provide the functionality needed to help consumers. Commissioner Navarro agreed and added that the current design is insufficient.

3. Heard a Presentation on FINRA's BrokerCheck

Gary Lisker (FINRA) said BrokerCheck is a web-based tool consumers can use to find information on securities investment advisors and brokers. Lisker said consumers can find information by conducting a "name search" and then can narrow the search by entering a city, state, or ZIP code. Lisker demonstrated a search that provided results regarding the registration status of the searched name. Lisker said BrokerCheck uses different shading/coloring, which allows a consumer to quickly identify whether a person is currently registered and whether there are enforcement actions. For example, Lisker said a gray background means the person was previously registered, and a red background means the person has been barred from the securities industry by either FINRA or the U.S. Securities and Exchange Commission (SEC). Lisker said a consumer can also see the years of experience the person has.

Lisker provided an overview of FINRA's "summary page" for an individual. This page provides registration information, a primary business address, firm association, disclosures (if any), years of experience, states in which a person holds registrations, and different firms a person has worked for during their career. Lisker said consumers can also generate a printable PDF report. Lisker presented how consumers can obtain disclosure information, allegations of misconduct, and regulatory actions on BrokerCheck. Lisker said investment advisors and brokers are offered an opportunity to file a comment to provide their position on the displayed information, which is also made available on BrokerCheck. Lisker said all disclosures are included so consumers can make informed decisions regarding conducting business with individuals.

In addition to "name search" capabilities, Lisker said BrokerCheck provides consumers with a "location search," which allows a consumer to enter a ZIP code and receive a list of investment advisors and brokers conducting business there.

Lisker said one of the challenges with BrokerCheck is not to provide a consumer with too much information. Because of this, Lisker said BrokerCheck lists the most important information, such as whether the person is licensed and the FINRA registrations the person holds, at the top of search results. Lisker said most consumers look at individual profiles on BrokerCheck rather than firm profiles. Lisker said BrokerCheck will display whether a person was previously registered with a firm that was expelled from the industry and why the firm was expelled.

Lisker provided an example of a person who was barred by FINRA for selling fraudulent corporate promissory notes and then moved laterally to another financial services industry. Lisker said the individual engaged with consumers who had no idea FINRA had barred him. Lisker said these consumers probably would not have trusted

this individual had they known about FINRA barring him. Lisker said consumers can make better decisions if more information is made available to the public.

In response to questions from Superintendent Carey regarding the source of information displayed on BrokerCheck, Lisker said the information comes from uniform registration forms individuals submit as part of the registration process and from FINRA's Central Registration Depository (CRD). Lisker said the CRD is used by state securities regulators and the SEC, which can both report disciplinary actions to the CRD. Lisker said the information in BrokerCheck is updated daily and reviewed for accuracy. Lisker said confidential information, such as Social Security numbers (SSNs), customer names, personal addresses, and phone numbers, is not displayed on BrokerCheck.

Director Deiter said the public disclosure of information to consumers is a meaningful endeavor, but FINRA and the NAIC are different types of organizations. He said FINRA is a self-regulatory organization, while the NAIC is not a regulator. Director Deiter said state insurance departments have different views regarding the seriousness of actions, what is reported to the NAIC, and how to communicate with consumers in their respective states.

In response to a question from Commissioner Navarro regarding the use of BrokerCheck, Lisker said FINRA does not track the internet protocol (IP) addresses of people who access BrokerCheck. He said there are 27 million searches per month. Lisker said FINRA does track what information is reviewed during a search and how long a person stays on a particular page of the site.

4. Heard a Presentation on the NAIC's Prototype Consumer Agent Broker Search Tool

Tim Mullen (NAIC) said he thinks the NAIC Members need to provide further direction on whether the NAIC should engage in direct communication with consumers and, if so, what information the NAIC should communicate to consumers on behalf of the NAIC Members.

Mullen said the NAIC provided a demonstration of an initial prototype of the search tool at the 2024 Summer National Meeting and engaged in a series of calls with regulator subject matter experts (SMEs) to arrive at the current design. Mullen said the current design primarily provides "name search" functionality. Mullen said a consumer can also search by National Producer Number (NPN), but most consumers will not know an individual's NPN. Mullen demonstrated a search that returned a list of states in which an individual is licensed, the lines of authority licensed to sell, and the individual's primary business address. Mullen said the search results intentionally limit the amount of information displayed. He said the design provides a link to the appropriate state insurance department if a consumer is seeking more information.

Mullen said the current design has led to questions about whether the search tool provides consumers with valuable information and whether the tool provides consumers with a consistent user experience, since consumers are referred to each state insurance department website for information. Mullen said a consumer will need to begin a new search once referred to a state insurance department. He said search functionality and search results will vary by state. Mullen said 34 states use the NAIC's State Based System (SBS) producer licensing look-up tool, which provides uniformity across these states. Mullen said no enforcement information is released through SBS.

Mullen said the current design limits the information disclosed to consumers from the NAIC and primarily directs consumers to state insurance departments, where a consumer must start a new search to obtain additional information. Mullen said the design reflects the desired functionality communicated to the NAIC. He said there is a need for further direction from the NAIC Members regarding the current design and what role the NAIC should have in creating a national system for the disclosure of information about insurance producers.

Director Cameron said the Committee should provide recommendations regarding the appropriate policy direction for the disclosure of producer information through the NAIC website for the full NAIC Membership to consider.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Attachment B

Draft: 7/3/25

Changes to MCAS Blanks and MCAS Data Call and Definition by Line of Business

Other Health

Adopted by Market Conduct Annual Statement Blanks (D) Working Gorup on May 22, 2025.

- Numerous revisions to Blank and Data Call and Definitions.

Private Passenger Auto (PPA)

Adopted by Market Conduct Annual Statement Blanks (D) Working Gorup on May 1, 2025.

- Added additional questions to Underwriting Activity to provide more accurate data
- Moved the question (Question 12) asking "If Yes, what percentage of your business is non-standard?" to Underwriting Activity so that the answer could be reported as a number

Homeowners

Adopted by Market Conduct Annual Statement Blanks (D) Working Gorup on May 22, 2025.

- Moved Question 08 asking "If Yes, what percentage of your business is non-standard?" to Underwriting Activity so that the answer could be reported as a number

Lender Placed Home and Auto (LPI)

Adopted by Market Conduct Annual Statement Blanks (D) Working Gorup on May 22, 2025.

- Added new data elements to the MCAS LPI Blank to provide more accurate reporting related to cancellations
  - #60 – Number of certificates for which Term of Coverage Completed during the period
  - #69 – Number of individual policies for which Term of Coverage Completed during the period
- Added new definitions to the MCAS LPI Data Call and Definitions Blank to provide more accurate reporting related to cancellations and definitions to the
  - Added the sentence "Coverage under an individual policy or a certificate under a group policy ending at the end of the term of coverage is not a cancellation, even if the coverage is renewed through a subsequent individual policy or certificate" to the definition of Cancellations
  - Added the definition of Term of Coverage Completed

Pet

Adopted by Market Conduct Annual Statement Blanks (D) Working Gorup on May 22, 2025.

- Removed the phrase "maximum benefit limits" from the second bullet point in the definition of Partial Payment which lists items not to be reported as partial payment claims

- Q109 on the MCAS Pet Blank asks “Number of claims closed during the period with partial payment – maximum benefit limit”
- The definition of partial payment now matches with the information that is being asked for in the blank

Disability Income

Adopted by Market Conduct Annual Statement Blanks (D) Working Gorup on May 22, 2025.

- Changed Question 83 (related to complaints) so that the verbiage is consistent with all MCAS lines of business

Long-Term Care (LTC)

Adopted by Market Conduct Annual Statement Blanks (D) Working Gorup on May 22, 2025.

- Changed Question 30 (related to complaints) so that the verbiage is consistent with all MCAS lines of business

Short-Term Limited Duration (STLD)

Adopted by Market Conduct Annual Statement Blanks (D) Working Gorup on May 22, 2025.

- Changed Question 111 (related to complaints) so that the verbiage is consistent with all MCAS lines of business

Other Health Insurance (2026)

Other Health Insurance Interrogatories

	Interrogatories - Individual Products	Yes/No Response	Explanation
01	Accident Only: Were there policies in force during the reporting period?		--
02	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?		--
03	Accident Only: Do the reported products include closed or frozen blocks of business?		--
04	Accident Only: Do any of the reported products contain pre-existing condition exclusions?		--
05	Accidental Death and Dismemberment: Were there policies in force during the reporting period?		--
06	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?		--
07	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?		--
08	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?		--
09	Specified Disease – Limited Benefit/Critical Illness: Were there policies in force during the reporting period?		--
10	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?		--
11	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?		--
12	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?		--
13	Hospital/Other Indemnity: Were there policies in force during the reporting period?		--
14	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?		--
15	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?		--
16	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?		--
17	Hospital/Surgical/Medical Expense: Were there policies in force during the reporting period?		--
18	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?		--
19	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?		--
20	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?		--
21	Has the company had a significant event/business strategy change that would affect the Individual product data reported this period?		--
22	If yes, explain the situation and how it may affect the data	--	
23	Additional jurisdiction-specific Individual product comments (optional):	--	

	Interrogatories - Associations/Trusts Products	Yes/No Response	Explanation
24	Accident Only: Were there policies/certificates in force during the reporting period?		--
25	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?		--
26	Accident Only: Do the reported products include closed or frozen blocks of business?		--
27	Accident Only: Do any of the reported products contain pre-existing condition exclusions?		--
28	Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?		--
29	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?		--
30	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?		--
31	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?		--
32	Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?		--
33	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?		--
34	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?		--
35	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?		--
36	Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?		--
37	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?		--
38	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?		--
39	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?		--
40	Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?		--
41	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?		--
42	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?		--
43	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?		--
44	Does the company have a contractual relationship (outside or in addition to the group policies issued to the Association/Trust) with each Association/Trust?		--
45	Does the company delegate authority to any of the associations/trusts to market products?		--
46	If yes, does the company conduct compliance audits of all associations/trusts allowed to market products?		--
47	Does the company delegate authority to any of the associations/trusts to collect policy or contract premiums?		--
48	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect policy or contract premiums?		--
49	Does the company delegate authority to any of the associations/trusts to collect and pay commissions?		--
50	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect and pay commissions?		--

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Other Health Insurance (2026)

51	Does the company delegate authority to any of the associations/trusts to adjudicate claims?		--
52	If yes, does the company conduct compliance audits of all associations/trusts allowed to adjudicate claims?		--
53	Has the company had a significant event/business strategy change that would affect the Associations/Trusts product data reported this period?		--
54	If yes, explain the situation and how it may affect the data	--	
55	Additional jurisdiction-specific Associations/Trusts product comments (optional):	--	
Interrogatories - Employer Group Products		Yes/No Response	Explanation
56	Accident Only: Were there policies/certificates in force during the reporting period?		--
57	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?		--
58	Accident Only: Do the reported products include closed or frozen blocks of business?		--
59	Accident Only: Do any of the reported products contain pre-existing condition exclusions?		--
60	Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?		--
61	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?		--
62	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?		--
63	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?		--
64	Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?		--
65	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?		--
66	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?		--
67	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?		--
68	Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?		--
69	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?		--
70	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?		--
71	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?		--
72	Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?		--
73	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?		--
74	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?		--
75	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?		--
76	Does the company allow any of the Employer Groups to adjudicate claims?		--
77	If yes, does the company have a contractual relationship (outside or in addition to the group policy issued to the Employer Group) with each Employer Group with this delegated authority?		--
78	If yes, does the company conduct compliance audits of all Employer Groups allowed to adjudicate claims?		--
79	Has the company had a significant event/business strategy change that would affect the Employer Group product data reported this period?		--
80	If yes, explain the situation and how it may affect the data	--	
81	Additional jurisdiction-specific Employer Group product comments (optional):	--	
Interrogatories - Third-Party Administrators/Vendors		Yes/No Response	Explanation
82	Does the company contract with third-parties, either third-party administrators or other vendors (other than Associations/Trusts and Employer Groups) for any administrative services related to Other Health products?		--
83	If yes, does the company issue any Other Health products through administrators/TPAs?		--
84	If yes, does the company contract any claims services related to Other Health products?		--
85	If yes, does the company contract any complaints handling related services related to Other Health products?		--
86	If yes, does the company contract any medical underwriting services related to Other Health products?		--
87	If yes, does the company contract any pricing services related to Other Health products?		--
88	If yes, does the company contract any producer appointment services related to Other Health products?		--
89	If yes, does the company contract any marketing, advertisement, or lead generation, services related to Other Health products?		--
90	If yes, does the company contract any policyholder services related to Other Health products?		--
91	If yes, does the company contract any premium collection services related to Other Health products?		--
92	If yes, does the company conduct compliance audits of all third parties to whom responsibilities have been delegated?		--
93	Additional jurisdiction-specific Third-Party Administrators/Vendors comments (optional):	--	
Interrogatories - General		Yes/No Response	Explanation
94	Does your company distribute its product through independent agents?		--
95	Does your company distribute its products through captive agents?		--
96	Does your company distribute its products through its employees?		--
97	Does the company contract with producers to collect premium or bind coverage on behalf of the company?		--
98	Does the company charge fees (other than commissions) to applicants or policyholders/certificate holders that are included in reported premium?		--
99	Additional jurisdiction-specific General comments (optional):	--	

Other Health Insurance (2026)

Policy/Certificate Administration

		Individual				Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
100	Direct Written Premium during the period.															
101	Earned premiums for reporting year.															
102	Number of policies/certificates in force at the beginning of the period.															
103	Number of covered lives on policies/certificates in force at the beginning of the period.											--	--	--	--	--
104	Number of new policy/certificate applications/enrollments received during the period.															
105	Number of new policy/certificates issued during the period.															
106	Number of covered lives on new policies/certificates issued during the period.											--	--	--	--	--
107	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period.															
108	Number of policies/certificates cancelled during the free look period during the period.															
109	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period.											--	--	--	--	--
110	Number of policy/certificate terminations and cancellations due to non-payment of premium during the period.															
111	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period.															
112	Number of rescissions during the period.						--	--	--	--	--	--	--	--	--	--
113	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder during the period.											--	--	--	--	--
114	Number of covered lives impacted on terminations and cancellations due to non-payment during the period.											--	--	--	--	--
115	Number of covered lives impacted by rescissions during the period.						--	--	--	--	--	--	--	--	--	--
116	Number of policies/certificates in force at the end of the period.															
117	Number of covered lives on policies/certificates in force at the end of the period.											--	--	--	--	--

Claims Administration (Including Pharmacy)

		Individual				Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
118	Number of claims pending at the beginning of the period.															
119	Total ~~N~~number of all claims received ~~(include non-clean claims)~~ during the period.															
120	Total number of claims denied, rejected or returned during the period.															
121	Number denied, rejected, or returned during the period as non-covered or maximum benefit exceeded.															
122	Number denied, rejected, or returned during the period as subject to pre-existing condition exclusion.															
123	Number denied, rejected, or returned during the period due to failure to provide adequate documentation.															
124	Number denied, rejected, or returned during the period due to being within the waiting period.		--					--					--			
125	Number of claims pending at the end of the period.															
126	Median number of days from receipt of claim to decision for denied claims during the period.															
127	Average number of days from receipt of claim to decision for denied claims during the period.															
128	Median number of days from receipt of claim to decision for approved claims during the period.															
129	Average number of days from receipt of claim to decision for approved claims during the period.															
130	Number of claims paid (include partially paid claims) during the period.															
131	Aggregate dollar amount of paid claims during the period.															
132	Number of claims during the period where the claims payment was reduced by premium owed.															
133	Dollar amount of claims payments during the period applied to unpaid premiums.															

Other Health Insurance (2026)

Consumer Complaints and Lawsuits

		Individual				Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
134	Number of complaints received ~~by Company (other than through the DOI) during the period~~ directly from any person or entity other than the DOI.															
	~~Number of complaints received through DOI.~~															
135	Number of complaints during the period resulting in claims reprocessing.															
136	Number of lawsuits open at the beginning of the period.															
137	Number of lawsuits opened during the period.															
138	Number of lawsuits closed during the period.															
139	Number of lawsuits closed during the period with consideration for the consumer.															
140	Number of lawsuits open at the end of the period.															

Marketing and Sales

		Individual				Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
141	Number of individual applications/enrollments pending at the beginning of the period.															
142	Number of individual applications/enrollments denied during the period for any reason.															
143	Number of individual applications/enrollments denied during the period - health status or condition.															
144	Number of individual applications/enrollments approved during the period.															
145	Number of individual applications/enrollments pending at the end of the period.															
146	Number of applications/enrollments received via phone (audio only) during the period.						--	--	--	--	--	--	--	--	--	--
147	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx) during the period.						--	--	--	--	--	--	--	--	--	--
148	Number of applications/enrollments received online (electronically) during the period.						--	--	--	--	--	--	--	--	--	--
149	Number of applications/enrollments received by mail during the period.						--	--	--	--	--	--	--	--	--	--
150	Number of applications/enrollments received by any other method during the period.						--	--	--	--	--	--	--	--	--	--
151	Commissions paid during reporting period (dollar amount of commissions incurred during the period).															
152	Unearned commissions returned to company on policies/certificates sold during the period.															

Other Health Insurance Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
153	First Attestor Information.						--
154	Second Attestor Information.						--
155	Overall Comments for the Filing Period.	--	--	--	--	--	

MCAS Market Conduct Annual Statement

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Line of Business: Other Health Insurance
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: May 31, 2027

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1 – Interrogatories – Individual Products

ID	Description	Response
1-01	~~Are you currently marketing these products in this jurisdiction?~~ Accident Only: Were there policies in force during the reporting period?	Yes/No
1-02	~~Do the products you are reporting on in response to this blank include closed or frozen blocks of business?~~ Accident Only: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-03	~~If yes, list the closed or frozen blocks of business?~~ Accident Only: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-04	~~Number of Other Health products offered to residents in this state~~ Accident Only: Do any of the reported products contain pre-existing condition exclusions?	~~Number~~ Yes/No
1-05	~~For products reported to this MCAS jurisdiction, list the states where your Other Health products are filed (provide SERFF tracking number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product, and describe the basis for not filing.~~ Accidental Death and Dismemberment: Were there policies in force during the reporting period?	~~Comment~~ Yes/No
1-06	~~For products reported to this MCAS jurisdiction, does the company issue these Other Health products through associations/trusts?~~ Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No

1-07	~~If yes, list the associations/trusts.~~ Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-08	~~If yes, do you have a contractual relationship with any association/trust?~~ Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-09	~~If yes, please identify which associations/trusts.~~ Specified Disease – Limited Benefit/Critical Illness: Were there policies in force during the reporting period?	~~Comment~~ Yes/No
1-10	~~If yes, does the contract allow any association/trust to market the product?~~ Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-11	~~If yes, please identify which associations/trusts.~~ Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-12	~~If yes, does the contract allow any association/trust to collect policy or contract premiums?~~ Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-13	~~If yes, does the contract allow any association/trust to collect and pay commissions?~~ Hospital/Other Indemnity: Were there policies in force during the reporting period?	Yes/No
1-14	~~If yes, please identify which associations/trusts.~~ Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?	~~Comment~~ Yes/No
1-15	~~If yes, does the contract allow any association/trust to adjudicate claims?~~ Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?	Yes/No
1-16	~~If yes, please identify which associations/trusts.~~ Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?	~~Comment~~ Yes/No
1-17	~~Has the company filed the associations by-laws and articles of incorporation in their state of domicile?~~ Hospital/Surgical/Medical Expense: Were there policies in force during the reporting period?	Yes/No

1-18	~~Has the company filed the association by-laws and articles of incorporation and policy forms in the situs state of the association?~~ Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-19	~~If yes please provide the state, and the SERFF tracking number, if applicable~~ Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-20	~~Has the company filed the association by-laws and articles of incorporation in the filing state?~~ Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-21	~~Has the company filed the certificate of insurance in the filing state, if applicable?~~ Has the company had a significant event/business strategy change that would affect the Individual product data reported this period?	Yes/No
1-22	~~Does the company contract with third-party administrators for administrative services related to Other Health products?~~ If yes, explain the situation and how it may affect the data.	~~Yes/No~~ Comment
1-23	~~If yes, does the company issue Other Health products through administrators/TPAs?~~ Additional jurisdiction-specific Individual product comments (optional):	~~Yes/No~~ Comment

Schedule 1 – Interrogatories – Associations/Trusts Products

1-24	~~If yes, how many administrators/TPAs?~~ Accident Only: Were there policies/certificates in force during the reporting period?	~~Number~~ Yes/No
1-25	~~If yes, list the TPAs and provide their respective National Producer Number (NPN), if required by the state.~~ Accident Only: Was the company actively writing policies in the jurisdiction at year-end?	~~Comment~~ Yes/No
1-26	~~If yes, does your company contract claims services related to Other Health products?~~ Accident Only: Do the reported products include closed or frozen blocks of business?	Yes/No
1-27	~~If yes, does your company contract complaints-related services related to Other Health products?~~ Accident Only: Do any of the reported products contain pre-existing condition exclusions?	Yes/No

1-28	~~If yes, does your company contract medical underwriting services related to Other Health products?~~ Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?	Yes/No
1-29	~~If yes, does your company contract pricing services related to Other Health products?~~ Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-30	~~If yes, does your company contract producer appointment services related to Other Health products?~~ Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?	Yes/No
1-31	~~If yes, does your company contract marketing, advertisement, or lead generation, services related to Other Health products?~~ Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-32	~~If yes, does your company contract policyholder services related to Other Health products?~~ Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?	Yes/No
1-33	~~If yes, does your company contract premium collection services related to Other Health products?~~ Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-34	~~Does your company audit third parties to whom you have delegated responsibilities?~~ Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?	Yes/No
1-35	~~If yes, please provide frequency of audits.~~ Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?	~~Comment~~ Yes/No
1-36	~~Does your company distribute its product through independent agents?~~ Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?	Yes/No
1-37	~~Does your company distribute its products through captive agents?~~ Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-38	~~Does your company distribute its products through its employees?~~ Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?	Yes/No

1-39	~~Does the company use pre-existing condition exclusions?~~ Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-40	~~If yes, identify which products.~~ Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?	~~Comment~~ Yes/No
1-41	~~Does the company contract with producers to collect premium or bind coverage on behalf of the company?~~ Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-42	~~For fees that are included in reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.~~ Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-43	~~For fees not included in the reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.~~ Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?	~~Comment~~ Yes/No
1-44	~~Additional state specific comments (optional)~~ Does the company have a contractual relationship (outside or in addition to the group policies issued to the Association/Trust) with each Association/Trust?	~~Comment~~ Yes/No
1-45	Does the company delegate authority to any of the associations/trusts to market products?	Yes/No
1-46	If yes, does the company conduct compliance audits of all associations/trusts allowed to market products?	Yes/No
1-47	Does the company delegate authority to any of the associations/trusts to collect policy or contract premiums?	Yes/No
1-48	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect policy or contract premiums?	Yes/No
1-49	Does the company delegate authority to any of the associations/trusts to collect and pay commissions?	Yes/No
1-50	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect and pay commissions?	Yes/No
1-51	Does the company delegate authority to any of the associations/trusts to adjudicate claims?	Yes/No
1-52	If yes, does the company conduct compliance audits of all associations/trusts allowed to adjudicate claims?	Yes/No

1-53	Has the company had a significant event/business strategy change that would affect the Associations/Trusts product data reported this period?	Yes/No
1-54	If yes, explain the situation and how it may affect the data	Comment
1-55	Additional jurisdiction-specific Associations/Trusts product comments (optional):	Comment

Schedule 1 – Interrogatories – Employer Group Products

1-56	Accident Only: Were there policies/certificates in force during the reporting period?	Yes/No
1-57	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-58	Accident Only: Do the reported products include closed or frozen blocks of business?	Yes/No
1-59	Accident Only: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-60	Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?	Yes/No
1-61	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-62	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?	Yes/No
1-63	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-64	Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?	Yes/No
1-65	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-66	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?	Yes/No
1-67	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-68	Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?	Yes/No
1-69	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-70	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?	Yes/No
1-71	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-72	Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?	Yes/No

1-73	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-74	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?	Yes/No
1-75	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-76	Does the company allow any of the Employer Groups to adjudicate claims?	Yes/No
1-77	If yes, does the company have a contractual relationship (outside or in addition to the group policy issued to the Employer Group) with each Employer Group with this delegated authority?	Yes/No
1-78	If yes, does the company conduct compliance audits of all Employer Groups allowed to adjudicate claims?	Yes/No
1-79	Has the company had a significant event/business strategy change that would affect the Employer Group product data reported this period?	Yes/No
1-80	If yes, explain the situation and how it may affect the data	Comment
1-81	Additional jurisdiction-specific Employer Group product comments (optional):	Comment

Schedule 1 – Interrogatories – Third Party Administrators/Vendors

1-82	Does the company contract with third-parties, either third-party administrators or other vendors (other than Associations/Trusts and Employer Groups) for any administrative services related to Other Health products?	Yes/No
1-83	If yes, does the company issue any Other Health products through administrators/TPAs?	Yes/No
1-84	If yes, does the company contract any claims services related to Other Health products?	Yes/No
1-85	If yes, does the company contract any complaints handling related services related to Other Health products?	Yes/No
1-86	If yes, does the company contract any medical underwriting services related to Other Health products?	Yes/No
1-87	If yes, does the company contract any pricing services related to Other Health products?	Yes/No
1-88	If yes, does the company contract any producer appointment services related to Other Health products?	Yes/No
1-89	If yes, does the company contract any marketing, advertisement, or lead generation, services related to Other Health products?	Yes/No
1-90	If yes, does the company contract any policyholder services related to Other Health products?	Yes/No

1-91	If yes, does the company contract any premium collection services related to Other Health products?	Yes/No
1-92	If yes, does the company conduct compliance audits of all third parties to whom responsibilities have been delegated?	Yes/No
1-93	Additional jurisdiction-specific Third-Party Administrators/Vendors comments (optional):	Comment

Schedule 1 – Interrogatories – General

1-94	Does your company distribute its product through independent agents?	Yes/No
1-95	Does your company distribute its products through captive agents?	Yes/No
1-96	Does your company distribute its products through its employees?	Yes/No
1-97	Does the company contract with producers to collect premium or bind coverage on behalf of the company?	Yes/No
1-98	Does the company charge fees (other than commissions) to applicants or policyholders/certificate holders that are included in reported premium?	Yes/No
1-99	Additional jurisdiction-specific General comments (optional):	Comment

Products

Product Identifiers	Explanation of Product Identifiers
Individual H-AO	Accident Only. Purchased by an individual
Individual ADD	Accidental Death and Dismemberment. Purchased by an individual
Individual SD	Specified Disease-Limited Benefit/Critical Illness. Purchased by an individual
Individual H-H/OI	Hospital/Other Indemnity. Purchased by an individual
Individual H-HSME	Hospital/Surgical/Medical Expense. Purchased by an individual
Association H-AO	Accident Only. Purchased through an association/trust
Association ADD	Accidental Death and Dismemberment. Purchased through an association/trust
Association SD	Specified Disease-Limited Benefit/Critical Illness. Purchased through an association/trust
Association H-H/OI	Hospital/Other Indemnity. Purchased through an association/trust
Association H-HSME	Hospital/Surgical/Medical Expense. Purchased through an association/trust
Employer Group H-AO	Accident Only. Purchased through an employer group
Employer Group ADD	Accidental Death and Dismemberment. Purchased through an employer group

Employer Group SD	Specified Disease-Limited Benefit/Critical Illness. Purchased through an employer group
Employer Group H-H/OI	Hospital/Other Indemnity. Purchased through an employer group
Employer Group H-HSME	Hospital/Surgical/Medical Expense. Purchased through an employer group

Schedule 2 – Policy/Certificate Administration

ID	Description
~~2-45~~ 2-100	Direct written premium during the period.
~~2-46~~ 2-101	Earned premiums for reporting year
~~2-47~~ 2-102	Number of policies/certificates in force at the beginning of the period
~~2-48~~ 2-103	Number of covered lives on policies/certificates in force at the beginning of the period (only answer for individual and association products)
~~2-49~~ 2-104	Number of new policy/certificate applications/enrollments received during the period
~~2-50~~ 2-105	Number of new policy/certificates issued during the period
~~2-51~~ 2-106	Number of Covered Lives on New Policies/Certificates Issued During the Period (only answer for individual and association products)
~~2-52~~ 2-107	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period
2-53 2-108	Number of policies/certificates cancelled during the free look period during the period.
~~2-54~~ 2-109	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period (only answer for individual and association products)
~~2-55~~ 2-110	Number of policy/certificate terminations and cancellations due to non-payment of premium during the period
~~2-56~~ 2-111	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period
~~2-57~~ 2-112	Number of rescissions during the period (only answer for individual products)
~~2-58~~ 2-113	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder during the period (only answer for individual and association products)
~~2-59~~ 2-114	Number of covered lives impacted on terminations and cancellations due to non-payment during the period (only answer for individual and association products)

~~2-60~~ 2-115	Number of covered lives impacted by rescissions during the period (only answer for individual products)
~~2-61~~ 2-116	Number of policies/certificates in force at the end of the period
~~2-62~~ 2-117	Number of covered lives on policies/certificates in force at the end of the period (only answer for individual and association products)

Schedule 3 – Claims Administration (Including Pharmacy)

ID	Description
~~3-63~~ 3-118	Number of claims pending at the beginning of the period
~~3-64~~ 3-119	Total ~~N~~number of all claims received ~~(include non-clean claims)~~ during the period
~~3-65~~ 3-120	Total number of claims denied, rejected or returned during the period
~~3-66~~ 3-121	Number denied, rejected, or returned during the period as non-covered or maximum benefit exceeded
~~3-67~~ 3-122	Number denied, rejected, or returned during the period as subject to pre-existing condition exclusion
~~3-68~~ 3-123	Number denied, rejected, or returned during the period due to failure to provide adequate documentation
~~3-69~~ 3-124	Number denied, rejected, or returned during the period due to being within the waiting period (do not answer for ADD products)
~~3-70~~ 3-125	Number of claims pending at the end of the period
~~3-71~~ 3-126	Median number of days from receipt of claim to decision for denied claims during the period
~~3-72~~ 3-127	Average number of days from receipt of claim to decision for denied claims during the period
~~3-73~~ 3-128	Median number of days from receipt of claim to decision for approved claims during the period
~~3-74~~ 3-129	Average number of days from receipt of claim to decision for approved claims during the period
~~3-75~~ 3-130	Number of claims paid (include partially paid claims) during the period
~~3-76~~ 3-131	Aggregate dollar amount of paid claims during the period
~~3-77~~ 3-132	Number of claims during the period where the claims payment was reduced by premium owed
~~3-78~~ 3-133	Dollar amount of claims payments during the period applied to unpaid premiums.

Schedule 4 – Consumer Complaints and Lawsuits

ID	Description
~~4-80~~ 4-134	Number of complaints received ~~by Company (other than through the DOI)~~ directly from any person or entity other than the DOI
~~4-81~~	~~Number of complaints received through DOI~~
~~4-82~~ 4-135	Number of complaints resulting in claims reprocessing
~~4-83~~ 4-136	Number of lawsuits open at the beginning of the period
~~4-84~~ 4-137	Number of lawsuits opened during the period
~~4-85~~ 4-138	Number of lawsuits closed during the period
~~4-86~~ 4-139	Number of lawsuits closed during the period with consideration for the consumer
~~4-87~~ 4-140	Number of lawsuits open at the end of the period

Schedule 5 – Marketing and Sales

ID	Description
~~5-88~~ 5-141	Number of individual applications/enrollments pending at the beginning of the period
~~5-89~~ 5-142	Number of individual applications/enrollments denied during the period for any reason
~~5-90~~ 5-143	Number of individual applications/enrollments denied during the period - health status or condition
~~5-91~~ 5-144	Number of individual applications/enrollments approved during the period
~~5-92~~ 5-145	Number of individual applications/enrollments pending at the end of the period
~~5-93~~ 5-146	Number of applications/enrollments received via phone (audio only) during the period (only answer for individual products)
~~5-94~~ 5-147	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx) during the period (only answer for individual products)
~~5-95~~ 5-148	Number of applications/enrollments received online (electronically) during the period (only answer for individual products)
~~5-96~~ 5-149	Number of applications/enrollments received by mail during the period (only answer for individual products)
~~5-97~~ 5-150	Number of applications/enrollments received by any other method during the period (only answer for individual products)
~~5-98~~ 5-151	Commissions paid during reporting period (dollar amount of commissions incurred during the period)

~~5-99~~ 5-152	Unearned commissions returned to company on policies/certificates sold during the period

Schedule 6– Other Health Insurance Attestation

ID	Description
~~6-100~~ 6-153	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~6-101~~ 6-154	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~6-102~~ 6-155	Overall Comments for the Period

Participation Requirements: All companies licensed and reporting at least $50,000 of other health insurance premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Report by Residency: This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is situsued.

General Definitions:

Other Health - Health insurance forms that are not subject to the Affordable Care Act (ACA). For this MCAS blank, they are Health-Accident Only; Health - Accidental Death and Dismemberment; Health-Specified Disease-Limited Benefit/Critical Illness; Health - Hospital/Other Indemnity; and Health - Hospital/Surgical/Medical Expense

Exclude the following from Other Health MCAS reporting:

- Medicare supplement
- Blanket policies
- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

Health-Accident Only - An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability (not disability income), or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident

Health-Accidental Death and Dismemberment - An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

Health-Specified Disease-Limited Benefit/Critical Illness - An insurance contract that pays benefits for the diagnosis and/or treatment of a specifically named disease, diseases, or critical illness. Benefits can be paid as expense incurred, per diem, or a principle sum.

Health-Hospital/Other Indemnity - An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred.

Health-Hospital/Surgical/Medical Expense - An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.

Association/Trust – For purposes of this MCAS blank, a non-employer group that offers benefits to its members (does not include banks or credit unions).

Exclude the following from Other Health MCAS reporting:

- Medicare supplement
- Blanket policies
- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

Individual Product - Policies marketed, sold, and issued to individual consumers, regardless of whether or not the policy forms have been filed with any State's department of insurance.

Group Product / Coverage - Policies issued to a trust, association, employer, or administrator for the purpose of marketing, selling, and issuing certificates to eligible members or employees, regardless of whether or not the policy forms have been filed with any State's department of insurance and regardless of where the association, trust, employer, or administrator is situsued.

~~**National Producer Number (NPN) -** This is a specific number provided by National Insurance Producers Registry (NIPR) to individuals and most business entities that are listed in the NIPR's Producer Database (PDB).~~

Policies/Certificates - Refers to the coverage documents provided to individuals, families, or eligible members (i.e., state residents) who are enrolled in coverage (not the association/trust)

Policyholder/Certificate holder – Refers to the individual or member who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association/trust)

Policyholder Service - A company's activities relating to servicing its policyholders which incudes, but is not limited to, notice/billing, disclosures, premium refunds and coverage questions.

Actively Writing Policies – Refers to premium written during the reporting period.

Pre-existing Condition - A medical condition of the policyholder/certificate holder that existed prior to eligibility for coverage under the Other Health policy.

Third party Entity – Licensed Administrators, licensed producers, vendors

Compliance Audits - A compliance audit is a formal review of an organization's procedures and operations mainly focusing on whether an entity is complying with internal rules, regulations, policies, decisions, and procedures. The audit ensures that the organization is fulfilling outside obligations such as agreements, rules and regulations, or standards.

Marketing - The process of actively promoting, selling, and distributing a product.

Schedule 2 Definitions (Policy/Certificate Administration):

Rescission – A rescission is a cancellation or discontinuance of coverage based on a misrepresentation that is retroactive to the issue date. (Does not include cancellations for non-payment.)

Free Look – A set number of days provided in an insurance policy/certificate that allows time for the purchaser to review the contract provisions with the right to return the policy/certificate for a full refund of all premium paid. Report the number of policies/certificates that were returned by the insured under the free look provision during the period, regardless of the original issuance date.

Schedule 3 Definitions (Claims Administration):

Claim – Provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Duplicate claims should not be reported.

For the purposes of this Market Conduct Annual Statement, a "Claim" includes any such request or demand, even those with incomplete or inadequate documentation and those made by an individual not eligible or covered under the policy against which the claim is made.

Communications with an insurer that are not explicit claims as per the definition above should not be reported on this MCAS. Such communications could include general queries regarding policy provisions, potential coverage, events reported for "information only", or other communications for which a clear request or demand for payment has not been made.

If a claim is reopened, treat the reopened claim as a new and distinct claim apart from the original claim. For reopened claims, the claim determination time period is measured from the date the claim was re-opened to the date a benefit determination is made.

Claims Received - provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

Claims Denied - provide the total number of claims denied during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed; includes rejected and returned claims, whether in whole or in part

Claims Paid - provide the total number of claims paid during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

Waiting Period: Period of time a covered person who is entitled to receive benefits must wait before coverage is provided. This applies to waiting periods that are per policy or per condition.

Schedule 4 Definitions (Consumer Complaints and Lawsuits):

Complaint - any written communication that expresses dissatisfaction with a specific person or entity. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose. A complaint should be reported to the state where the policyholder resides.

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.).
- Complaints received from third parties.

Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for Other Health Insurance products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Schedule 5 Definitions (Marketing and Sales)

Commissions - The total amount of compensation paid to any individual or entity for their consideration in marketing, selling, and attracting potential insureds, by whatever means this compensation is provided. Do not include monetary valuables paid to any individual or entity that is generally not able to be converted into actual money. NOTE: For products ***not*** related to the actual sale of a contract, do not include any amounts paid for the specific purpose of marketing, encouraging or promoting. Do not include any fees or other compensation paid for outsourced services.

Schedule 6– Other Health Insurance Attestation

By completing the attestation information, those named understand, agree, and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

Private Passenger Auto (2026)

Private Passenger Auto Interrogatories

		Yes/No Response	Explanation
01	Were there policies in force during the reporting period that provided Collision coverage?		———
02	Were there policies in force during the reporting period that provided Comprehensive coverage?		———
03	Were there policies in force during the reporting period that provided Bodily Injury coverage?		———
04	Were there policies in force during the reporting period that provided Property Damage coverage?		———
05	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?		———
06	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?		———
07	Were there policies in force during the reporting period that provided Medical Payments coverage?		———
08	Were there policies in force during the reporting period that provided Combined Single Limits coverage?		———
09	Were there policies in force during the reporting period that provided Personal Injury Protection coverage?		———
10	Was the company actively writing policies in the state at year end?		———
11	Does the company write in the non-standard market?		———
~~12~~	~~If Yes, what percentage of your business is non-standard?~~	———	
~~13~~12	If Yes, how is non-standard defined?	———	
~~14~~13	Has the company had a significant event/business strategy that would affect data for this reporting period?		———
~~15~~14	If yes, add additional comments.	———	
~~16~~15	Has all or part of this block of business been sold, closed or moved to another company during the reporting period?		———
~~17~~16	If yes, add additional comments.	———	
~~18~~17	How does the company treat subsequent supplemental or additional payments on previously closed claims?	———	
~~19~~18	Does the company use Managing General Agents (MGAs)?		———
~~20~~19	If yes, list the names of the MGAs	———	
~~21~~20	Does the company use Third Party Administrators (TPAs)?		———
~~22~~21	If yes, list the names of the TPAs	———	
~~23~~22	Does the company use telematics or usage-based data:?		———
~~24~~23	Does the company use digital claim settlement?		———
~~25~~24	If yes, list the names of the vendors providing third-party data and algorithms used in the digital claim settlement process	———	
~~26~~25	Additional state specific Claims comments (optional):	———	
~~27~~26	Additional state specific Underwriting comments (optional):	———	

Private Passenger Auto (2026)

Private Passenger Auto Claims Activity

		Collision				Comprehensive				Bodily Injury	Property Damage			
		Digital	Hybrid	Non-Digital	All	Digital	Hybrid	Non-Digital	All		Digital	Hybrid	Non-Digital	All
~~28~~27	Number of claims open at the beginning of the period.													
~~29~~28	Number of claims opened during the period.													
~~30~~29	Number of claims closed with payment during the period.													
~~31~~30	Number of claims closed without payment during the period.													
~~32~~31	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.													
~~33~~32	Number of claims remaining open at the end of the period.													
~~34~~33	Median days to final payment.													
~~35~~34	Number of claims closed with payment within 0-30 days.													
~~36~~35	Number of claims closed with payment within 31-60 days.													
~~37~~36	Number of claims closed with payment within 61-90 days.													
~~38~~37	Number of claims closed with payment within 91-180 days.													
~~39~~38	Number of claims closed with payment within 181-365 days.													
~~40~~39	Number of claims closed with payment beyond 365 days.													
~~41~~40	Number of claims closed without payment within 0-30 days.													
~~42~~41	Number of claims closed without payment within 31-60 days.													
~~43~~42	Number of claims closed without payment within 61-90 days.													
~~44~~43	Number of claims closed without payment within 91-180 days.													
~~45~~44	Number of claims closed without payment within 181-365 days.													
~~46~~45	Number of claims closed without payment beyond 365 days.													

Private Passenger Auto (2026)

Private Passenger Auto Claims Activity (Continued)

		UMBI and UIMBI	UMPD and UIMPD				Medical Payments	Combined Single Limits	Personal Injury Protection
			Digital	Hybrid	Non-Digital	All			
~~28~~27	Number of claims open at the beginning of the period.					———			
~~29~~28	Number of claims opened during the period.					———			
~~30~~29	Number of claims closed with payment during the period.					———			
~~31~~30	Number of claims closed without payment during the period.					———			
~~32~~31	Number of claims closed during the					———			
~~33~~32	Number of claims remaining open at the end of the period.					———			
~~34~~33	Median days to final payment.		———	———	———				
~~35~~34	Number of claims closed with payment within 0-30 days.					———			
~~36~~35	Number of claims closed with payment within 31-60 days.					———			
~~37~~36	Number of claims closed with payment within 61-90 days.					———			
~~38~~37	Number of claims closed with payment within 91-180 days.					———			
~~39~~38	Number of claims closed with payment within 181-365 days.					———			
~~40~~39	Number of claims closed with payment beyond 365 days.					———			
~~41~~40	Number of claims closed without payment within 0-30 days.					———			
~~42~~41	Number of claims closed without payment within 31-60 days.					———			
~~43~~42	Number of claims closed without payment within 61-90 days.					———			
~~44~~43	Number of claims closed without payment within 91-180 days.					———			
~~45~~44	Number of claims closed without payment within 181-365 days.					———			
~~46~~45	Number of claims closed without payment beyond 365 days.					———			

Private Passenger Auto (2026)

Private Passenger Auto Underwriting Activity

		Value
~~47~~46	Number of autos which have policies in force at the end of the period.	
~~48~~47	Number of policies in force at the end of the period.	
~~49~~48	Number of new policies written during the period.	
49	Number of non-standard policies issued during the period.	
50	Total number of policies in force at the end of the period that have Collision coverage.	
51	Total number of policies in force at the end of the period that have Comprehensive coverage.	
52	Total number of policies in force at the end of the period that have Bodily Injury coverage.	
53	Total number of policies in force at the end of the period that have Property Damage coverage.	
54	Total number of policies in force at the end of the period that have UMBI and UIMBI coverage.	
55	Total number of policies in force at the end of the period that have UMPD and UIMPD coverage.	
56	Total number of policies in force at the end of the period that have Medical Payments coverage.	
57	Total number of policies in force at the end of the period that have Combined Single Limits coverage.	
58	Total number of policies in force at the end of the period that have Personal Injury Protection coverage.	
59	Number of policies in force at the end of the period that are enrolled in a telematics or usage-based data product(s).	
~~50~~60	Dollar amount of direct written premium during the period.	
~~51~~61	Number of company-initiated non-renewals during the period.	
~~52~~62	Number of cancellations for non-pay or non-sufficient funds.	
~~53~~63	Number of cancellations at the insured's request	
~~54~~64	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.	
~~55~~65	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.	
~~56~~66	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.	
~~57~~67	Number of complaints received directly from any person or entity other than the DOI.	

Lawsuit Activity

		Collision	Comprehensive	Bodily Injury	Property Damage	UMBI and UIMBI	UMPD and UIMPD	Medical Payments	Combined Single Limits	Personal Injury Protection	Non-Claim Related Lawsuits
~~58~~68	Number of lawsuits open at beginning of the period.										
~~59~~69	Number of lawsuits opened during the period.										
~~60~~70	Number of lawsuits closed during the period.										
~~61~~71	Number of lawsuits open at end of period.										
~~62~~72	Number of lawsuits closed with consideration for the consumer.										

Private Passenger Auto Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
~~63~~73	First Attestor Information						———
~~64~~74	Second Attestor Information						———
~~65~~75	Overall Comments for the Filing Period	———	———	———	———	———	

Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

Line of Business: Private Passenger Auto
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: April 30, 2027

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1—Interrogatories

ID	Description	Response
1-01	Were there policies in-force during the reporting period that provided Collision coverage?	Yes/No
1-02	Were there policies in-force during the reporting period that provided Comprehensive?	Yes/No
1-03	Were there policies in-force during the reporting period that provided Bodily Injury coverage?	Yes/No
1-04	Were there policies in-force during the reporting period that provided Property Damage coverage?	Yes/No
1-05	Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?	Yes/No
1-06	Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?	Yes/No
1-07	Were there policies in-force during the reporting period that provided Medical Payments coverage?	Yes/No
1-08	Were there policies in-force during the reporting period that provided Combined Single Limits coverage?	Yes/No
1-09	Were there policies in-force during the reporting period that provided Personal Injury Protection coverage?	Yes/No
1-10	Was the Company still actively writing policies in the state at year end?	Yes/No
1-11	Does the Company write in the non-standard market?	Yes/No
~~1-12~~	~~If yes, what percentage of your business is non-standard?~~	~~Percentage~~

~~1-13~~ 1-12	If yes, how is non-standard defined?	Comment
~~1-14~~ 1-13	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
~~1-15~~ 1-14	If yes, add additional comments	Comment
~~1-16~~ 1-15	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
~~1-17~~ 1-16	If yes, add additional comments	Comment
~~1-18~~ 1-17	How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim	Comment
~~1-19~~ 1-18	Does the company use Managing General Agents (MGAs)?	Yes/No
~~1-20~~ 1-19	If yes, list the names of the MGAs.	Comment
~~1-21~~ 1-20	Does the company use Third Party Administrators (TPAs)?	Yes/No
~~1-22~~ 1-21	If yes, list the names of the TPAs.	Comment
~~1-23~~ 1-22	Does the company use telematics or usage-based data?	Yes/No
~~1-24~~ 1-23	Does the company use digital claim settlement?	Yes/No
~~1-25~~ 1-24	If yes, list the names of the vendors providing third-party data and algorithms used in the digital claim settlement process.	Comment
~~1-26~~ 1-25	Additional state specific Claims Comments	Comment
~~1-27~~ 1-26	Additional state specific Underwriting Comments	Comment

Coverages

Coverages	**Reported also at the Digital Claim Handling Process Level of Detail***
Collision	X
Comprehensive/Other Than Collision	X
Bodily Injury	
Property Damage	X

Uninsured Motorists and Underinsured Motorists (UMBI)	
Uninsured Motorists and Underinsured Motorists (UMPD)	X
Medical Payments	
Combined Single Limits	
Personal Injury Protection	

* Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only toclaims related data elements)
Additionally, an "All" breakout will be included for the reporting of Median Days to Final Payment.

Schedule 2—Private Passenger Auto Claim Activity, Counts Reported by Claimant, by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two bodily injury claimants (one property damage claimant, one collision claim for the insured, and one medical payment claim for the insured), it would be reported as follows: Collision – 1, Bodily Injury – 2; Property Damage – 1; and Medical Payments – 1. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

ID	Description
~~2-28~~ 2-27	Number of claims open at the beginning of the period
~~2-29~~ 2-28	Number of claims opened during the period
~~2-30~~ 2-29	Number of claims closed with payment during the period.
~~2-31~~ 2-30	Number of claims closed without payment during the period.
~~2-32~~ 2-31	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.
~~2-33~~ 2-32	Number of claims remaining open at the end of the period
~~2-34~~ 2-33	Median days to final payment
~~2-35~~ 2-34	Number of claims closed with payment within 0-30 days
~~2-36~~ 2-35	Number of claims closed with payment within 31-60 days
~~2-37~~ 2-36	Number of claims closed with payment within 61-90 days

~~2-38~~ 2-37	Number of claims closed with payment within 91-180 days
~~2-39~~ 2-38	Number of claims closed with payment within 181-365 days
~~2-40~~ 2-39	Number of claims closed with payment beyond 365 days
~~2-41~~ 2-40	Number of claims closed without payment within 0-30 days
~~2-42~~ 2-41	Number of claims closed without payment within 31-60 days
~~2-43~~ 2-42	Number of claims closed without payment within 61-90 days
~~2-44~~ 2-43	Number of claims closed without payment within 91-180 days
~~2-45~~ 2-44	Number of claims closed without payment within 181-365 days
~~2-46~~ 2-45	Number of claims closed without payment beyond 365 days

Schedule 3 – Private Passenger Auto Underwriting Activity

ID	Description
~~3-47~~ 3-46	Number of autos which have policies in force at the end of the period.
~~3-48~~ 3-47	Number of policies in force at the end of the period.
~~3-49~~ 3-48	Number of new policies written during the period.
3-49	Number of non-standard policies issued during the period.
3-50	Total number of policies in force at the end of the period that have Collision coverage.
3-51	Total number of policies in force at the end of the period that have Comprehensive coverage.
3-52	Total number of policies in force at the end of the period that have Bodily Injury coverage.
3-53	Total number of policies in force at the end of the period that have Property Damage coverage.
3-54	Total number of policies in force at the end of the period that have UMBI and UIMBI coverage.
3-55	Total number of policies in force at the end of the period that have UMPD and UIMPD coverage.

3-56	Total number of policies in force at the end of the period that have Medical Payments coverage.
3-57	Total number of policies in force at the end of the period that have Combined Single Limits coverage.
3-58	Total number of policies in force at the end of the period that have Personal Injury Protection coverage.
3-59	Number of policies in force at the end of the period that are enrolled in a telematics or usage-based data product(s).
~~3-50~~ 3-60	Dollar amount of direct written premium during the period.
~~3-51~~ 3-61	Number of company-initiated non-renewals during the period.
~~3-52~~ 3-62	Number of cancellations for non-pay or non-sufficient funds.
~~3-53~~ 3-63	Number of cancellations at the insured's request.
~~3-54~~ 3-64	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
~~3-55~~ 3-65	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
~~3-56~~ 3-66	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
~~3-57~~ 3-67	Number of complaints received directly from any person or entity other than the DOI.

Schedule 4—Private Passenger Auto Lawsuit Activity

ID	Description
~~4-58~~ 4-68	Number of lawsuits open at beginning of the period.
~~4-59~~ 4-69	Number of lawsuits opened during the period.
~~4-60~~ 4-70	Number of lawsuits closed during the period.
~~4-61~~ 4-71	Number of lawsuits open at end of period.
~~4-62~~ 4-72	Number of lawsuits closed with consideration for the consumer.

Schedule 5—Private Passenger Auto Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
~~5-63~~ 5-73	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~5-64~~ 5-74	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~5-65~~ 5-75	Overall Comments for the Period

Definitions:

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

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

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

Report cancellations separately for:

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

Exclude:

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

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

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

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

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

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

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

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Each claimant/insured reporting a loss is counted separately.

Include:

- Both first- and third-party claims.

Exclude:

- An event reported for "information only".
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also "Date of Final Payment".

Exclude:

- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured's deductible.

Clarifications:

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

Calculation Clarification:

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

Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment for claims closed with payment during the reporting period:

- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also "Date of Final Payment".

Include:

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

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

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties.

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

Clarification:

- Rental/transportation/tow expenses which are paid as a result or part of a collision claim should not be counted as separate claims.

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

Clarification:

- Rental/transportation/tow expenses which are paid as a result or part of a comprehensive/other than collision claim should not be counted as separate claims.

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

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

Include:

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

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

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

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

Coverage - UMPD – Includes both Uninsured Motorist Property Damage Coverage and Underinsured Motorist Property Damage Coverage.

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

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

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

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

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

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

Calculation Clarification:

- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claims was received.
- Report a claim as "closed with payment" or "closed without payment" if it is closed in the company's claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company's claims system, would you report the days to final payment.

Example:

- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
    - The claim would be reported as open in the "00" MCAS submission and closed in the "01" MCAS submission.
    - The number of days to final payment would be calculated as 30 days and reported in the "01" MCAS submission.

Date the Claim was Reported – The date an insured or claimant first reported his or her loss to either the company or insurance agent.

Digital Claim Handling Process Level of Detail Breakdown:

Digital Claim – A claim involving a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim

was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or in the productionof the initial loss settlement offer. Digital claims utilize only digital information toestablish the extent of damage and to produce a loss settlement determination through the application of one or more automated loss algorithms applied to digital information. No human inspection or appraisal of the damaged property isconducted by the insurance company, independent adjuster, or other person relied upon by the insurance company during the life cycle of the claim.

Examples of digital claim information include, but are not limited to, photos taken by a claimant or insured, photos taken by a plane or drone, and/or dataprovided by in-vehicle or in-property sensors.

Hybrid C**laim** – A claim whereby the initial loss settlement determination began as a digital claim, however, at some point in the claim life cycle required the useof human resources in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer.

Non-Digital Claim – means any claim other than a Digital Claim or HybridClaim.

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

Calculation Clarification:

- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
- Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Lawsuit –An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

Exclude:

- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, interpleader actions, and declaratory judgment actions filed or brought by an insurer.

For purposes of reporting lawsuits for Private Passenger Auto products:

- Include all lawsuits, whether or not a hearing or proceeding before the court occurred.
- With the exception of class action lawsuits, report a lawsuit with two or more complainants as one lawsuit.
- With the exception of class action lawsuits, report a lawsuit in the jurisdiction in which the policy was issued.
- Report claim related lawsuits broken out by coverage as outlined in the schedule.
- Report non-claim related lawsuits in aggregate as outlined in the schedule.

Treatment of class action lawsuits:

- Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
- Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Median Days to Final Payment – The median value for all claims closed with payment during the period.

Calculation for losses with one final payment date during the reporting period:

- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:

- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:

- Subrogation payments should not be included.

Calculation Clarification / Example:

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

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

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

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

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

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

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

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

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

Closing Time	# of Claims
< 30	22
31-60	13

61-90	18
91-180	11
181-365	12
>365	15

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

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

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

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

Exclude:
- Renewals or 're-written' policies unless there was a lapse in coverage.

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

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

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

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

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

Private Passenger Auto Insurance – Those policies issued on automobiles owned or leased by an individual or by husband and wife resident in the same household that are reported on lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement.

Include:

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

Exclude:

- Policies written on antiques, collectibles, all-terrain vehicles, snowmobiles, trailers, dune buggies.
- Miscellaneous vehicles written on Inland Marine policies.
- Other vehicles classified by ISO as miscellaneous that do not fall under the various states' Motor Vehicle Responsibility laws.
- 'Fleet' policies are generally considered to be a commercial policy and would not be included unless the premium for these policies is being reported as 'private passenger auto' insurance on lines 19.1, 19.2 or 21.1 of the state page of the financial annual statement.
- Non-owned vehicle insurance policies.
- Lender-placed or creditor-placed policies.
- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.

Telematics and Usage-Based Data – Data which is collected through devices installed in a vehicle, through mobile applications, or other method. These devices then transmit the data in real time back to insurers. Examples of usage-based data collected via telematics includes - but is not limited to - miles driven, time of day, where the vehicle is driven (Global Positioning System or GPS), rapid acceleration, hard braking, hard cornering and air bag deployment.

Homeowners (2026)

Homeowners Interrogatories

		Yes No Response	Explanation
01	Were there policies in-force during the reporting period that provided Dwelling coverage?		———
02	Were there policies in-force during the reporting period that provided Personal Property coverage?		———
03	Were there policies in-force during the reporting period that provided Liability coverage?		———
04	Were there policies in-force during the reporting period that provided Medical Payments coverage?		———
05	Were there policies in-force during the reporting period that provided Loss of Use coverage?		———
06	Was the company still actively writing policies in the state at year end?		———
07	Does the company write in the non-standard market?		———
~~08~~	~~If Yes, what percentage of your business is non-standard?~~	———	
~~09~~08	If Yes, how is non-standard defined?	———	
~~10~~09	Has the company had a significant event/business strategy that would affect data for this reporting period?		———
~~11~~10	If yes, add additional comments.	———	
~~12~~11	Has all or part of this block of business been sold, closed or moved to another company during the reporting period?		———
~~13~~12	If yes, add additional comments.	———	
~~14~~13	How does the company treat subsequent supplemental or additional payments on previously closed claims?	———	
~~15~~14	Does the company use Managing General Agents (MGAs)?		———
~~16~~15	If yes, list the names of the MGAs.	———	
~~17~~16	Does the company use Third Party Administrators (TPAs)?		———
~~18~~17	If yes, list the names of the TPAs.	———	
~~19~~18	Does the company use digital claim settlement?		———
~~20~~19	If yes, list the names of the vendors providing third-party dataand algorithms used in the digital claim settlement process.	———	
~~21~~20	Additional state specific Claims comments (optional):	———	
~~22~~21	Additional state specific Underwriting comments (optional):	———	

Homeowners Claims Activity

		Dwelling				Personal Property			
		Digital	Hybrid	Non-Digital	All	Digital	Hybrid	Non-Digital	All
~~23~~22	Number of claims open at the beginning of the period.								———
~~24~~23	Number of claims opened during the period.								———
~~25~~24	Number of claims closed with payment during the period.								———
~~26~~25	Number of claims closed without payment during the period.								———
~~27~~26	Number of claims open at the end of the period.								———
~~28~~27	Median days to final payment.							———	
~~29~~28	Number of claims closed with payment within 0-30 days.								———

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Homeowners (2026)

Homeowners Claims Activity

		Dwelling				Personal Property			
		Digital	Hybrid	Non-Digital	All	Digital	Hybrid	Non-Digital	All
~~30~~29	Number of claims closed with payment within 31-60 days.								———
~~31~~30	Number of claims closed with payment within 61-90 days.								———
~~32~~31	Number of claims closed with payment within 91-180 days.								———
~~33~~32	Number of claims closed with payment within 181-365 days.								———
~~34~~33	Number of claims closed with payment beyond 365 days.								———
~~35~~34	Number of claims closed without payment within 0-30 days.								———
~~36~~35	Number of claims closed without payment within 31-60 days.								———
~~37~~36	Number of claims closed without payment within 61-90 days.								———
~~38~~37	Number of claims closed without payment within 91-180 days.								———
~~39~~38	Number of claims closed without payment within 181-365 days.								———
~~40~~39	Number of claims closed without payment beyond 365 days.								———

Homeowners Underwriting Activity

		Total
~~41~~40	Number of dwellings which have policies in force at the end of the period.	
~~42~~41	Number of dwelling fire policies in force at the end of the period.	
~~43~~42	Number of homeowner policies in force at the end of the period.	
~~44~~43	Number of tenant/renter/condo policies in force at the end of the period.	
~~45~~44	Number of all other residential property policies in force at the end of the period.	
~~46~~45	Number of new business policies written during the period.	
46	Number of non-standared policies issued during the period.	
47	Dollar amount of direct premium written during the period.	
48	Number of company-initiated non-renewals during the period.	
49	Number of cancellations for non-pay or non-sufficient funds.	
50	Number of cancellations at the insured's request	
51	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.	
52	Number of company-initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to a related company.	
53	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.	
54	Number of complaints received directly from any person or entity other than the DOI.	

Version 2026.0.0 (Updated 05/22/2024)

Homeowners (2026)

Lawsuit Activity

		Dwelling	Personal Property	Liability	Medical Payments
55	Number of lawsuits open at beginning of the period				
56	Number of lawsuits opened during the period				
57	Number of lawsuits closed during the period				
58	Number of lawsuits open at end of period				
59	Number of lawsuits closed with consideration for the consumer				

Homeowners Attestation

		First Name	Middle Name	Last Name	Suffix
60	First Attestor Information				
61	Second Attestor Information				
62	Overall Comments for the Filing Period	———	———	———	———

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Market Conduct Annual Statement Property & Casualty Homeowner Data Call & Definitions

Line of Business: Homeowners

Reporting Period: January 1, 2026 through December 31, 2026

Filing Deadline: April 30, 2027

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1—Interrogatories

ID	Description	Comment
1-01	Were there policies in-force during the reporting period that provided Dwelling coverage?	Yes/No
1-02	Were there policies in-force during the reporting period that provided Personal Property coverage?	Yes/No
1-03	Were there policies in-force during the reporting period that provided Liability coverage?	Yes/No
1-04	Were there policies in-force during the reporting period that provided Medical Payments coverage?	Yes/No
1-05	Were there policies in-force during the reporting period that provided Loss of Use coverage?	Yes/No
1-06	Was the Company still actively writing policies in the state at year end?	Yes/No
1-07	Does the Company write in the non-standard market?	Yes/No
~~1-08~~	~~If yes, what percentage of your business is non-standard?~~	~~Comment~~
~~1-09~~ 1-08	If yes, how is non-standard defined?	Comment
~~1-10~~ 1-09	Has the company had a significant event/business strategy that would affect data for this reporting period? Yes/No	Yes/No
~~1-11~~ 1-10	If yes, add additional comments	Comment

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~~1-12~~ 1-11	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
~~1-13~~ 1-12	If yes, add additional comments	Comment
~~1-14~~ 1-13	How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim	Comment
~~1-15~~ 1-14	Does the company use Managing General Agents (MGAs)?	Yes/No
~~1-16~~ 1-15	If yes, list the names of the MGAs.	Comment
~~1-17~~ 1-16	Does the company use Third Party Administrators (TPAs)?	Yes/No
~~1-18~~ 1-17	If yes, list the names of the TPAs.	Comment
~~1-19~~ 1-18	Does the company use digital claim settlement?	Yes/No
~~1-20~~ 1-19	If yes, list the names of the vendors providing third-party data and algorithms used in the digital claim settlement process.	Comment
~~1-21~~ 1-20	Claims Comments	Comment
~~1-22~~ 1-21	Underwriting Comments	Comment

Coverages	**Reported also at the Digital Claim Handling Process Level of Detail***
Dwelling (includes – Other Structures)	**X**
Personal Property	**X**
Liability	
Medical Payments	
Loss of Use	

***Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only to claims related data elements)**
Additionally, an "All" breakout will be included for the reporting of Median Days to Final Payment

Schedule 2—Homeowners Claims Activity, Counts Reported by Claimant and by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two liability claimants, two medical payment claims, one dwelling claim for the insured, and one personal property claim for the insured, you would report as follows: Dwelling – 1; Personal Property – 1; Liability – 2; Medical Payments – 2. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

ID	Description
~~2-23~~ 2-22	Number of claims open at the beginning of the period
~~2-24~~ 2-23	Number of claims opened during the period
~~2-25~~ 2-24	Number of claims closed during the period, with payment
~~2-26~~ 2-25	Number of claims closed during the period, without payment
~~2-27~~ 2-26	Number of claims open at the end of the period
~~2-28~~ 2-27	Median days to final payment
~~2-29~~ 2-28	Number of claims closed with payment within 0-30 days
~~2-30~~ 2-29	Number of claims closed with payment within 31-60 days
~~2-31~~ 2-30	Number of claims closed with payment within 61-90 days
~~2-32~~ 2-31	Number of claims closed with payment within 91-180 days
~~2-33~~ 2-32	Number of claims closed with payment within 181-365 days
~~2-34~~ 2-33	Number of claims closed with payment beyond 365 days
~~2-35~~ 2-34	Number of claims closed without payment within 0-30 days
~~2-36~~ 2-35	Number of claims closed without payment within 31-60 days
~~2-37~~ 2-36	Number of claims closed without payment within 61-90 days
~~2-38~~ 2-37	Number of claims closed without payment within 91-180 days
~~2-39~~ 2-38	Number of claims closed without payment within 181-365 days

~~2-40~~ 2-39	Number of claims closed without payment beyond 365 days

Schedule 3—Homeowners Underwriting Activity

ID	Description
~~3-41~~ 3-40	Number of dwellings which have policies in-force at the end of the period
~~3-42~~ 3-41	Number of dwelling fire policies in force at the end of the period.
~~3-43~~ 3-42	Number of homeowner policies in force at the end of the period.
~~3-44~~ 3-43	Number of tenant/renter/condo policies in force at the end of the period.
~~3-45~~ 3-44	Number of all other residential property policies in force at the end of the period.
~~3-46~~ 3-45	Number of new business policies written during the period
3-46	Number of non-standard policies issued during the period
3-47	Dollar amount of direct premium written during the period
3-48	Number of Company-Initiated non-renewals during the period
3-49	Number of cancellations for non-pay or non-sufficient funds
3-50	Number of cancellations at the insured's request
3-51	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-52	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-53	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-54	Number Of Complaints Received Directly From Any Person or Entity Other than the DOI

Schedule 4– Lawsuit Activity

Reporting Breakdown

Dwelling (includes – Other Structures)	Claim related lawsuits
Personal Property	
Liability	
Medical Payments	
Loss of Use	
Non-claim Related Lawsuits	Non-claim related lawsuits

ID	Description
4-55	Number of lawsuits open at beginning of the period
4-56	Number of lawsuits opened during the period
4-57	Number of lawsuits closed during the period
4-58	Number of lawsuits open at end of period
4-59	Number of lawsuits closed with consideration for the consumer

Schedule 4– Homeowners Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
4-60	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
4-61	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
4-62	Overall Comments for the Period

Definitions:
In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. *Exclude:* lender-placed or creditor-placed policies.

Please note: In the Underwriting Section there are questions asking for policies in-force by type of policy. These are asking for a count of the policies in-force that meet the specifications to be included on the MCAS. Please use the following as a guide to determine which policy types should be reported for each question:

(3-45) Number of dwelling fire policies in force at the end of the period.
Include dwelling policies that meet the definition of a dwelling policy as defined within this document. This would typically include policies written on forms DP-1, DP-2 and DP-3.

(3-46) Number of homeowner policies in force at the end of the period.
Include homeowner policies that meet the definition of a homeowner policy as defined within this document. This would typically include policies written on forms HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8.

(3-47) Number of tenant/renter/condo policies in force at the end of the period.
Include tenant/renter/condo policies that meet the definition of a tenant/renter/condo policy as defined within this document. This would typically include policies written on forms HO-4 and HO-6.

(3-48) Number of all other residential property policies in force at the end of the period.
Include other policies that meet the specifics of MCAS reporting, but that do not fall into one of the categories requested in questions 3-45, 3-46 and 3-47. If your company only write policies that fall into the forms specified for questions 3-45, 3-46 and 3-47, this number will be 0.

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

Report cancellations separately for:

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

Exclude:

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

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

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

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

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

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

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

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Each claimant/insured reporting a loss is counted separately.

Include:
- Both first and third party claims.

Exclude:
- An event reported for "information only".
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also "Date of Final Payment".

Exclude:
- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured's deductible.

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

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

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment for claims closed with payment during the reporting period:
- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on that supplemental payment from the time the request for supplemental payment was received to the date of the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also "Date of Final Payment".

Include:

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

Calculation Clarification:

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

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

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties.

Coverage - Dwelling (includes – Other Structures) – Coverage for dwellings under Homeowners Policies and Dwelling Fire and Dwelling Liability Policies. It includes coverage for Other Structures.

Coverage - Loss of Use – Loss of Use provided under Homeowners Policies.

Coverage - Personal Property – Personal Property provided under Homeowners Policies.

Coverage - Liability – Liability insurance provided under Homeowners Policies.

Coverage - Medical Payments – Medical Payments provided under Homeowners Policies.

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

Calculation Clarification:

- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment date was made during the reporting period regardless of the date of loss or when the claims was received.
- Report a claim as "closed with payment" or "closed without payment" if it is closed in the company's claims system during the reporting period (even if the final payment was issued in a prior reporting period.
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company's claims system, would you report the days to final payment.

Example:

- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
    - The claim would be reported as open in the "00" MCAS submission and closed in the "01" MCAS submission.
    - The number of days to final payment would be calculated as 30 days and reported in the "01" MCAS submission.

Date the Claim was Reported – The date an insured or claimant first reported his or her loss to either the company or insurance agent.

Digital Claim Handling Process Level of Detail Breakdown:

Digital Claim – A claim involving a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or in the productionof the initial loss settlement offer. Digital claims utilize only digital information toestablish the extent of damage and to produce a loss settlement determination through the application of one or more automated loss algorithms applied to digital information. No human inspection or appraisal of the damaged property isconducted by the insurance company, independent adjuster, or other person relied upon by the insurance company during the life cycle of the claim.

Examples of digital claim information include, but are not limited to, photos taken by a claimant or insured, photos taken by a plane or drone, and/or dataprovided by in-vehicle or in-property sensors.

Hybrid Claim – A claim whereby the initial loss settlement determination began as a digital claim, however, at some point in the claim life cycle required the useof human resources in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer.

Non-Digital Claim – means any claim other than a Digital Claim or HybridClaim.

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

Calculation Clarification:

- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
- Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:

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

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

Include:

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

Homeowners Policies – Policies that combine liability insurance with one or more other types of insurance such as property damage, personal property damage, medical payments and additional living expenses.

Include:

- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.
- Renters insurance,-Policies covering log homes, land homes, and site built homes are included.
- Inland Marine or Personal Articles endorsements.
- Include policies written on the HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 policy forms.

Exclude:

- Farmowners is not included as it is considered to be Commercial Lines for purposes of this project.
- Umbrella policies.
- Lender-placed or creditor-placed policies.

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

Exclude:

- Stand-alone Inland Marine Policies.

Lawsuit –An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

Exclude:

- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, interpleader actions, and declaratory judgment actions filed or brought by an insurer.
- Arbitrations, mediation, appraisal, or any other form of dispute resolution not brought in a court of law.

For purposes of reporting lawsuits for Homeowner products:

- For non-claims related lawsuits, include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer as a defendant.

- Include all lawsuits, whether or not a hearing or proceeding before the court occurred.
- With the exception of class action lawsuits, report a lawsuit with two or more complainants as one lawsuit.
- With the exception of class action lawsuits, report a lawsuit in the jurisdiction in which the policy was issued.
- Report claim related lawsuits broken out by coverage as outlined in the schedule.
- Report non-claim related lawsuits in aggregate as outlined in the schedule.

Treatment of Class Action Lawsuits:

- Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
- Include an explanatory note with your submission state the number of class action lawsuits included in the data and the general cause of the action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

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

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

Median Days to Final Payment – The median value for all claims closed with payment during the period.

Calculation for losses with one final payment date during the reporting period:

- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:

- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:

- Subrogation payments.

Calculation Clarification / Example:

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

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

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

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

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

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

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

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

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

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

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

Medical Payments Coverage – Provides coverage for medical expenses resulting from injuries sustained by a claimant regardless of liability.

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

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

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

Exclude:

- 'Re-written' policies unless there was a lapse in coverage.

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

Include:

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

Exclude:

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

Calculation Clarification:

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

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

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

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

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

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

Tenant/Renters/Condo Policies – Policies that provide coverage for the personal property of tenants, renters, condominium and cooperative unit owners. Include policies typically written on the HO-4 and HO-6 policy forms.

MCAS Market Conduct Annual Statement

Lender-Placed Insurance (2026)

Lender-Placed Insurance Interrogatories

		Yes/No Response	Explanation
01	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed auto coverage?		_____
02	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were single-interest lender-placed auto.	_____	
03	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed auto coverage?		_____
04	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were dual-interest lender-placed auto.	_____	
05	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners hazard coverage?		_____
06	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were single-interest lender-placed homeowners hazard	_____	
07	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners hazard coverage?		_____
08	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were dual-interest lender-placed homeowners hazard	_____	
09	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners flood coverage?		_____
10	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were single-interest lender-placed homeowners flood	_____	
11	Were there policies/certificates in-force during the reporting period that provided dual-		_____
12	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were dual-interest lender-placed homeowners flood coverage.	_____	
13	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners wind-only coverage?		_____
14	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were single-interest lender-placed homeowners wind-only	_____	
15	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners wind-only coverage?		_____
16	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were dual-interest lender-placed homeowners wind-only	_____	

Lender-Placed Insurance (2026)

17	Were there policies-in-force during the reporting period that provided blanket vendor single-interest auto (vehicle) coverage?								———	
18	Were there policies-in-force during the reporting period that provided blanket vendor single-interest home (residential property) coverage?								———	
19	Was the company still actively writing policies/certificates in the state at year end?								———	
20	Has the company had a significant event/business strategy that would affect data for this reporting period?								———	
21	If yes, add additional comments:						———			
22	Has all or part of this block of business been sold, closed or moved to another company during the year?								———	
23	If yes, add additional comments						———			
24	How does the company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? For example: Reopen original claim/open new claim						———			
25	Does the company require third parties it contracts with to forward insurance-related complaints to the company so the company may report the complaints in its complaints logs?								———	
26	Additional comments if desired:						———			
27	Does the company monitor third parties it contracts with to ensure insurance complaints are forwarded to the company?								———	
28	Additional comments if desired						———			
29	Additional state specific Claims comments						———			
30	Additional state specific Underwriting comments						———			

Lender-Placed Claims Activity

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Blanket Vendor Single-Interest Auto	Blanket Vendor Single-Interest Home
31	Number of claims open at the beginning of the period.										
32	Number of claims opened during the period.										
33	Number of claims closed during the period, with payment										
34	Number of claims closed during the period, without payment										

35	Number of claims remaining open at the end of the period										
35	Number of claims closed with payment within 0-30 days.										

Lender-Placed Insurance (2026)

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Blanket Vendor Single-Interest Auto	Blanket Vendor Single-Interest Home
36	Number of claims closed with payment within 31-60 days.										
37	Number of claims closed with payment within 61-90 days.										
39	Number of claims closed with payment within 91-180 days.										
40	Number of claims closed with payment within 181-365 days.										
41	Number of claims closed with payment beyond 365 days.										
42	Number of claims closed without payment within 0-30 days.										
43	Number of claims closed without payment within 31-60 days.										
44	Number of claims closed without payment within 61-90 days.										
45	Number of claims closed without payment within 91-180 days.										
46	Number of claims closed without payment within 181-365 days.										
47	Number of claims closed without payment beyond 365 days.										
48	Median days to final payment.										
49	Number of suits open at beginning of the period.										
50	Number of suits opened during the period.										
51	Number of suits closed during the period.										
52	Number of suits closed during the period with consideration for the borrower.										
53	Number of suits open at end of period.										

Lender-Placed Underwriting Activity

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Blanket Vendor Single-Interest Auto	Blanket Vendor Single-Interest Home
54	Number of master policies in-force at beginning of the period.										
55	Number of master policies added during the period.										
56	Number of master policies canceled for any reason during the period.										
57	Number of master policies in-force at the end of the period.										

Lender-Placed Insurance (2026)

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Blanket Vendor Single-Interest Auto	Blanket Vendor Single-Interest Home
58	Number of certificates in-force at the beginning of the period.										
59	Number of certificates written during the period.										
60	Number of certificates for which Term of Coverage Completed during the period.										
~~60~~ 61	Number of certificates in-force at the end of the period.										
~~61~~ 62	Number of certificates flat-cancelled during the period.										
~~62~~ 63	Number of certificates cancelled for reasons other than										
~~63~~ 64	Number of flat cancellations on certificates within 45 days of placement.										
~~64~~ 65	Number of flat cancellations on certificates within 45-90 days of placement.										
~~65~~ 66	Number of flat cancellations on certificates after 90 days from placement.										
~~66~~ 67	Number of individual policies in-force at the beginning of the period.										
~~67~~ 68	Number of individual policies written during the period.										
69	Number of individual policies for which Term of Coverage Completed during the period.										
~~68~~ 70	Number of individual policies in-force at the end of the period.										
~~69~~ 71	Number of individual policies cancelled for reasons other than flat cancellations during the period.										
~~70~~ 72	Number of individual policies flat-cancelled during the period.										
~~71~~ 73	Number of flat cancellations on individual policies within 45 days of placement.										
~~72~~ 74	Number of flat cancellations on individual policies within 45-90 days of placement.										
~~73~~ 75	Number of flat cancellations on individual policies after 90 days from placement.										
~~74~~ 76	Average gross placement rate during period.										

Lender-Placed Insurance (2026)

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Vendor Single-Interest Auto	Vendor Single-Interest Home
~~75~~ 77	Dollar amount of gross written premium during the period.										
~~76~~ 78	Dollar amount of net written premium during the period.										
~~77~~ 79	Net written premium during period for policies/certificates for which no separate charge is made to the borrower.										
~~78~~ 80	Dollar amount of premium earned during the period.										
~~79~~ 81	Dollars of claims paid during the period.										
~~80~~ 82	Dollars of claims incurred during the period.										
~~81~~ 83	Number of complaints received directly from the DOI.										
~~82~~ 84	Number of complaints received directly from any person or entity other than the DOI.										

Lender-Placed Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
~~83~~ 85	First Attestor Information						———
~~84~~ 86	Second Attestor Information						———
~~85~~ 87	Overall Comments for the Filing Period	———	———	———	———	———	

Property & Casualty Market Conduct Annual Statement
Lender-Placed Data Call & Definitions

Lines of Business: Lender-Placed Auto and Lender-Placed Homeowners
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: April 30, 2027

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestors	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1—Interrogatories

ID	Description	Response
1-01	Were there policies/certificates in-force during the	Yes/No
1-02	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which	Comment
1-03	Were there policies/certificates in-force during the	Yes/No
1-04	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which	Comment
1-05	Were there policies/certificates in-force during the reporting period that provided single-interest lender-	Yes/No
1-06	If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during	Percentage
1-07	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-	Yes/No
1-08	If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during	Percentage
1-09	Were there policies/certificates in-force during the reporting period that provided single-interest lender-	Yes/No
1-10	If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during	Percentage
1-11	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-	Yes/No
1-12	If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during	Percentage

1-13	Were there policies/certificates in-force during the reporting period that provided single-interest lender-	Yes/No
1-14	If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued	Percentage
1-15	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-	Yes/No
1-16	If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued	Percentage
1-17	Were there policies-in-force during the reporting	Yes/No
1-18	Were there policies-in-force during the reporting period that provided blanket vendor single interest	Yes/No
1-19	Was the company still actively writing	Yes/No
1-20	Has the company had a significant event/business	Yes/No
1-21	If yes, add additional comments	Comment
1-22	Has this block of business or part of this block of	Yes/No
1-23	If yes, add additional comments	Comment
1-24	How does the company treat subsequent supplemental payments on previously closed claims	Comment
1-25	Does the company require third parties it contracts with to forward insurance-related complaints to the	Yes/No
1-26	Add additional comment if desired	Comment
1-27	Does the company monitor third parties it contracts	Yes/No
1-28	Add additional comment if desired	Comment
1-29	Claims Comments	Comment (if necessary)
1-30	Underwriting Comments	Comment (if necessary)

Coverages

Single-Interest Lender-Placed Auto
Dual-Interest Lender-Placed Auto
Single-Interest Lender-Placed Homeowners Hazard
Dual-Interest Lender-Placed Homeowners Hazard
Single-Interest Lender-Placed Homeowners Flood
Dual-Interest Lender-Placed Homeowners Flood
Single-Interest Lender-Placed Homeowners Wind-Only
Dual-Interest Lender-Placed Homeowners Wind-Only
Blanket Vendor Single-Interest Auto (Vehicle)
Blanket Vendor Single-Interest Home (Residential Property)

Schedule 2—Lender-Placed Auto and Homeowners and Lender-Placed Blanket Vendor Single-Interest Auto and Home Claims Activity, Counts Reported by Claimant, by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim.

ID	Description
2-31	Number of claims open at the beginning of the period
2-32	Number of claims opened during the period
2-33	Number of claims closed during the period, with payment
2-34	Number of claims closed during the period, without payment
2-35	Number of claims remaining open at the end of the period
2-36	Number of claims closed with payment within 0-30 days
2-37	Number of claims closed with payment within 31-60 days
2-38	Number of claims closed with payment within 61-90 days
2-39	Number of claims closed with payment within 91-180 days
2-40	Number of claims closed with payment within 181-365 days
2-41	Number of claims closed with payment beyond 365 days
2-42	Number of claims closed without payment within 0-30 days
2-43	Number of claims closed without payment within 31-60 days
2-44	Number of claims closed without payment within 61-90 days
2-45	Number of claims closed without payment within 91-180 days
2-46	Number of claims closed without payment within 181-365 days
2-47	Number of claims closed without payment beyond 365 days
2-48	Median days to final payment
2-49	Number of suits open at beginning of the period
2-50	Number of suits opened during the period
2-51	Number of suits closed during the period
2-52	Number of suits closed during the period with consideration for the borrower
2-53	Number of suits open at end of the period

Schedule 3—Lender-Placed Auto and Home Underwriting Elements

ID	Description
3-54	Number of master policies in-force at beginning of the period
3-55	Number of master policies added during the period
3-56	Number of master policies canceled for any reason during the period
3-57	Number of master policies in-force at the end of the period
3-58	Number of certificates in-force at the beginning of the period
3-59	Number of certificates written during the period
3-60	Number of certificates for which Term of Coverage Completed during the period
~~3-60~~ 3-61	Number of certificates in-force at the end of the period

~~3-61~~ 3-62	Number of certificates flat-cancelled during the period
~~3-62~~ 3-63	Number of certificates cancelled for reasons other than flat cancellations during the period
~~3-63~~ 3-64	Number of flat cancellations on certificates within 45 days of placement
~~3-64~~ 3-65	Number of flat cancellations on certificates within 45-90 days of placement
~~3-65~~ 3-66	Number of flat cancellations on certificates after 90 days from placement
~~3-66~~ 3-67	Number of individual policies in-force at the beginning of the period
~~3-67~~ 3-68	Number of individual policies written during the period
3-69	Number of individual policies for which Term of Coverage Completed during the period
~~3-68~~ 3-70	Number of individual policies in-force at the end of the period
~~3-69~~ 3-71	Number of individual policies cancelled for reasons other than flat cancellations during the period
~~3-70~~ 3-72	Number of individual policies flat-cancelled during the period
~~3-71~~ 3-73	Number of flat cancellations on individual policies within 45 days of placement
~~3-72~~ 3-74	Number of flat cancellations on individual policies within 45-90 days of placement
~~3-73~~ 3-75	Number of flat cancellations on individual policies after 90 days from placement
~~3-74~~ 3-76	Average gross placement rate during period
~~3-75~~ 3-77	Dollar amount of gross written premium during the period
~~3-76~~ 3-78	Dollar amount of net written premium during the period
~~3-77~~ 3-79	Net written premium during period for policies/certificates for which no separate charge is made to the borrower
~~3-78~~ 3-80	Dollar amount of premium earned during the period
~~3-79~~ 3-81	Dollars of claims paid during the period

~~3-80~~ 3-82	Dollars of claims incurred during the period
~~3-81~~ 3-83	Number of complaints received directly from the DOI
~~3-82~~ 3-84	Number of complaints received directly from any person or entity other than the DOI

Schedule 3—Blanket Vendor Single-Interest Auto and Home Underwriting Elements

ID	Description
3-54	Number of master policies in-force at beginning of the period
3-55	Number of master policies added during the period
3-56	Number of master policies canceled for any reason during the period
3-57	Number of master policies in-force at the end of the period
3-58 3-77	Dollar amount of gross written premium during the period
3-59 3-78	Dollar amount of net written premium during the period
3-60 3-79	Net written premium during period for policies/certificates for which no separate charge is made to the borrower
3-61 3-80	Dollar amount of premium earned during the period
3-62 3-81	Dollar of claims paid during the period
3-63 3-82	Dollars of claims incurred during the period
3-64 3-83	Number of complaints received directly from the DOI
3-65 3-84	Number of complaints received directly from any person or entity other than the DOI

Schedule 4—Lender-Placed Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;

3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
~~4-83~~ 4-85	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~4-84~~ 4-86	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~4-85~~ 4-87	Overall Comments for the Period

Participation Requirements: All companies licensed and reporting at least $50,000 of lender-placed auto, $50,000 of lender-placed homeowners (hazard, wind-only, and flood collectively), or $50,000 of blanket vendor single-interest auto and home gross premium within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Definitions:
Lender-placed insurance has the same meaning as "Creditor-placed insurance" to be reported in the Credit Insurance Experience Exhibit (CIEE) of the Statutory Annual Statement. Lender-placed insurance means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to the property as a result of fire, theft, collision or other risk of loss that would either impair a creditor's interest or adversely affect the value of collateral.

Except for data element "Net premium written during period for policies/certificates for which no separate charge is made to the borrower," report experience for lender-placed insurance products for which a separate charge is made to the borrower regardless of

whether the charge to the borrower is made at loan origination, periodically while the loan is outstanding or following issuance of coverage under the master policy.

Lender-placed auto has the same meaning as "creditor-placed auto" to be reported in the CIEE. Lender-placed auto means lender-placed insurance on autos, boats or other vehicles.

Lender-placed homeowners has the same means as "creditor-placed homeowners" to be reported in the CIEE. Lender-placed homeowners means lender-placed insurance on homes, mobile homes and other real estate.

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the CIEE. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

Lender-placed homeowners hazard means that portion of lender-placed homeowners required to be reported in the CIEE covering perils other than flood or wind-only (in those states in which insurers may exclude wind coverage).

Lender-placed homeowners flood means that portion of lender-placed homeowners required to be reported in the CIEE covering the peril of flood only.

Lender-placed wind-only means that portion of lender-placed homeowners required to be reported in the CIEE covering the peril of wind only.

Lender-placed blanket vendor means that portion of lender-placed

Single-interest means insurance that protects only the creditor's interest in the collateral securing the debtor's credit.

Dual-interest means insurance that protects the creditor's and the debtor's interest in the collateral securing the debtor's credit transaction. Dual-interest includes insurance commonly referred to as limited dual-interest.

Blanket Vendor Single-Interest (VSI), for purposes of reporting experience in this Lender-Placed MCAS, means coverage issued to a lender or servicer to protect a lender's interest and which:

- Is provided through a blanket policy covering eligible collateral securing loans in the lender/servicer's portfolio
- Premium charges to the lender/servicer are based on aggregate exposures insured as opposed to any characteristics specific to any individual vehicle or property;

- No individual certificates or policies are issued to borrowers
- Has no ongoing tracking of insurance on borrower's loans; and
- If there is a charge to the borrower at loan origination, the same charge is made for all borrowers with eligible collateral regardless of insurance status.

Blanket VSI Auto experience and Blanket VSI Home experience is reported separately from Single-Interest Auto, Dual-Interest Auto, Single-Interest Home, and Dual-Interest Home.

Average Gross Placement Rate – The total number of coverages placed before cancellations during the reporting period divided by the average number of exposures during the reporting period. Average number of exposures means the average number of vehicles covered by Lender Placed Auto policies or average number of properties covered by Lender Placed Home policies during the reporting period.

Cancellations – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage. Coverage under an individual policy or a certificate under a group policy ending at the end of the term of coverage is not a cancellation, even if the coverage is renewed through a subsequent individual policy or certificate. See also Flat Cancellation

Certificate – Lender-placed insurance issued under a master policy for an individual vehicle or property, respectively.

Example:

- If the insurer issues 300 certificates under a lender-placed master policy or policies, report 300.

Claim – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy/certificate. Each claimant/insured reporting a loss is counted separately.

Include:

- Both first and third party claims.

Exclude:

- An event reported for "information only".
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also "Date of Final Payment".

Exclude:

- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured's deductible.

Clarifications:

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

Calculation Clarification:

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

Handling additional payment on previously reported claim/subsequent supplemental payment for claims closed with payment during the reporting period:

- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also "Date of Final Payment".

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.

- A demand for payment for which it was determined that no relevant policy/certificate was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured's deductible.

Complaints Received Directly from any Person or Entity Other than the Department of Insurance – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties, including, but not limited to, lenders or servicers

Complaints Received Directly from the Department of Insurance – All complaints:

- As identified by the DOI as a complaint.
- Related to LPI or insurance tracking.
- Sent or otherwise forwarded by the DOI to the reporting company.

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

- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claim was received.
- Report a claim as "closed with payment" or "closed without payment" if it is closed in the company's claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company's claims system, would you report the days to final payment.

Example:

- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
    - The claim would be reported as open in the "00" MCAS submission and closed in the "01" MCAS submission.

- The number of days to final payment would be calculated as 30 days and reported in the "01" MCAS submission.

Date the Claim was Reported – The date an insured or claimant first reported his or her claim to either the company or insurance agent.

Dollars of Claims Incurred During Period – The total dollars incurred for claims for the particular type of lender-placed insurance during the period. Include incurred claim dollars only for lender-placed insurance for which a separate charge is made to the borrower.

Dollars of Claims Paid During Period – The total dollars paid for claims for the particular type of lender-placed insurance during the period. Include paid claim dollars only for lender-placed insurance for which a separate charge is made to the borrower.

Flat Cancellation – The coverage was cancelled effective the date of coverage with 100% refund of premium.

Gross Premium Written During Period – The total premium written before any reductions for refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.

In-force – A master policy, individual policy, or certificate in effect during the reporting period.

Individual Policy – Lender-placed insurance issued for an individual vehicle or property, respectively.

Example:

- If the insurer issues 300 lender-placed policies for individual vehicles or properties (as opposed to issuing master policies to lenders or servicers), report 300.

Lawsuit – An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.
For purposes of reporting lawsuits in the MCAS blank:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;

- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer – A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought.

Master Policy – A group policy providing coverage for the vehicles or property serving as collateral for a portfolio of loans. Individual coverage, typically in the form of a certificate, is issued from the Master Policy at the direction of the lender/servicer or automatically at the point in time when the borrower's required voluntary insurance ceases to be in-force.

Median Days to Final Payment – The median value for all claims closed with payment during the period.

Calculation for claims with one final payment date during the reporting period:

- Date the claim was reported to the company to the date of final payment.

Calculation for claims with multiple final payment dates during the reporting period:

- Date the request for supplemental payment was received to the date of final payment (for each different final payment date.)

Exclude:

- Subrogation payments.

Calculation Clarification / Example:

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

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

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

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

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

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

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

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

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

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

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

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

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

Net Premium Written During Period – Gross premium written less refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.

Net Premium Written During Period for Policies/Certificates for Which No Separate Charge is Made to the Borrower – Gross premium written less refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which no separate charge is made to the borrower.

Premiums Earned During Period – Earned premiums for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made t**o the borrower.**

Term of Coverage Completed – Include individual policies and certificates for which the term of coverage was completed and ended during the period.

Line of Business: Pet

Reporting Period: January 1, 2026 through December 31, 2026

Filing Deadline: April 30, 2027

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1 – Interrogatories

ID	Description	Comment
1-01	Did the company conduct any business related to individual pet insurance policies during the period?	Yes/No
1-02	Did the company conduct any business related to group pet insurance policies during the period?	Yes/No
1-03	Did the company conduct any stand-alone pet Wellness Insurance business during the reporting period?	Yes/No
1-04	Did the company conduct any Accident & Illness, Accident only, or Illness only pet insurance business during the reporting period?	Yes/No
1-05	Did the company conduct any pet insurance business during the reporting period that does not fit into the following categories: Wellness Only, Accident & Illness, Accident only, or Illness only?	Yes/No
1-06	If yes, describe the other types of pet insurance business conducted during the reporting period	Comment
1-07	On which annual statement line(s) of business on the state page of the statutory annual statement does the company report pet insurance experience?	Comment
1-08	Was the company still actively marketing or writing pet insurance in the jurisdiction at the end of the reporting period?	Yes/No
1-09	Has the company had a significant event/business strategy change	Yes/No

	that would affect data for this reporting period?	
1-10	If yes, explain the situation and how it may affect the data	Comment
1-11	Has all or part of the company's pet insurance block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-12	If yes, describe the nature and extent of the transaction(s)	Comment
1-13	How does the company treat subsequent supplemental or additional payments on previously closed claims?	Comment
1-14	Does the company use pet program administrators, managing general agents (MGA) or insurance producers for purposes of supporting the pet insurance business being reported, other than the sale, solicitation, or negotiation of business?	Yes/No
1-15	If yes, provide the names, NPN (if applicable) and functions for each third party identified in question 14	Comment
1-16	Does the company have a system of supervision in place to oversee and potentially audit each type of third party identified in question 14?	Yes/No
1-17	If yes, please provide frequency of audits, if any, for each type of third party identified in question 14	Comment
1-18	Does the company require third parties identified in question 14 to forward insurance-related complaints to the company so the company may report the complaints in its complaint logs?	Yes/No
1-19	Does the company or any of its pet program administrators, managing general agents (MGA) or insurance producers offer a non-insurance wellness program to the consumers of the company's pet insurance products?	Yes/No
1-20	Additional comments if desired:	Comment
1-21	Additional state specific Underwriting Activity comments (optional)	Comment
1-22	Additional state specific Claims Activity comments (optional)	Comment
1-23	Additional state specific Marketing & Sales comments (optional)	Comment
1-24	Additional state specific Lawsuit and Complaint comments (optional)	Comment

Schedule 2 – Underwriting Activity

The Underwriting Activity schedule is to be reported for both Individual and Group policies/certificates

ID	Description
2-25	Number of policies in force at the beginning of the period

2-26	Number of certificates in force at the beginning of the period (Group only)
2-27	Number of covered pets on policies/certificates in force at the beginning of the period
2-28	Number of policies in force during the period that included accident-only coverage
2-29	Number of certificates in force during the period that included accident-only coverage (Group only)
2-30	Number of policies in force during the period that included illness-only coverage
2-31	Number of certificates in force during the period that included illness-only coverage (Group only)
2-32	Number of policies in force during the period that included accident and illness coverage
2-33	Number of certificates in force during the period that included accident and illness coverage (Group only)
2-34	Number of policies in force during the period that included wellness coverages (other than a wellness only policy)
2-35	Number of certificates in force during the period that included wellness coverages (other than a wellness only policy) (Group only)
2-36	Number of policies in force during the period that covered wellness as an insurance benefit (and did not cover accident and/or illness)
2-37	Number of certificates in force during the period that covered wellness as an insurance benefit (and did not cover accident and/or illness) (Group only)
2-38	Number of policies returned during the period under the consumer's "Right to Examine and Return the Policy"
2-39	Number of certificates returned during the period under the consumer's "Right to Examine and Return the Policy" (Group only)
2-40	Number of policies cancelled/terminated during the period at the policyholder's request
2-41	Number of certificates cancelled/terminated during the period at the certificate holders request (Group only)
2-42	Number of policies cancelled/terminated during the period by the insurer
2-43	Number of certificates cancelled/terminated during the period by the insurer (Group only)
2-44	Number of policies cancelled/terminated during the period for non-pay or non-sufficient funds
2-45	Number of certificates cancelled/terminated during the period for non-pay or non-sufficient funds (Group only)
2-46	Number of company-initiated policy non-renewals during the period
2-47	Number of company-initiated certificate non-renewals during the period (Group only)

2-48	Number of certificates expired during the period (Group only)
2-49	Number of new policies issued during the period
2-50	Number of new certificates issued during the period (Group only)
2-51	Number of covered pets on new policies/certificates issued during the period
2-52	Number of policies in force at end of the period
2-53	Number of certificates in force at the end of the period (Group only)
2-54	Number of covered pets on policies/certificates in force at the end of the period
2-55	Number of renewal policies issued during the period
2-56	Number of renewal certificates issued during the period (Group only)
2-57	Dollar amount of direct premium written during the period
2-58	Dollar amount of direct premium earned during the period
2-59	Number of applications pending at beginning of the period
2-60	Number of new applications received during the period (Individual Only)
2-61	Number of new applications denied for health status or condition during the period (Individual Only)
2-62	Number of new applications denied for any other reason during the period (Individual Only)
2-63	Number of applications pending at the end of the period (Individual Only)
2-64	Number of policies issued during the period that included a preexisting condition exclusion
2-65	Number of certificates issued during the period that included a preexisting condition exclusion (Group only)

Schedule 3 – Claims Activity

The Claims Activity schedule is to be reported for Wellness (Only), Accident & Illness, and Other policy types. Report median day data elements in aggregate only.

ID	Description
3-66	Number of claims open at the beginning of the period
3-67	Number of claims opened during the period
3-68	Number of claims closed during the period
3-69	Number of claims closed during the period with full payment
3-70	Dollar amount of claims closed with full payment during the period
3-71	Median days to claim closure for claims closed with full payment (Aggregate only)

3-72	Number of claims closed during the period with partial payment
3-73	Dollar amount requested for claims closed with partial payment during the period
3-74	Dollar amount of claims closed with partial payment during the period
3-75	Median days to claim closure for claims closed with partial payment (Aggregate only)
3-76	Median days to final payment for all claims paid in full and closed with partial payment (Aggregate only)
3-77	Number of claims closed during the period, without payment
3-78	Dollar amount requested for claims closed without payment during the period
3-79	Median days to claim closure for claims closed without payment during the period (Aggregate only)
3-80	Number of claims open at the end of the period
3-81	Number of claims closed during the period with full payment 0-30 days
3-82	Number of claims closed during the period with full payment 31-60 days
3-83	Number of claims closed during the period with full payment 61-90 days
3-84	Number of claims closed during the period with full payment 91-180 days
3-85	Number of claims closed during the period with full payment 181-365 days
3-86	Number of claims closed during the period with full payment beyond 365 days
3-87	Number of claims closed during the period with partial payment 0-30 days
3-88	Number of claims closed during the period with partial payment 31-60 days
3-89	Number of claims closed during the period with partial payment 61-90 days
3-90	Number of claims closed during the period with partial payment 91-180 days
3-91	Number of claims closed during the period with partial payment 181-365 days
3-92	Number of claims closed during the period with partial payment beyond 365 days
3-93	Number of claims closed during the period without payment within 0-30 days
3-94	Number of claims closed during the period without payment within 31-60 days
3-95	Number of claims closed during the period without payment within 61-90 days
3-96	Number of claims closed during the period without payment within 91-180 days
3-97	Number of claims closed during the period without payment within 181-365 days
3-98	Number of claims closed during the period without payment beyond 365 days
3-99	Number of claims closed during the period without payment – ineligibility
3-100	Number of claims closed during the period without payment – preexisting condition exclusion
3-101	Number of claims closed during the period without payment – waiting period
3-102	Number of claims closed during the period without payment – maximum benefit limit
3-103	Number of claims closed during the period without payment – claim amount less than

	deductible
3-104	Number of claims closed during the period without payment – inadequate documentation
3-105	Number of claims closed during the period without payment – hereditary disorder exclusion
3-106	Number of claims closed during the period without payment – congenital anomaly or disorder exclusion
3-107	Number of claims closed during the period without payment – chronic condition exclusion
3-108	Number of claims closed during the period without payment for reasons other than questions 99-107
3-109	Number of claims closed during the period with partial payment – maximum benefit limit
3-110	Number of claims closed during the period with partial payment – inadequate documentation
3-111	Number of claims closed during the period with partial payment for reasons other than questions 109-110
3-112	Number of claimant requests/benefit requests subject to a preexisting condition exclusion

Schedule 4 – Marketing and Sales

The Marketing and Sales schedule is to be reported for both Individual and Group policies/certificates

ID	Description
4-113	Dollar amount of commissions incurred during the period
4-114	Unearned commissions returned to the company during the period

Schedule 5 – Lawsuit and Complaint Activity

The Lawsuit and Complaint Activity schedule is to be reported for both Individual and Group policies/certificates

ID	Description
5-115	Number of complaints received directly from any person or entity other than the DOI
5-116	Number of lawsuits open at the beginning of the period
5-117	Number of lawsuits opened during the period
5-118	Number of lawsuits closed during the period
5-119	Number of lawsuits open at the end of the period
5-120	Number of lawsuits closed with consideration for the consumer

Schedule 6 – Pet Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
6-121	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
6-122	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
6-123	Overall Comments for the Period

In determining what business to report for a particular jurisdiction, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

Participation Requirements: All companies licensed and reporting any pet insurance within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Definitions for the purposes of MCAS reporting:

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year.

- These should be reported every time a policy cancels during the reporting period. (i.e., if a policy cancels for non-pay three times in a policy period and is reinstated each time; each cancellation should be counted.)

Exclude:

- Policies cancelled for 're-write' purposes where there is no lapse in coverage.
- Policies returned by the owner under the right to review or the free look provision.

Chronic Condition – A condition that can be treated or managed, but not cured.

Claim – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy/certificate. Each claimant/insured reporting a loss is counted separately.

Exclude:

- An event reported for "information only."
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed with Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. *See also "Date of Final Payment."*

Exclude:

- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured's deductible.

Clarifications:

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

Calculation Clarification:

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

Handling additional payment on previously reported claim/subsequent supplemental payment for claims closed with payment during the reporting period:

- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

Claims Closed without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also "Date of Final Payment."

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy/certificate was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured's deductible.

Calculation Clarification:

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

Commissions – Compensation, as defined as Commissions and Brokerage Expenses in the statutory financial annual statement instructions, paid to a producer or appropriately licensed entity for the sale, solicitation or negotiation of pet insurance.

Complaints Received Directly from any Person or Entity Other than the

Department of Insurance – Any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the jurisdiction's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties

Congenital Anomaly or Disorder – A condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

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

- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claim was received.
- Report a claim as "closed with payment" or "closed without payment" if it is closed in the company's claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company's claims system, would you report the days to final payment.

Example:

- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
    - The claim would be reported as open in the "00" MCAS submission and closed in the "01" MCAS submission.
    - The number of days to final payment would be calculated as 30 days and reported in the "01" MCAS submission.

Hereditary Disorder – An abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

Individual vs. Group Policies – Report business associated with individual policy forms as individual. Report business associated with group policy forms, such as certificates, as group. Report business issued to individuals in the Individual column even if it is marketed through a group channel.

Insurer Non-Renewals – Non-renewals initiated by the reporting entity. A non-renewal is the termination of coverage at the end of the policy contract period.

Exclude:

- Non-renewals occurring as a result of nonpayment of premium (these data are reported separately, as policyholder cancellations).

Lawsuit – An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits in the Pet MCAS blank:

- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each jurisdiction in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer – A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant or policyholder in an amount greater than offered by the reporting company before the lawsuit was brought.

Managing General Agent (MGA) – An insurance producer authorized by an insurance company to manage all or part of the insurer's business. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. Many states regulate the activities and contracts of MGAs.

Median – A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If

the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

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

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

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

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

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

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

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

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

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

National Producer Number (NPN) – A specific number provided by National Insurance Producers Registry (NIPR) to individuals and most business entities that are listed in the NIPR's Producer Database (PDB).

Non-Insurance Wellness Program – a subscription or reimbursement-based program

that is separate from an insurance policy that provides goods and services to promote the general health, safety, or wellbeing of the pet. This definition is not intended to classify a contract directly between a service provider and a pet owner that only involves the two parties as being "the business of insurance," unless other indications of insurance also exist.

Number of Policies Renewed – Number of pet insurance policies renewed during the specified period. If the policyholder number remains the same, count the policy as renewed.

Group Policy Clarifications:

- One group policy should be reported regardless of the number of products made available to the group.
- An insured group that changes products to another product offered by the same carrier should not be reported as a termination renewal, if a group changes to a new product with the same carrier this should be reported as a policy renewal (not as a policy issued).

Individual Policy Clarifications:

- An individual that changes policies to another policy offered by the same carrier should be reported as a termination.
- At renewal, if an individual changes to a new product with the same carrier this should be reported as a policy issued (not as a policy renewal).

Other Policy Type – Any policy type other than a Wellness Policy and/or an Accident/Illness Policy.

Partial Payment – A claim not paid in full for costs included within the terms of coverage of the insurance policy/certificate.

- Removal from a claim of charges for costs not covered in the policy – where there is full payment for costs covered in the policy – is not considered a partial payment.
- Do not report as partial payment claims that are reduced by deductibles, copays, ~~maximum benefit limits,~~ or other limitations set by the insurance policy/certificate.

Pet Insurance means a property insurance policy that provides coverage for one or more of the following: accidents, illnesses or wellness of pets. Pet insurance does not include non-insurance wellness programs for pets.

Pet Program Administrator – An individual or entity that directly or indirectly underwrites, collects charges or premium from, or adjusts or settles claims on residents of a state, in connection with pet coverage offered or provided by an insurer, unless excepted by statute.

Policies/Certificates – Refers to the coverage documents provided to individuals or

families (i.e., state residents) who are enrolled in coverage.

Policyholder/Certificate Holder – Refers to the individual who is afforded benefits of the coverage according to the laws of the state in which they reside. Policyholder is the individual when purchased in the individual market. Certificate holder is the individual when purchased through a group, which is the policyholder.

Policyholder Cancellations – Policies cancelled at any point during the reporting period at the request of or in response to the policyholder. Exclude policies terminated for nonpayment of premium.

Preexisting Condition – Any condition for which any of the following are true prior to the effective date of a pet insurance policy or during any waiting period:

- A veterinarian provided medical advice;
- The pet received previous treatment; or
- Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

A condition for which coverage is afforded on a policy cannot be considered a preexisting condition on any renewal of the policy.

Renewal – To issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.

Right to Examine and Return the Policy (Free Look) – Report the number of policies/certificates that were returned by the owner under the free look provision during the period, regardless of the original issuance date. Count any policy returned under the Free Look provision even if an alternative policy was ultimately purchased by the insured.

Veterinarian – An individual who holds a valid license to practice veterinary medicine from the appropriate licensing entity in the jurisdiction in which he or she practices.

Waiting Period – The period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.

Disability Income (2026)

Disability Income Interrogatories

		Yes/No Response	Explanation
01	Does the company have Individual Voluntary Short-Term coverage to report?		--
02	Does the company have Individual Voluntary Long-Term coverage to report?		--
03	Does the company have Individual Employer-Paid Short-Term coverage to report?		--
04	Does the company have Individual Employer-Paid Long-Term coverage to report?		--
05	Does the company have Group Voluntary Short-Term coverage to report?		--
06	Does the company have Group Voluntary Long-Term coverage to report?		--
07	Does the company have Group Employer-Paid Short-Term coverage to report?		--
08	Does the company have Group Employer-Paid Long-Term coverage to report?		--
09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?		--
10	If Yes, explain.	--	
11	Has all or part of the reporting entity's disability income protection business been sold, closed, or moved to another insurer during the reporting period?		--
12	If Yes, explain.	--	
13	Number of class action lawsuits?	--	
14	Additional state specific Underwriting comments (optional):	--	
15	Additional state specific claims comments (optional):	--	
16	Additional comments (optional):	--	

Disability Income Claims Information

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
17	Pending benefit determinations, beginning of reporting period.								
18	Active paid claims, beginning of reporting period.								
19	Claims received during reporting period.								
20	New paid claim determinations during reporting period.								
21	Claim denials during reporting period.								
22	Paid claims closed during reporting period.								
23	Pending benefit determinations, end of reporting period.								
24	Active paid claims, end of reporting period.								

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Disability Income (2026)

Disability Income Claims Decisions Processed

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
25	Number of claims processed with initial claim decision within 1-14 days.		--		--		--		--
26	Number of claims processed with initial claim decision within 15-30 days.		--		--		--		--
27	Number of claims processed with initial claim decision within 31-45 days.		--		--		--		--
28	Number of claims processed with initial claim decision over 45 days.		--		--		--		--
29	Median Processing Time: The median processing time for claims resulting in payments reported in lines 25 through 28.		--		--		--		--
30	Number of claims processed with initial claim decision within 1-30 days.	--		--		--		--	
31	Number of claims processed with initial claim decision within 31-60 days.	--		--		--		--	
32	Number of claims processed with initial claim decision within 61-90 days.	--		--		--		--	
33	Number of claims processed with initial claim decision over 90 days.	--		--		--		--	
34	Median Processing Time: The median processing time for claims resulting in payments reported in lines 30 through 33.	--		--		--		--	

Disability Income Resulting in Closed Without Payment

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
35	Number of claims closed without payment within 1-14 days.		--		--		--		--
36	Number of claims closed without payment within 15-30 days.		--		--		--		--
37	Number of claims closed without payment within 31-45 days.		--		--		--		--
38	Number of claims closed without payment over 45 days.		--		--		--		--
39	Median Processing Time: The median processing time for claims closed without payment reported in lines 35 through		--		--		--		--
40	Number of claims closed without payment within 1-30 days.	--		--		--		--	
41	Number of claims closed without payment within 31-60 days.	--		--		--		--	
42	Number of claims closed without payment within 61-90 days.	--		--		--		--	
43	Number of claims closed without payment over 90 days.	--		--		--		--	
44	Median Processing Time: The median processing time for claims closed without payment reported in lines 40 through	--		--		--		--	

Disability Income Claims Denied - Reasons

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
45	Claimant not covered under the policy as of date of disability onset.								
46	Claimant returned to work during elimination period.								
47	Pre-existing condition.								
48	Claimant not disabled under the policy definition of disabled.								
49	Lack of documentation.								
50	Disability arising from diagnosis excluded under the policy.								
51	Disability due to work-related injury or condition excluded under the policy.								
52	Disability caused by excluded circumstance other than a work-related injury.								
53	Misrepresentation.								
54	All other denials.								

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Disability Income (2026)

Disability Income Claims Closed After Initial Payment(s)

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
55	Claimant returned to work - own occupation/job.								
56	Claimant returned to work - any occupation/job.								
57	Lack of documentation.								
58	Non-participation in evaluation.								
59	Death of claimant.								
60	Failure to participate in rehabilitation.								
61	Misrepresentation.								
62	Claimant had offsetting compensation.								
63	Maximum benefit reached.								
64	Not disabled with respect to "own occupation" but *has not returned to work.*								
65	Not disabled with respect to "any occupation" but *has not returned to work.*								
66	Other closed after payment.								

Disability Income Underwriting Activity (Group & Individual)

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
67	Number of policies in force at the beginning of the reporting period.								
68	Number of new policies issued during the reporting period.								
69	Dollar amount of direct written premium.								
70	Number of policyholder cancellations and non-renewals.								
71	Number of insurer non-renewals.								
72	Number of insurer cancellations.								
73	Number of rescissions within two years from policy issue.								
74	Number of rescissions after two years from policy issue.								
75	Number of policies in force at the end of the reporting period.								

Disability Income Covered Lives Related to Underwriting Activity (Group Only)

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
76	Number of lives covered under policies in force at the beginning of the reporting period.	--	--	--	--				
77	Number of lives covered under new policies issued during the reporting period.	--	--	--	--				
78	Number of lives covered under policyholder cancellations and non-renewals.	--	--	--	--				
79	Number of lives covered under insurer non-renewals.	--	--	--	--				
80	Number of lives covered under insurer cancellations.	--	--	--	--				
81	Number of lives covered under rescinded policies.	--	--	--	--				
82	Number of lives covered under policies in force at the end of the reporting period.	--	--	--	--				

Disability Income (2026)

Disability Income Complaints and Lawsuits

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
83	Number of complaints received directly from any person or entity other than the DOI.								
84	Number of lawsuits open as of the beginning of the reporting period.								
85	Number of new lawsuits opened during the reporting period.								
86	Number of lawsuits closed during the reporting period (total).								
87	Number of lawsuits closed during the reporting period with consideration for the consumer.								
88	Number of lawsuits open as of the end of the period.								

Disability Income Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
89	First Attestor Information						--
90	Second Attestor Information						--
91	Overall Comments for the Filing Period	--	--	--	--	--	

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Line of Business: Disability Income Insurance
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: April 30, 2027

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1—Interrogatories

ID	Description	Response
1-01	Does the company have Individual Voluntary Short-Term coverage to report?	Yes/No
1-02	Does the company have Individual Voluntary Long-Term coverage to report?	Yes/No
1-03	Does the company have Individual Employer-Paid Short-Term coverage to report?	Yes/No
1-04	Does the company have Individual Employer-Paid Long-Term coverage to report?	Yes/No
1-05	Does the company have Group Voluntary Short-Term coverage to report?	Yes/No
1-06	Does the company have Group Voluntary Long-Term coverage to report?	Yes/No
1-07	Does the company have Group Employer-Paid Short-Term coverage to report?	Yes/No
1-08	Does the company have Group Employer-Paid Long-Term coverage to report?	Yes/No
1-09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-10	If Yes, explain:	Comment
1-11	Has all or part of the reporting entity's disability income protection business been sold, closed, or moved to another insurer during the reporting period?	Yes/No
1-12	If Yes, explain:	Comment

1-13	Number of class action lawsuits?	Number
1-14	Additional underwriting comments (optional):	Comment
1-15	Additional claims comments (optional):	Comment
1-16	Additional comments (optional):	Comment

Product Type Identifiers

Each product will represent a unique mix of three characteristics related to method of payment (voluntary v. employer-paid), duration of the benefit period (short term v. long term) and method of product marketing and sales (group v. individual). The mix of these three characteristics yields eight possible product types:

- Individual voluntary short-term
- Individual voluntary long-term
- Individual employer-paid short term
- Individual employer-paid long term
- Group voluntary short-term
- Group voluntary long-term
- Group employer-paid short-term
- Group employer-paid long-term

Schedule 2—Claims Information

ID	Description
2–17	Pending benefit determinations, beginning of reporting period.
2–18	Active paid claims, beginning of reporting period.
2–19	Claims received during reporting period.
2–20	New paid claim determinations during reporting period.
2–21	Claim denials during reporting period.
2–22	Paid claims closed during reporting period.
2–23	Pending benefit determinations, end of reporting period.
2–24	Active paid claims, end of reporting period.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Schedule 3—Claims Decisions Processed

ID	Description
3–25	Number of claims processed with initial claim decision within 1-14 days (Short term)
3–26	Number of claims processed with initial claim decision within 15-30 days (Short term)
3–27	Number of claims processed with initial claim decision within 31-45 days (Short term)
3–28	Number of claims processed with initial claim decision over 45 days (Short term)
3–29	Median Processing Time: The median processing time for claims resulting in payments reported in 3-25 through 3-28 (Short term)
3–30	Number of claims processed with initial claim decision within 1-30 days (Long term)
3–31	Number of claims processed with initial claim decision within 31-60 days (Long term)
3–32	Number of claims processed with initial claim decision within 61-90 days (Long term)
3–33	Number of claims processed with initial claim decision over 90 days (Long term)
3–34	Median Processing Time: The median processing time for claims resulting in payments reported in 3-30 through 3-33 (Long term)

Schedule 4—Resulting in Closed Without Payment

ID	Description
4–35	Number of claims closed without payment within 1-14 days (Short term)
4–36	Number of claims closed without payment within 15-30 days (Short term)
4–37	Number of claims closed without payment within 31-45 days (Short term)
4–38	Number of claims closed without payment over 45 days (Short term)
4–39	Median Processing Time: The median processing time for claims closed without payment reported in 4-35 through 4-38 (Short term)
4–40	Number of claims closed without payment within 1-30 days (Long term)
4–41	Number of claims closed without payment within 31-60 days (Long term)
4–42	Number of claims closed without payment within 61-90 days (Long term)
4–43	Number of claims closed without payment over 90 days (Long term)
4–44	Median Processing Time: The median processing time for claims closed without payment reported in 4-40 through 4-43 (Long term)

Schedule 5—Claims Denied – Reasons

ID	Description
5–45	Claimant not covered under the policy as of date of disability onset.
5–46	Claimant returned to work during elimination period.
5–47	Pre-existing condition.
5–48	Claimant not disabled under the policy definition of disabled.
5–49	Lack of documentation.
5–50	Disability arising from diagnosis excluded under the policy.
5–51	Disability due to work-related injury or condition excluded under the policy.
5–52	Disability caused by excluded condition or circumstance other than a work-related injury.
5–53	Misrepresentation.
5–54	All other denials.

Schedule 6—Claims Closed After Initial Payment(s)

ID	Description
6–55	Claimant returned to work – own occupation/job.
6–56	Claimant returned to work – any occupation/job.
6–57	Lack of documentation.
6–58	Non-participation in evaluation.
6-59	Death of claimant.
6–60	Failure to participate in rehabilitation.
6–61	Misrepresentation.
6–62	Claimant had offsetting compensation.
6–63	Maximum benefit reached.
6–64	Not disabled with respect to "own occupation" but *has not returned to work.*
6–65	Not disabled with respect to "any occupation" but *has not returned to work.*
6–66	Other closed after payment.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Schedule 7—Disability Insurance Underwriting Activity (Group & Individual)

ID	Description
7–67	Number of policies in force at the beginning of the reporting period.
7–68	Number of new policies issued during the reporting period.
7–69	Dollar amount of direct written premium.
7–70	Number of policyholder cancellations and non-renewals.
7–71	Number of insurer non-renewals.
7–72	Number of insurer cancellations.
7–73	Number of rescissions within two years from policy issue.
7–74	Number of rescissions after two years from policy issue.
7–75	Number of policies in force at the end of the reporting period.

Schedule 8—Covered Lives Related to Underwriting Activity (Group Only)

ID	Description
8–76	Number of lives covered under policies in force at the beginning of the reporting period.
8–77	Number of lives covered under new policies issued during the reporting period.
8–78	Number of lives covered under policyholder cancellations and non-renewals.
8–79	Number of lives covered under insurer non-renewals.
8–80	Number of lives covered under insurer cancellations.
8–81	Number of lives covered under rescinded policies.
8–82	Number of lives covered under policies in force at the end of the reporting period.

Schedule 9—Complaints and Lawsuits

ID	Description
9–83	Number of complaints received directly from any person or entity other than the DOI.
9–84	Number of lawsuits open as of the beginning of the reporting period.
9–85	Number of new lawsuits opened during the reporting period.
9–86	Number of lawsuits closed during the reporting period (total).
9–87	Number of lawsuits closed during the reporting period with consideration for the consumer.
9–88	Number of lawsuits open as of the end of the period.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Schedule 10—Disability Income Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
10-89	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
10-90	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
10-91	Overall Comments for the Period

Disability Income Insurance (or Disability Income Protection)–Disability income (DI) insurance is insurance that provides payments when an insured is disabled or unable to work because of illness, disease or injury, including incidental benefits. Policies may provide monthly benefits for loss of income from disability, either on a short-term or a long-term basis. This does not include insurance policies specifically intended to satisfy an employer's obligations or liabilities arising from incidents covered under the various states' Worker's Compensation Acts, Jones Act, United States Longshoreman and Harbor Workers Act, and similar statutes.
Reporting entities are required to report data on all Disability Income Insurance Coverage issued by the reporting entity as set forth on the DI MCAS blank.

Participation Requirements: All companies licensed and reporting at least $50,000 of disability income written premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Terms defined within these DI MCAS INSTRUCTIONS are to be utilized in completing the DI MCAS report. Reporting entities are required to file DI MCAS data consistent with the definitions provided within these INSTRUCTIONS.

These instructions are organized by MCAS DI Schedule or Section. Line numbers correspond to the line numbers appearing on the MCAS blank.

Individual v. Group Policies—Individual policies are marketed to, or are purchased directly by, individuals. Group policies are sold and purchased by or through group sponsors such as associations, employers, or groups of employers. Policies that originated as group coverage, but covering individuals who are no longer members or eligible participants of the group sponsor and are not linked to some other group or trust, are to be reported as individual coverage.

Short term v. Long-term DI— Short term DI policies offer benefit payments during a disability for no more than two years. Long term policies cover disability for a significantly longer period, often to the age of retirement.

Voluntary v. Employer Paid—Voluntary coverage is coverage for which an individual pays **all** of the premium, irrespective of whether the policy is a group or individual policy. Employer-paid policies are coverage for which an employer pays **any portion** of the premium, and may also be individual or group coverage.

NOTE: Contact the Department of Insurance for the relevant jurisdiction if you have any questions regarding how to categorize any such products or policies for any particular jurisdiction.

Contact Information

MCAS Administrator—The MCAS Administrator is the person responsible for preparing and filing the DI MCAS report.

MCAS Contact—The MCAS Contact is the primary company representative for DOI communications regarding the DI MCAS report; can be same as the MCAS Administrator.

MCAS Attestor—The person who attests to the completeness and accuracy of the MCAS data.

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

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

Interrogatories

The Interrogatories Section is intended to allow reporting entities the opportunity to provide regulators with relevant contextual information that may help them interpret the data, and to afford a general overview of the nature of a company's book of business.

Significant events or change to business strategy—(1-09 and 1-10) If a reporting entity experienced a significant event or a business strategy change, describe the experience and explain the significance with respect to data filed in this report.

Sales, closures and movement of DI business—(1-11 and 1-12) Described instances in which portions of the reporting entity's DI business has been sold, closed or moved to another insurer, and describe what impact, if any, these activities have on the data reported herein.

Number of class action lawsuits—(1-13) Reporting entities should put the total class action lawsuits for DI business.

Underwriting information comments—(1-14) Reporting entities should provide any additional underwriting information that might assist insurance departmental personnel in interpreting specific data or in analyzing this MCAS report.

Claims information comments—(1-15) Reporting entities should provide any additional claims information that may assist insurance department personnel in interpreting specific data or in analyzing this MCAS report.

Additional Comments—(1-16) Reporting entities should provide any additional information related to features or characteristics of their DI business in a given state that would assist department personnel in interpreting specific data or in analyzing this MCAS report.

Schedule 2 – Claims.

A claim is a request or demand for payment of benefits under a disability income policy. For purposes of this Market Conduct Annual Statement, a "claim" includes any such request or demand, even those with incomplete or inadequate documentation and those made by an individual not eligible or covered under the policy against which the claim is made.

Communications with an insurer that are not explicit claims as per the definition above should not be reported on this MCAS. Such communications could include general queries regarding policy provisions, potential coverage, events reported for "information only,' or other communications for which a clear request or demand for payment has not been made.

If a claim is reopened, treat the reopened claim as a new and distinct claim apart from the original claim. For reopened claims, the claim determination time period is measured from the date the claim was re-opened to the date a benefit determination is made.

In Schedule 2 and Schedule 3 "initial benefit determination" refers to a reporting entity's decision to pay benefits under the policy or to deny the claim – not to a reporting entity's decision to continue payment or to close a claim that has been in previous payment status. These latter decisions are to be reported on Schedule 6.

Pending benefit determinations, beginning of reporting period—(2-17) Report the number of open or pending claims for which no decision to pay or deny has been made as of the beginning of the reporting period (January 1).

Active paid claims, beginning of reporting period—(2-18) Report the number claims from the prior reporting period for which payment is continuing to be made at the beginning of the reporting period (January 1).

Claims received during reporting period—(2-19) The number of new claims received by the reporting entity during the reporting period (January 1)

New paid claim determinations during reporting period—(2-20) Report the number of claims for which a benefit determination has been made at any time during the reporting period that resulted in a decision to make a payment.

Claim denials during reporting period—(2-21) Report the number of initial benefit determinations made at any time during the reporting period that resulted in a decision to deny payment.

Paid claims closed during reporting period—(2-22) Report the number of claims with an initial benefit determination resulting in payment that are closed or are no longer receiving payments during the reporting period.

Pending benefit determinations, end of reporting period—(2-23) Report the number of open or pending claims for which no decision to pay or deny has been made as of the end of the reporting period (December 31).

Active paid claims, end of period—(2-24) Report the number of claims for which payment is continuing to be made at the end of the reporting period(December 31).

Schedule 3 and Schedule 4

These schedules capture information about claims processing times. All processing times should be calculated as the number of days from the receipt of a claim in the mailroom or other claims intake unit, until the decision is made to either pay or deny the claim. Do not include any additional days until payment is actually made to, or received by, the claimant.

Median processing times—(3-29, 3-34; 4-39, 4-44)

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

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

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

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

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

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

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

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

Closing Time	# of Claims
< 30	22
31-60	13
61-90	18
>90	16

The sum of the claims reported across each closing time interval is 69, so that the median is the 35th claim. This claim falls into the closing time interval "31-60 days." Any reported median that falls outside of this range (i.e. less than 31 or greater than 60) will indicate a data error.

Schedule 5 Claim Denials – Reasons

Schedule 5 captures information about claims closed without payment. Categories are mutually exclusive such that each claim should be reported in **one and only one** category.

Claimant not covered under the policy—(5-45) A claim determination decision that the claimant is not insured or covered under the policy, against which a claim for benefits is made, as of the date of claimed disability onset.

Claimant returned to work during elimination period—(5-46) Many policies have an elimination period, which is defined as the time between the onset of a disability and benefit eligibility.

Pre-existing condition—(5-47) A medical condition of the insured that existed prior to eligibility for coverage under a disability income policy.

Claimant not disabled under the policy definition of disabled—(5-48) The claimant is not disabled as per policy definitions. Include in this line instances in which an individual is deemed physically capable of work as well as instances where the decline in income or wages is insufficient to trigger coverage.

Lack of documentation—(5-49) Instances in which a claimant fails to submit requested documentation sufficient to demonstrate disability.

> Exclude**:** cases where requested documentation has been submitted but still fails to establish sufficient evidence of a disability.

Disability arising from diagnosis excluded under the policy— (5-50) An injury or condition specifically identified in the policy as excluded from coverage. For example, some policies exclude

conditions whose diagnosis relies to a significant degree on the insured's subjective expressions of symptoms or for which there exists no objective lab, imaging or other medical test. Examples might include fibromyalgia or chronic fatigue syndrome. Other policies might exclude psychological conditions or substance abuse.

Disability due to work-related injury or condition excluded under the policy— (5-51) Claims denied under an exclusion or injuries or condition arising from paid employment.

Disability caused by excluded condition or circumstance other than a work-related injury— (5-52) A disability arising from circumstances or causes that are specifically excluded under the policy. Common examples might include disabilities arising in connection with the commission of a felony, and act of war, or an excluded activity such as non-commercial aviation.

Exclude: denials due to a work-related injury reported in 5-51.

Misrepresentation—(5-53) Claim denials due to false or incorrect information on an application for coverage or in the application for policy benefits.

Other denials—(5-54) All claim denials that are not reported in 5-45 through 5-52.

Schedule 6 – Claims closed after initial payments

Include claims closed, after initial payment, at any time during the reporting period regardless of the reporting year in which they were received. Categories are intended to be mutually exclusive, such that a claim should be reported in **one and only one** category.

Claimant returned to work – own occupation / job (6-55)

Claimant returned to work – any occupation / job (6-56)

The above two lines (6-55 and 6-56) should include claims for which payment has been terminated because an individual formerly considered disabled has returned to employment sufficient to end coverage. The own occupation/job (6-55) refers to those instances in which a claimant returns to previous employment or employment of the same class as is defined in the policy (usually under an "own occupation" definition of disability). The any occupation/job (6-56) should include instances in which a claimant returns to work, but at a materially different job class (usually defined in an "any occupation" definition of disability).

The remaining lines should only include benefit terminations under conditions in which the insured has not returned to employment of a kind necessary to end disability coverage.

Lack of documentation—(6-57) Include claims in which payment has been terminated due to a failure to obtain documentation pertaining to medical records, earnings loss, or any other evidence of continued disability.

Non-participation in evaluation—(6-58) Payment termination due to the failure to an insured to comply with a reporting entity's requirements for an independent medical, occupational or other similar evaluation.

Death of claimant—(6-59)

Failure to participate in rehabilitation—(6-60) Instances in which an insured refuses to comply with policy requirements pertaining to participation in rehabilitation, worksite accommodations, or other program designed to facilitate a return to employment.

Misrepresentation—(6-61) See definition under schedule 5 (5-52); **Misrepresentation** in the context of a claim denial.

Claimant had offsetting compensation—(6-62) Claims for which payment is terminated due to off-setting income available to an insured, such as social security benefits, workers compensation payments, or other source of income. This category may include instances in which an insured has not availed themselves available sources of income, depending on policy provisions.

Maximum benefit reached—(6-63) Claim payments terminated because the maximum level of benefits afforded by the policy has been reached. Include all claims terminated due to maximum payment amount, maximum benefit period, or other cap defined in the policy.

The next two lines (6-64 and 6-65) should include all other instances in which a claimant has not returned to work but is deemed capable of returning to work pursuant to policy provisions. *Exclude claims which are more appropriately reported in 6-57 through 6-63.* Use the same definitions of "own occupation" and "any occupation" as for 6-55 and 6-56.

Not disabled with respect to own occupation but has not returned to work—(6-64) Claimant has been deemed as not disabled with respect to "own occupation," but has not returned to work based on the company's records.

Not disabled with respect to any occupation but has not returned to work—(6-65) Claimant has been deemed as not disabled with respect to "any occupation," but has not returned to work based on the company's records.

Other closed after payment—(6-66) Include all claims which resulted in any payment, and for which payment has terminated during the reporting period, that are not reported in 6-55 through 6-65.

Schedule 7 – Disability Insurance Underwriting Activity (both Group and Individual DI)

The following definitions are referring to the number of policies in force.

Policies in force at the beginning of reporting period—(7-67) The number of in force policies at the beginning of the reporting period (January 1).

Policies issued—(7-68) New policies issued at any time during the reporting period. Exclude policy renewals.

Direct written premium—(7-69)

Policyholder cancellations and non-renewals—(7-70) Policies cancelled or non-renewed at any point during the reporting period at the request of or in response to the policyholder. Include policies terminated for nonpayment of premium.

Insurer non-renewals—(7-71) Non-renewals initiated by the reporting entity. A non-renewal is the termination of coverage at the end of the policy contract period.

> Exclude: non-renewals occurring as a result of nonpayment of premium (these data are reported in 7-70).

Insurer cancellations—(7-72) A cancelation is the termination of an in-force policy during the policy contract period.

> Exclude: cancellations resulting from nonpayment of premium (these data are reported in 7-70).

Rescissions within two years—(7-73) A rescission is the termination of coverage by the reporting entity, retroactive to the beginning of the policy contract period. Include rescissions occurring within two years of the date the policy was first issued.

Rescissions after two years—(7-74) Rescissions occurring beyond two years after the date a policy was first issued.

Policies in force at the end of reporting period—(7-75) The number of in force polices at the end of the reporting period (December 31).

Schedule 8 –Covered Lives Related to Underwriting Activity (Group DI Only)

For group coverage, each line should record the number of lives covered under policies reported in Schedule 7.

Lives covered under policies in force beginning of period—(8-76) The number of lives covered under policies in force at the beginning of the reporting period (January 1). These are lives covered under the policies reported in 7-67.

Lives covered under new policies issued—(8-77) The number of lives covered under new policies issued at any time during the reporting period, corresponding to the policies reported in 7-68. *Report the number of covered lives on the effective date of the policy.*

Lives covered under policyholder cancellations and non-renewals—(8-78) The number of lives covered under policies that were terminated at the request of or in response to the policyholder. Include policies cancelled or non-renewed at any time during the reporting period. *Report the number of covered lives as of the date that coverage ended.* The lives reported here should correspond to the policy termination reported in 7-70

Lives covered under insurer non-renewals—(8-79) The number of lives covered under policies subject to non-renewals initiated by a reporting entity, *as of the date that coverage terminated.* A non-renewal is the termination of coverage at the end of the policy contract period. The lives reported correspond to the policies reported on 7-71. Exclude non-renewals resulting from a nonpayment of premium (these data are reported on 8-78).

Lives covered under insurer cancellations—(8-80) The number of lives on cancellations initiated by the reporting entity, *as of the date that coverage terminated.* A cancellation is the termination of an in-force policy during the policy contract period. The lives reported should correspond to policies reported on 7-72. Exclude cancellations resulting from non-payment of premiums, (these data are reported on 8-78).

Lives covered under rescinded policies—(8-81) A rescission is the termination of coverage by the reporting entity, retroactive to the beginning of the policy contract period. Report the number of lives *as of the date that the rescission occurred.* The lives reported here should correspond to the policies reported in 7-73 and 7-74.

Lives covered under policies in force at the end of the reporting period—(8-82) The number of lives covered by policies in force at the end of the reporting period (December 31). The lives reported here should correspond to the policies reported in 7-75.

Schedule 9 Complaints and Lawsuits

Use the following definitions of complaints and lawsuits for reporting the number of complaints/lawsuits for the items in Schedule 9.

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

> Report only complaints pertaining to or arising from insurance operations associated with Disability Income Insurance, such as marketing and sales, policy service, claims handling or any other operations directly related to a disability income insurance policy.

Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuit in the Disability Income MCAS blank:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member reside. Include an explanatory note in the Additional Comments field (1-16) with your submission stating the general cause of action.

Complaints received directly from any entity other than the DOI—(9-83) The number of complaints received directly by a reporting entity from any person or entity other than a department of insurance.

Lawsuits open —(9-84) The number of lawsuits in process that have not been resolved or closed at the beginning of the reporting period (January 1).

New lawsuits—(9-85) The number of new lawsuits filed against the reporting entity at any time during the data year.

Lawsuits closed—(9-86) Include all lawsuits closed at any time during the reporting period, regardless of the manner in which the lawsuit was resolved.

Lawsuits closed during the period with consideration for the consumer—(9-87) A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought.

Lawsuits Open at the end of the period—(9-88) Total of lawsuits that remain open or active at the end of the reporting period (December 31).

Long-Term Care (2026)

Long-Term Care Interrogatories

		Yes/No Response	Explanation
01	Does the company have data to report for Stand-Alone Long-Term Care?		--
02	Does the company have data to report for Life Long-Term Care Hybrid?		--
03	Does the company have data to report for Annuity Long-Term Care Hybrid?		--
04	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period?		--
05	If yes, add additional comments.	--	
06	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?		--
07	If yes, add additional comments.	--	
08	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?		--
09	If yes, add additional comments.	--	
10	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?		--
11	If yes, add additional comments.	--	
12	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?		--
13	If yes, add additional comments.	--	
14	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?		--
15	If yes, add additional comments.	--	
16	Additional state specific Stand-Alone Long-Term Care comments (optional).	--	
17	Additional state specific Life Long-Term Care Hybrid comments (optional).	--	
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional).	--	

Long-Term Care General Information

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.			
20	Number of new business policies/contracts issued during the period.			
21	Number of free look cancellations during the period.			
22	Number of lapses during the period.			
23	Number of rescissions during the period.			
24	Number of policies/contracts in-force as of the end of the reporting period.			
25	Number of internal replacements during the period.			
26	Number of external replacements during the period.	--		
27	Number of policies/contracts replaced where age of insured at replacement was < 65.	--		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.	--		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.			
30	Number of complaints received directly from ~~consumers~~ any person or entity other than the DOI.			

Long-Term Care Claimants and Claimant Requests Activity

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
31	Number of claimants approved for benefits as of the beginning of the period.			
32	Number of claimants with pending claimant request determinations as of the beginning of the period.			
33	Number of new claimants during the period.			
34	Number of claimants with pending claimant request determinations as of the end of the period.			
35	Number of claimants approved for benefits as of the end of the period.			
36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).			
37	Number of claimant requests denied or not paid because of preexisting condition exclusion.			
38	Number of claimant requests denied or not paid because of elimination or waiting period not met.			

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Long-Term Care (2026)

Long-Term Care Claimants and Claimant Requests Activity Continued

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
39	Number of claimant requests denied or not paid because services provided not covered under the policy.			
40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.			
41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.			
42	All other claimant requests denied or closed without payment.			
43	Number of claim request determinations made within 0-30 days.			
44	Number of claim request determinations made within 31-60 days.			
45	Number of claim request determinations made within 61-90 days.			
46	Number of claim request determinations made beyond 90 days.			

Long-Term Care Benefit Payment Requests Activity

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
47	Number of benefit payment requests pending as of the beginning of the period.			
48	Number of benefit payment requests received during the period.			
49	Number of benefit payment requests denied or not paid during the period.			
50	Number of benefit payment requests pending as of the end of the period.			
51	Number of benefit payment requests paid within 0-30 days.			
52	Number of benefit payment requests paid within 31-60 days.			
53	Number of benefit payment requests paid within 61-90 days.			
54	Number of benefit payment requests paid beyond 90 days.			
55	Number of benefit payment requests denied or not paid within 0-30 days.			
56	Number of benefit payment requests denied or not paid within 31-60 days.			
57	Number of benefit payment requests denied or not paid within 61-90 days.			
58	Number of benefit payment requests denied or not paid beyond 90 days.			

Long-Term Care Lawsuit Activity

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
59	Number of lawsuits open as of the beginning of the period.			
60	Number of lawsuits opened during the period.			
61	Number of lawsuits closed during the period - total.			
62	Number of lawsuits closed during the reporting period with consideration for the consumer.			
63	Number of lawsuits open as of the end of the period.			

Long-Term Care Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
64	First Attestor Information.						--
65	Second Attestor Information.						--
66	Overall comments for the filing period.	--	--	--	--	--	

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Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

Line of Business: Individual Stand-Alone Long-Term Care
Individual Long-Term Care Hybrid Products
Life-LTC Hybrid Products
Annuity-LTC Hybrid Products
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: April 30, 2027

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Long-Term Care Product Types

Product Identifier	Explanation of Product Identifiers
SALTC	Stand-Alone – Long-Term Care Products
LifeLTC	Life – Long-Term Care Hybrid Products
AnnLTC	Annuity – Long-Term Care Hybrid Products

Schedule 1 - Interrogatories

ID	Description	Response
1-1	Does the company have data to report for Stand-Alone Long-Term Care?	Yes/No
1-2	Does the company have data to report for Life Long-Term Care Hybrid?	Yes/No
1-3	Does the company have data to report for Annuity Long-Term Care Hybrid?	Yes/No
1-4	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-5	If yes, add additional comments.	Comment
1-6	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-7	If yes, add additional comments.	Comment

1-8	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-9	If yes, add additional comments.	Comment
1-10	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-11	If yes, add additional comments.	Comment
1-12	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-13	If yes, add additional comments.	Comment
1-14	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-15	If yes, add additional comments.	Comment
1-16	Additional state specific Stand-Alone Long-Term Care comments (optional).	Comment
1-17	Additional state specific Life Long-Term Care Hybrid comments (optional).	Comment
1-18	Additional state specific Annuity Long-Term Care Hybrid comments (optional).	Comment

Schedule 2 - General Information

ID	Description
2-19	Number of policies/contracts in-force as of the beginning of the reporting period.
2-20	Number of new business policies/contracts issued during the period.
2-21	Number of free look cancellations during the period.
2-22	Number of lapses during the period.
2-23	Number of rescissions during the period.
2-24	Number of policies/contracts in-force as of the end of the reporting period.
2-25	Number of internal replacements during the period.
2-26	Number of external replacements during the period.
2-27	Number of policies/contracts replaced where age of insured at replacement was < 65.
2-28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.
2-29	Number of policies/contracts replaced where age of insured at replacement was > 80.
2-30	Number of complaints received directly from ~~consumers~~ any person or entity other than the DOI.

Schedule 3 - Claimants

ID	Description
3-31	Number of claimants approved for benefits as of the beginning of the period.
3-32	Number of claimants with pending claimant request determinations as of the beginning of the period.
3-33	Number of new claimants during the period.
3-34	Number of claimants with pending claimant request determinations as of the end of the period.
3-35	Number of claimants approved for benefits as of the end of the period.

Schedule 4 - Claimant Requests Denied/Not Paid

ID	Description
4-36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).
4-37	Number of claimant requests denied or not paid because of preexisting condition exclusion.
4-38	Number of claimant requests denied or not paid because of elimination or waiting period not met.
4-39	Number of claimant requests denied or not paid because services provided not covered under the policy.
4-40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.
4-41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.
4-42	All other claimant requests denied or closed without payment.

Schedule 5 - Claimant Request Determinations Timeliness

ID	Description
5-43	Number of claim request determinations made within 0-30 days.
5-44	Number of claim request determinations made within 31-60 days.
5-45	Number of claim request determinations made within 61-90 days.
5-46	Number of claim request determinations made beyond 90 days.

Schedule 6 - Benefit Payment Requests

ID	Description
6-47	Number of benefit payment requests pending as of the beginning of the period.
6-48	Number of benefit payment requests received during the period.
6-49	Number of benefit payment requests denied or not paid during the period.
6-50	Number of benefit payment requests pending as of the end of the period.

Schedule 7 - Benefit Payment Request Timeliness

ID	Description
7-51	Number of benefit payment requests paid within 0-30 days.
7-52	Number of benefit payment requests paid within 31-60 days.
7-53	Number of benefit payment requests paid within 61-90 days.
7-54	Number of benefit payment requests paid beyond 90 days.
7-55	Number of benefit payment requests denied or not paid within 0-30 days.
7-56	Number of benefit payment requests denied or not paid within 31-60 days
7-57	Number of benefit payment requests denied or not paid within 61-90 days.
7-58	Number of benefit payment requests denied or not paid beyond 90 days.

Schedule 8 - Lawsuit Activity

ID	Description
8-59	Number of lawsuits open as of the beginning of the period.
8-60	Number of lawsuits opened during the period.
8-61	Number of lawsuits closed during the period - total.
8-62	Number of lawsuits closed during the reporting period with consideration for the consumer.
8-63	Number of lawsuits open as of the end of the period.

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

Schedule 9 - Long-Term Care Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.

5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
9-64	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title).
9-65	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title).
9-66	Overall comments for the filing period.

General Instructions – All LTC Products:

For the purpose of the MCAS Long-term care insurance reporting blank:

1. "Long-term care insurance" means that as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), with the exception that long-term care insurance riders attached to a life insurance policy or an annuity contract, and group insurance plans are not included.
2. Schedules 3, 4 and 5 refer to claimants and claimant requests. A claimant request is the initial request for LTC benefits under the policy or contract. It is the determination by the insurer that the claimant is entitled to benefits under the policy or contract.
3. Reporting for schedules 3 through 5 is to be done on a "per claimant" basis (counts each individual who makes one or a series of requests or demands for payment of benefits under a policy) [Model #641, Appendix E]
4. Schedules 6 and 7 refer to individual benefit payment requests following the initial determination by the insurer that the claimant is entitled to benefits under the policy or contract. The purpose of the schedules is to differentiate between initial coverage request activities (Schedules 3, 4 and 5) and benefit payment request activities (Schedules 6 and 7) once the insurer has affirmed the initial coverage requests.
5. Reporting for schedules 6 and 7 is to be done on a "per transaction" basis (counts each benefit payment request pending and benefit payment made). [Model #641, Appendix E]

General Instructions – Life and Annuity Hybrid LTC

1. For purposes of the LTC Hybrid Product MCAS, "LTC Hybrid Product" means those products providing Long-Term Care insurance as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), as part of a Life-LTC hybrid insurance policy or Annuity-LTC hybrid contract. Such LTC hybrid benefits may be built into the life policy or annuity contract, or may be attached to such policy or contract by a rider. Report experience for Life-LTC hybrid products separately from Annuity-LTC hybrid products in the schedules provided. Report experience on individual LTC hybrid policies and contracts only. Do not report experience on group policies and contracts.
2. For Schedule 2, report experience for all policies or contracts with LTC hybrid benefits. For all data elements in Schedule 2, report the number of policies or contracts with Life-LTC hybrid or Annuity-LTC hybrid benefits and which meet the definition of the specific data element. For example, for data element 2-19 in the Life-LTC hybrid schedules, report the number of life insurance policies with LTC benefits in force at the beginning of the reporting period. For data element 2-19 in the Annuity-LTC hybrid schedules, report the number of annuity contracts with LTC benefits in force at the beginning of the reporting period. For data element 2-20, report the number of new business policies or contracts with LTC hybrid benefits.
3. For Schedules 3 through 7, report the experience for those policies or contracts with LTC hybrid benefits and report experience only for the LTC benefit portion of the policy or contract. For example, report experience for claimants, claimant requests denied/not paid, claimant request determination timeliness, benefit payment requests, and benefit payment request timeliness only for the LTC benefit portion of the LTC hybrid product.
4. For Schedule 8, report experience for those policies or contracts with some form of LTC benefit. Report lawsuit experience for all lawsuits related to the LTC product, regardless of what aspect of the product, coverage or benefit the lawsuit is about.

Definitions:

Benefit Payment Request—A request for benefits after the insurer has determined the insured is entitled to benefits following the initial claimant request. (See Claimant Request and Claimant Request Determination, below.) Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment request. The data elements in Schedule 4 capture the period of time between the company's receipt of a claim form, bill, invoice, or other satisfactory documentation to the date the company makes

payment for an approved claimant (after satisfaction of the waiting or elimination period, if any).

Claimant - An insured under an in-force policy or contract who the insurer has determined has met the benefit trigger of the policy or contract, or is in the process of making such determination, and such insured is, or may be, eligible to submit benefit payment requests.

Claimant Request - A request or demand for payment made by an insured, or a representative of the insured, for a loss that may be included within the terms of coverage of the LTC stand-alone or LTC hybrid policy or contract. It does not include events that were reported by the insured for "information only" or an inquiry of coverage when a claim has not actually been presented (opened) for payment.
If a claim is re-opened, report the claim as a new claim and the claim determination time period should be measured from the date the claim was re-opened to the benefit trigger determination date.

Claimant Request Determination - A determination as to whether an insured has met a contractual provision of an LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity. For purposes of this blank, the term applies to the initial claimant request, and captures the period of time from notice of claim to the benefit trigger/claimant request determination date. For claimant requests that are denied/not paid, report the period of time from the date of notice of claim to the date the claimant was notified of the determination to deny or not pay the claim.

Claimant Request Denied or Not Paid because Benefit Eligibility Criteria Not Met - A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract, that a benefit trigger has not been met, or a required certification by a licensed health care practitioner has not been provided, or a plan of care has not been provided.

Claimant Request Denied or Not Paid Because Claimant Did Not Pursue - A claimant or policyholder made a request or demand for payment for the purpose of receiving a benefit trigger/claimant request determination and/or benefit payment under the LTC benefit of a policy or contract, but did not provide the necessary documentation or contact the insurer again (inactivity could be the result of death.)

Claimant Request Denied or Not Paid Because Elimination or Waiting Period Not Met - A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract that the elimination/waiting period had not yet elapsed.

Claimant Request Denied or Not Paid Because Services Provided Not Covered - Expenses incurred for services and support which are not eligible for reimbursement under the LTC benefit of a policy or contract, such as an expense incurred for home health care when the policy or contract only provides benefits for nursing home confinements.

Claimant Request Denied or Not Paid Because of Preexisting Condition Exclusion - A denial of coverage because benefits for the medical advice or treatment recommended by, or received from a provider of health care services are subject to a restriction as a pre-existing condition for a period of time following the effective date of coverage of an insured person.

Claimant Request Denied or Not Paid Because Provider or Facility Not Qualified - A long-term care provider or facility does not meet the minimum level of requirements or licensing as outlined in the policy or contract.
Complaint—Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.

Denied or Not Paid - A request or demand for payment that is not paid for any reason.

- Under Schedule 4, if a denial could be reported under more than one of the categories, report the denial in the category that is most specific to the circumstances surrounding the denial. If a claimant's request was denied, the denial should not be counted more than once.
- Under Schedule 5, exclude denials for failure to meet the waiting or elimination period or because of an applicable preexisting condition.

The term does not include a request or demand for payment that is in excess of the applicable contractual limits.

Elimination Period - A period of time, as specified in the policy or contract, during which the insured incurs qualified long-term care services and support for which benefits are not payable until the end of such period.

Free Look - A set number of days provided in an insurance policy or contract that allows time for the owner/purchaser to review the policy or contract provisions with the right to return the policy or contract for a full refund of all monies paid. Report the number of policies that were returned by the owner under the free look provision.

Lapse - The termination of the entire policy or contract or the termination of the LTC benefit of the policy or contract due to nonpayment of premium.

Lawsuit - An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.
For purposes of reporting lawsuits for LTC hybrid products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer - A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.
New Business Policy or Contract—A newly written agreement that puts insurance coverage into effect under a policy or contract during the reporting period

Pending Claim - A claim that has not yet been paid or denied.

Replacement - Replacement of any life policy, annuity contract or LTC policy already in force with a new policy or contract with LTC insurance coverage.

- External Replacement—If the policy or contract to be replaced was issued by another insurer.
- Internal Replacement—If the policy or contract to be replaced was issued by your company.

For Data Elements 2-25 (Number of Internal Replacements) and 2-26 (Number of External Replacements), report the number of policies included in data element 2-20 (Number of new business policies) which are replacements of any type of life, annuity or long-term care policies.

Rescission - Invalidation of a policy or contract or invalidation of the LTC coverage portion of a policy or contract by an insurer, in accordance with the guidelines provided in the NAIC Long-Term Care Insurance Model Act (#640).

Waiting Period - See definition of Elimination Period.

Short-Term Limited Duration Insurance (2026)

Short-Term Limited Duration Insurance Interrogatories

		Yes No Response	Explanation
01	List the states where your STLD products are marketed.	---	
02	Does the company offer STLD policies/certificates with up to a 90-day duration?		---
03	Does the company offer STLD policies/certificates with 91- to 180-day duration?		---
04	Does the company offer STLD policies/certificates with 181- to 364-day duration?		---
05	Number of STLD forms offered to residents in this state.	---	
06	Number of STLD forms offered in all states.	---	
07	Number of STLD forms filed in this state.	---	
08	Number of STLD forms filed in all states.	---	
09	List the states where your STLD products are filed (provide SERFF tracking number and form number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product and describe the basis for not filing.	---	
10	How many policy forms have waiting periods that apply to the entire policy/certificate?	---	
11	How many policy forms have waiting periods that apply per specific benefits?	---	
12	Do any waiting periods exceed the policy/certificate term?		---
13	If yes, please explain	---	
14	Does the company issue STLD products through associations?		---
15	If yes, list the associations.	---	
16	If yes, do you have a contractual relationship with each Association?		---
17	If yes, does the contract cover the marketing of your product?		---
18	If yes, does the contract cover the collection of dues and fees?		---
19	If yes, does the contract cover commissions?		---
20	If yes, what other operational areas are covered in the contract?	---	
21	Does the company issue STLD products through trusts?		---
22	If yes, how many?	---	
23	Does the company issue STLD products through administrators?		---
24	If yes, how many?	---	
25	Does the company contract with third-party administrators for administrative services related to STLD products?		---
26	If yes, does your delegation structure include claims related to STLD products?		---
27	If yes, does your delegation structure include complaints related to STLD products?		---
28	If yes, does your delegation structure include medical underwriting related to STLD products?		
29	If yes, does your delegation structure include pricing related to STLD products?		---
30	If yes, does your delegation structure include producer appointments related to STLD products?		---
31	If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLD products?		---

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Short-Term Limited Duration Insurance (2026)

Short-Term Limited Duration Insurance Interrogatories (Continued)

		Yes No Response	Explanation
32	Does your company audit Third parties to whom you have delegated responsibilities?		---
33	If yes, please provide frequency of audits.	---	
34	Does the company offer renewals/reissues?		---
35	Are any renewals/reissues subject to optional or mandatory underwriting?		---
36	If yes, identify the products or plans subject to underwriting upon renewal/reissue	---	
37	Are there limitations on the number renewals per individual?		---
38	Does your company offer renewal(s) without underwriting for an additional charge?		---
39	If yes, identify the products or plans subject to underwriting for an additional charge	---	
40	Are the limitations on renewals based on state, federal, or company rules?		---
41	Does your company distribute its product through independent agents?		---
42	Does your company distribute its products through captive agents?		---
43	Does your company distribute its products through its employees?		---
44	What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other)	---	
45	Additional State Specific Comments (optional)	---	

Policy/Certificate Administration

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
46	Direct Written Premium.									
47	Earned premiums for Reporting Year.									
48	Number of Policies/Certificates in Force at the Beginning of the Period.									
49	Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period.									
50	Number of new policy/certificate applications received during the period.									
51	Number of new policy/certificates issued during the period.									
52	Number of new policies/certificates denied during the period.									
53	Number of Covered Lives on New Policies/Certificates Issued During the Period.									
54	Member months for policies/certificates newly issued during the period.									
55	Number of policy/certificate renewal/reissue applications received during the period.									
56	Number of policies/certificates renewed/reissued during the period.									
57	Number of policies/certificates non-renewed or denied at the option of insurer during the period.									
58	Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period.									
59	Number of renewals/reissues allowed.									
60	Member months for policies/certificates renewed/reissued during the period.									
61	Member months for policies/certificates renewed/reissued which had an option to renew/reissue									
62	Member months for other than new policies/certificates or renewal/reissued policies/certificates during the period									
63	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder									

Policy/Certificate Administration (Continued)

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
64	Number of policies/certificates cancelled during the free look period.									
65	Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period.									
66	Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period.									
67	Number of policy/certificate terminations and cancellations due to non-payment of premium.									
68	Number of Policies/Certificates Cancelled by Insurer for Any Reason Other Than Non-Payment of Premium During the Period.									
69	Number of Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period.									
70	Number of Lives on Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period.									
71	Number of rescissions.									
72	Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificateholder.									
73	Number of insured lives impacted on terminations and cancellations due to nonpayment.									
74	Number of insured lives impacted by rescissions.									
75	Number of Policies/Certificates in Force at the End of the Period.									
76	Number of Covered Lives on Policies/Certificates in Force at the End of the Period.									

Prior Authorizations

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
77	Number of Prior Authorization Requests Pending at the Beginning of the Period.									
78	Number of prior authorizations requested during period.									
79	Number of prior authorizations approved during period.									
80	Number of prior authorizations denied during period.									
81	Number of claims where prior authorization penalties were assessed.									
82	Number of Prior Authorization Requests Pending at the End of the Period.									
83	Median Number of Days from Receipt of Prior Authorization Request to Decision.									
84	Average Number of Days from Receipt of Prior Authorization to Decision.									

Short-Term Limited Duration Insurance (2026)

Claims Administration (Including Pharmacy)

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
85	Number of Claims Pending at the Beginning of the Period.									
86	Number of claims received.									
87	Total number of claims denied, rejected or returned.									
88	Number of denied, rejected, or returned due to claims submission coding error(s).									
89	Number of denied, rejected, or returned for lack of Prior Authorization.									
90	Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation.									
91	Number of denied, rejected, or returned as Not medically necessary.									
92	Number of denied, rejected, or returned as Subject to pre-existing condition exclusion.									
93	Number denied, rejected, or returned due to failure to provide adequate documentation.									
94	Number denied, rejected, or returned due to being within the waiting period.									
95	Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded.									
96	Number of denied, rejected, or returned for Out-of-Network provider.									
97	Number of Claims Pending at End of Period.									
98	Median Number of Days from Receipt of Claim to Decision for Denied Claims.									
99	Average Number of Days from Receipt of Claim to Decision for Denied Claims.									
100	Median Number of Days from Receipt of Claim to Decision for Approved Claims.									
101	Average Number of Days from Receipt of Claim to Decision for Approved Claims.									
102	Number of Claim Decisions Appeals Pending At Beginning of Period.									
103	Number of Claim Decision Appeals Received During the Period.									
104	Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period.									
105	Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period.									
106	Number of Claim Decision Appeals Rejected and Not Considered for Any Reason.									
107	Number of Claim Decision Appeals Pending at End of Period.									
108	Average Number of Days from Receipt of Appeal to Decision.									
109	Number of claims paid.									
110	Dollar Amount of Claims Paid During the Reporting Period									

Short-Term Limited Duration Insurance (2026)

Consumer Complaints and Lawsuits

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
111	Number of complaints received ~~by Company (other than through the DOI)~~ directly from any person or entity other than the DOI.									
112	Number of complaints received through DOI.									
113	Number of complaints resulting in claims reprocessing.									
114	Number of Lawsuits Open at Beginning of the Period.									
115	Number of Lawsuits Opened During the Period.									
116	Number of Lawsuits Closed During the Period.									
117	Number of Lawsuits Closed During the Period with Consideration for the Consumer.									
118	Number of Lawsuits Open at End of Period.									

Marketing and Sales

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
119	Number of Individual Applications Pending at the Beginning of the Period.									
120	Number of applications received.									
121	Number of Renewal/Reissue Individual Applications Received During the Period.									
122	Number of New Individual Applications Denied During the Period for Any Reason.									
123	Number of New Individual Applications Denied During the Period - Health Status or Condition.									
124	Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason.									
125	Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition.									
126	Number of New Individual Applications Approved During the Period.									
127	Number of Renewal/Reissue Individual Applications Approved During the Period.									
128	Number of Individual Applications Pending at the End of the Period.									
129	Number of applications initiated via phone.									
130	Number of applications completed via phone.									
131	Number of applications initiated face-to-face.									
132	Number of applications completed face-to-face.									
133	Number of applications initiated online (Electronically).									
134	Number of applications completed online (Electronically).									
135	Number of New Individual Applications initiated by Mail During the Period.									

Short-Term Limited Duration Insurance (2026)

Marketing and Sales (Continued)

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
136	Number of New Individual Applications completed by Mail During the Period.									
137	Number of New Individual Applications initiated by Any Other Method During the Period.									
138	Number of New Individual Applications completed by Any Other Method During the Period.									
139	Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period).									
140	Unearned Commissions returned to company on policies/certificates sold during the period?									
141	Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period).									

Short-Term Limited Duration Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
142	First Attestor Information						---
143	Second Attestor Information						---
144	Overall Comments for the Filing Period	---	---	---	---	---	

Market Conduct Annual Statement
Short-Term Limited Duration Insurance
Data Call & Definitions

Line of Business: Short-Term Limited Duration Insurance

Reporting Period: January 1, 2026 through December 31, 2026

Filing Deadline: May 31, 2027

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1 – Interrogatories

ID	Description	Response
1-01	List the states where your STLD products are marketed	Comment
1-02	Does the company offer STLD policies/certificates with up to a 90-day duration?	Yes/No
1-03	Does the company offer STLD policies/certificates with 91- to 180-day duration?	Yes/No
1-04	Does the company offer STLD policies/certificates with 181- to 364-day duration?	Yes/No
1-05	Number of STLD forms offered to residents in this state	Comment
1-06	Number of STLD forms offered in all states	Comment
1-07	Number of STLD forms filed in this state	Comment
1-08	Number of STLD forms filed in all states	Comment
1-09	List the states where your STLD products are filed (provide SERFF tracking number and form number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product, and describe the basis for not filing	Comment

1-10	How many policy forms have waiting periods that apply to the entire policy/certificate?	Number
1-11	How many policy forms have waiting periods that apply per specific benefits?	Number
1-12	Do any waiting periods exceed the policy/certificate term?	Yes/No
1-13	If yes, please explain	Comment
1-14	Does the company issue STLD products through associations?	Yes/No
1-15	If yes, list the associations	Comment
1-16	If yes, do you have a contractual relationship with each Association?	Yes/No
1-17	If yes, does the contract cover the marketing of your product?	Yes/No
1-18	If yes, does the contract cover the collection of dues and fees?	Yes/No
1-19	If yes, does the contract cover commissions?	Yes/No
1-20	If yes, what other operational areas are covered in the contract?	Comment
1-21	Does the company issue STLD products through trusts?	Yes/No
1-22	If yes, how many?	Comment
1-23	Does the company issue STLD products through administrators?	Yes/No
1-24	If yes, how many?	Comment
1-25	Does the company contract with third-party administrators for administrative services related to STLD products?	Yes/No
1-26	If yes, does your delegation structure include claims related to STLD products?	Yes/No
1-27	If yes, does your delegation structure include complaints related to STLD products?	Yes/No
1-28	If yes, does your delegation structure include medical underwriting related to STLD products?	Yes/No
1-29	If yes, does your delegation structure include pricing related to STLD products?	Yes/No
1-30	If yes, does your delegation structure include producer appointments related to STLD products?	Yes/No
1-31	If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLD products?	Yes/No
1-32	Does your company audit Third parties to whom you have delegated responsibilities?	Yes/No
1-33	If yes, please provide frequency of audits	Comment

1-34	Does the company offer renewals/reissues?	Yes/No
1-35	Are any renewals/reissues subject to optional or mandatory underwriting?	Yes/No
1-36	If the response to 1-36 is Yes, identify the products or plans subject to underwriting upon renewal/reissue	Comment
1-37	Are there limitations on the number renewals per individual?	Yes/No
1-38	Does your company offer renewal(s) without underwriting for an additional charge?	Yes/No
1-39	If the response to 1-39 is Yes, identify the products or plans subject to underwriting for an additional charge	Comment
1-40	Are the limitations on renewals based on state, federal, or company rules?	Yes/No
1-41	Does your company distribute its product through independent agents?	Yes/No
1-42	Does your company distribute its products through captive agents?	Yes/No
1-43	Does your company distribute its products through its employees?	Yes/No
1-44	What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other)	Comment
1-45	Additional State Specific Comments (optional)	Comment

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

Products

Product Identifiers	Explanation of Product Identifiers
STLD <=90	Short-Term Limited Duration Insurance not sold through an Association with a term less than or equal to 90 days
STLD 91-180	Short-Term Limited Duration Insurance not sold through an Association with a term greater than 90 and less than or equal to 180 days
STLD 181 - 364	Short-Term Limited Duration Insurance not sold through an Association with a term greater than 180 days and less than 364 days
STLD Not Sitused <=90	Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term less than or equal to 90 days
STLD Not Sitused 91-180	Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 90 and less than or equal to 180 days
STLD Not Sitused 181 - 364	Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 180 days and less than 364 days
STLD Sitused <=90	Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term less than or equal to 90 days
STLD Sitused 91-180	Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 90 and less than or equal to 180 days
STLD Sitused >181 - 364	Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 180 days and less than 364 days

Schedule 2 – Policy/Certificate Administration

2-46	Direct Written Premium.
2-47	Earned premiums for Reporting Year
2-48	Number of Policies/Certificates in Force at the Beginning of the Period
2-49	Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period
2-50	Number of new policy/certificate applications received during the period
2-51	Number of new policy/certificates issued during the period
2-52	Number of new policies/certificates denied during the period
2-53	Number of Covered Lives on New Policies/Certificates Issued During the Period
2-54	Member months for policies/certificates newly issued during the period
2-55	Number of policy/certificate renewal/reissue applications received during the period
2-56	Number of policies/certificates renewed/reissued during the period
2-57	Number of policies/certificates non-renewed or denied at the option of insurer during the period
2-58	Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period
2-59	Number of renewals/reissues allowed
2-60	Member months for policies/certificates renewed/reissued during the period
2-61	Member months for policies/certificates renewed/reissued which had an option to renew/reissue without underwriting
2-62	Member months for other than new policies/certificates or renewal/reissued policies/certificates during the period
2-63	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder
2-64	Number of policies/certificates cancelled during the free look period
2-65	Number of policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
2-66	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
2-67	Number of policy/certificate terminations and cancellations due to non-payment of premium
2-68	Number of policies/certificates cancelled by insurer for any reason other than non-payment of premium during the period

2-69	Number of policies/certificates cancelled by insurer following filing of a claim or prior authorization request by the policyholder/certificate holder during the period
2-70	Number of lives on policies/certificates cancelled by insurer following filing of a claim or prior authorization request by the policyholder/certificate holder during the period
2-71	Number of rescissions
2-72	Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificate holder
2-73	Number of insured lives impacted on termination and cancellations due to nonpayment
2-74	Number of insured lives impacted by rescissions
2-75	Number of Policies/Certificates in Force at the End of the Period
2-76	Number of Covered Lives on Policies/Certificates in Force at the End of the Period

Schedule 3 – Prior Authorizations

3-77	Number of Prior Authorization Requests Pending at the Beginning of the Period
3-78	Number of prior authorizations requested during period
3-79	Number of prior authorizations approved during period
3-80	Number of prior authorizations denied during period
3-81	Number of claims where prior authorization penalties were assessed
3-82	Number of Prior Authorization Requests Pending at the End of the Period
3-83	Median Number of Days from Receipt of Prior Authorization Request to Decision
3-84	Average Number of Days from Receipt of Prior Authorization to Decision

Schedule 4 – Claims Administration (Including Pharmacy)

4-85	Number of Claims Pending at the Beginning of the Period
4-86	Number of claims received
4-87	Total number of claims denied, rejected or returned
4-88	Number of denied, rejected, or returned due to claims submission coding error(s)
4-89	Number of denied, rejected, or returned for lack of Prior Authorization

4-90	Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation
4-91	Number of denied, rejected, or returned as Not medically necessary
4-92	Number of denied, rejected, or returned as Subject to pre-existing condition exclusion
4-93	Number denied, rejected, or returned due to failure to provide adequate documentation
4-94	Number denied, rejected, or returned due to being within the waiting period
4-95	Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded
4-96	Number of denied, rejected, or returned for Out-of-Network provider
4-97	Number of Claims Pending at End of Period
4-98	Median Number of Days from Receipt of Claim to Decision for Denied Claims
4-99	Average Number of Days from Receipt of Claim to Decision for Denied Claims
4-100	Median Number of Days from Receipt of Claim to Decision for Approved Claims
4-101	Average Number of Days from Receipt of Claim to Decision for Approved Claims
4-102	Number of Claim Decisions Appeals Pending At Beginning of Period
4-103	Number of Claim Decision Appeals Received During the Period
4-104	Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period
4-105	Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period
4-106	Number of Claim Decision Appeals Rejected and Not Considered for Any Reason
4-107	Number of Claim Decision Appeals Pending at End of Period
4-108	Average Number of Days from Receipt of Appeal to Decision
4-109	Number of claims paid
4-110	Dollar amount of claims paid during the period

Schedule 5 – Consumer Complaints and Lawsuits

5-111	Number of complaints received ~~by Company (other than through the DOI)~~ directly from any person or entity other than the DOI
5-112	Number of complaints received through DOI
5-113	Number of complaints resulting in claims reprocessing
5-114	Number of Lawsuits Open at Beginning of the Period
5-115	Number of Lawsuits Opened During the Period
5-116	Number of Lawsuits Closed During the Period

5-117	Number of Lawsuits Closed During the Period with Consideration for the Consumer
5-118	Number of Lawsuits Open at End of Period

Schedule 6 – Marketing and Sales

6-119	Number of Individual Applications Pending at the Beginning of the Period
6-120	Number of applications received
6-121	Number of Renewal/Reissue Individual Applications Received During the Period
6-122	Number of New Individual Applications Denied During the Period for Any Reason
6-123	Number of New Individual Applications Denied During the Period - Health Status or Condition
6-124	Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason
6-125	Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition
6-126	Number of New Individual Applications Approved During the Period
6-127	Number of Renewal/Reissue Individual Applications Approved During the Period
6-128	Number of Individual Applications Pending at the End of the Period
6-129	Number of applications initiated via phone
6-130	Number of applications completed via phone
6-131	Number of applications initiated face-to-face
6-132	Number of applications completed face-to-face
6-133	Number of applications initiated online (Electronically)
6-134	Number of applications completed online (Electronically)
6-135	Number of New Individual Applications initiated by Mail During the Period
6-136	Number of New Individual Applications completed by Mail During the Period
6-137	Number of New Individual Applications initiated by Any Other Method During the Period
6-138	Number of New Individual Applications completed by Any Other Method During the Period
6-139	Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period)
6-140	Unearned Commissions returned to company on policies/certificates sold during the period

6-141	Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period)

Schedule 7– Short-Term Limited Duration Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

7-142	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
7-143	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
7-144	Overall Comments for the Period

Participation Requirements: All companies licensed and reporting at least $50,000 of Short-Term Limited Duration Insurance (STLD) premium for all coverages reportable in

MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Report by Residency: This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is situsted.

General Definitions:

Short-Term Limited-Duration Insurance - Health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract. (state and federal government guidelines may have renewal duration limitations)

Association – For purposes of this MCAS blank, a non-employer group that secures benefits for its members.

Individual STLD Product – Policies marketed, sold, and issued to individual consumers, regardless of whether or not the policy forms have been filed with any State's department of insurance. An individual STLD policy is **not** issued to a trust, association, or administrator.

Group STLD Product/Coverage - Policies issued to a trust, association, or administrator for the purpose of marketing, selling, and issuing certificates to individual consumers, regardless of whether or not the policy forms have been filed with any State's department of insurance and regardless of where the association, trust, or administrator is situsted.

New Policies/Certificates Issued - STLD policy/certificate issued to an individual or family for whom no prior short-term coverage has been placed with the same insurer within the previous 63 days

Policies / Certificates - Refers to the coverage documents provided to individuals or families (i.e., state residents) who are enrolled in coverage (not the association)

Policyholder / Certificateholder – Refers to the individual who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association). Policyholder is the individual when purchased in the individual market.

Certificateholder is the individual when purchased through an Association, which is the policyholder.

Renewal / Reissue - STLD policy/certificate issued to an individual or family for whom prior short-term coverage has been placed with the same insurer within 63 days of the prior coverage. If a policy is re-underwritten based on health factors or provides different benefits, it should be reported as a new policy/certificate issued.

Schedule 2 Definitions (Policy/Certificate Administration):

Rescission – A rescission is a cancellation or discontinuance of coverage that is retroactive to the issue date. (Does not include cancellations for non-payment.)

Written Premium - Provide the total annual written premium for all policies and/or certificates issued to insureds residing in the state for which reporting is being completed

Earned Premium – Total premium earned from all policies/certificates written by the insurer during the specified period.

Free Look – A set number of days provided in an insurance policy/certificate that allows time for the purchaser to review the contract provisions with the right to return the policy/certificate for a full refund of all premium paid. Report the number of policies/certificates that were returned by the insured under the free look provision during the period, regardless of the original issuance date.

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

Schedule 3 and 4 Definitions (Prior Authorization and Claims Administration):

Prior Authorization – A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification, this includes any provision requiring the insured to notify the company prior to treatment.

Claim – For the purposes of this data call a claim means any individual line of service within a bill for services.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Claims are to be reported at the service line level.
- Capitated claims are to be reported if an Explanation of Benefits (EOB) is generated.
- Duplicate claims should not be reported.

Claims Received - provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

Claims Denied - provide the total number of claims denied during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed; includes rejected and returned claims, whether in whole or in part

Clarification:

- The nine claim denial reporting categories are not exhaustive. Claim denials reported in the categories should be a subset of the reported total denials.

Claims Paid - provide the total number of claims paid during the reporting period for individual policyholders and/or group certificateholders residing in the state for which reporting is being completed.

Waiting Period: Period of time a covered person who is entitled to receive benefits for sicknesses must wait before coverage is provided. This applies to waiting periods that are per policy or per condition.

Schedule 5 Definitions (Consumer Requested Reviews/Grievance/Complaints):

Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for Short-Term Limited Duration Insurance products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

Schedule 6 Definitions (Marketing and Sales)

Commissions - The total amount of compensation paid to any individual or entity for their consideration in marketing, selling, and attracting potential insureds, by whatever means this compensation is provided. Do not include monetary valuables paid to any individual or entity that is generally not able to be converted into actual money. NOTE: For products *not* related to the actual sale of a contract, do not include any amounts paid for the specific purpose of marketing, encouraging or promoting.

Other Remuneration - Any monetary consideration provided by the insurer through the course of the insurance transaction. This is not commissions and are separate amounts paid for as a result of the insurance transaction.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

REGULATOR-TO-REGULATOR SESSION

Virtual Meeting

MARKET ANALYSIS PROCEDURES (D) WORKING GROUP
July 21, 2025

Summary Report

The Market Analysis Procedures (D) Working Group met July 21, 2025, in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group:

1. Adopted its June 23 minutes, which included the following action:
   A. Adopted its May 27 minutes, which included the following action:
      i. Adopted its April 21 minutes, which included the following action:
         a. Adopted its March 3 minutes.
         b. Received a report from the Market Analysis Prioritization Tool (MAPT) Recommendations Ad Hoc Group.
         c. Referred the Market Analysis Review System (MARS) Level 1 requirements discussion to the Market Regulation Certification (D) Working Group.
         d. Discussed possible new lines of business for the Market Conduct Annual Statement (MCAS).
         e. Discussed an extension of the first MCAS filing date for fraternals.
         f. Discussed the April 14 lunch-and-learn session.
         g. Discussed revising the MARS Level 2 guidance in the *Market Regulation Handbook.*
      ii. Adopted a one-year MCAS filing extension for fraternals. The first MCAS filing for fraternals will be on April 30, 2027, covering the 2026 data year.
      iii. Heard a report from the MAPT Recommendations Ad Hoc Group.
      iv. Heard a report from the Market Regulation Certification (D) Working Group on its progress drafting a market analysis requirement. A draft proposal is being drafted and distributed for comment.
      v. Discussed revisions to the MCAS private passenger auto (PPA) and homeowners ratio 7—the reported number of lawsuits to the reported claims closed without payment. Suggestions were made to include both claims-related and non-claims-related lawsuits and to change the denominator to each total exposure units, policies in force, or total claims.
      vi. Discussed revisions to the MARS Level 2 guidance in the *Market Regulation Handbook.*
   B. Received a report from the MAPT Recommendations Ad Hoc Group, which has completed its work. The results will be sent to Working Group members, interested state insurance regulators, and market analysis chiefs (MACs).
   C. Discussed the MCAS PPA and homeowners ratio 7. A motion was brought to change the denominator to policies in force, but it was not seconded.
   D. Discussed the June 9 lunch-and-learn session on MCAS tableau reports in i-Site+. The next lunch-and-learn session is scheduled for Sept. 8.
   E. Discussed revisions to the MARS Level 2 guidance in the *Market Regulation Handbook.*

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2. Discussed the MAPT Recommendations Ad Hoc Group report.

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Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Thursday, July 24, 2025

Summary Report

The Market Conduct Annual Statement Blanks (D) Working Group met July 10, 2025. During this meeting, the Working Group:

1. Adopted its May 22 minutes, which included the following action:
   A. Adopted the Market Conduct Annual Statement (MCAS) other health blank and data call and definitions proposal.
   B. Adopted changes to the homeowners MCAS reporting.
   C. Discussed an MCAS lender-placed insurance Lender Placed Home and Auto Insurance (LPI) proposal related to coverage renewal.
   D. Discussed the removal of the MCAS complaints data element for collecting the number of complaints received directly from the department of insurance (DOI).
   E. Adopted an update to the pet MCAS definition of "partial payment."
   F. Received an update and proposal from the MCAS travel subject matter expert (SME) group.

2. Adopted its May 1 minutes, which included the following action:
   A. Adopted its April 3 minutes, which included the following action:
      i. Adopted its March 6 minutes.
      ii. Reviewed the other health MCAS SME group proposal.
      i. Considered adoption of changes to the private passenger auto (PPA) MCAS blank. no motion to adopt was made, the Working Group agreed to table the proposal until its next meeting.
      iii. Discussed comments received regarding the travel MCAS blank.
      iv. Discussed the Center for Economic Justice (CEJ) proposal form on LPI MCAS and the reporting of a subsequent individual policy or certificate following the expiration of the term of the previous individual policy or certificate.
   B. Considered adoption of the MCAS other health blank and data call and definitions proposal. Because the motion to adopt was not seconded, the Working Group agreed to table the proposal until its next meeting.
   C. Adopted the MCAS PPA blank and data call and definitions proposal.
   D. Considered adoption of the MCAS LPI proposal. The Working Group agreed to discuss the proposal further during its next meeting.
   E. Adopted consistent MCAS complaints data element wording.

3. Adopted the travel MCAS proposal received from the SME group.

4. Discussed how to handle reporting for discretionary groups on the other health MCAS.

5. Discussed a proposal to clarify the exclusion of blanket policies on the other health MCAS.

6. Reviewed the adjusted LPI MCAS validation calculation proposed by Rhode Island.

7. Determined that the next MCAS line of business to be reviewed by the Working Group will be long-term care (LTC).

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Virtual Meeting

MARKET CONDUCT EXAMINATION GUIDELINES (D) WORKING GROUP
July 23, 2025

Summary Report

The Market Conduct Examination Guidelines (D) Working Group met July 23. During this meeting, the Working Group:

1. Discussed an updated exposure draft of the Conducting the Property and Casualty Travel Insurance Examination chapter, for inclusion in the *Market Regulation Handbook* (Handbook. Revisions were made in response to comments received from the U.S. Travel Insurance Association (USTIA) and the American Property Casualty Insurance Association (APCIA). The exposure draft was circulated to Working Group members, interested regulators, and interested parties on July 17. The comment period on the draft ends Aug. 15. The chapter is based on the *Travel Insurance Model Act* (#632).
2. Discussed a May 22 exposure draft of a new Conducting the Pet Insurance Examination chapter, for inclusion in the Handbook. The comment period on the draft ended June 21; comments dated June 23 from Virginia were presented at the meeting. Revisions to the underwriting and rating section of the chapter were discussed, to address the Virginia comments. The underwriting and rating-related revisions will be drafted by the regulator pet insurance subject matter experts and exposed in a subsequent exposure draft, to be circulated after the meeting. The chapter is based on the *Pet Insurance Model Act* (#633).
3. Received an update from the Working Group chair regarding the progress made by the pet insurance regulator subject matter experts on the drafting of standardized data requests for pet insurance policies in force, complaints and claims.
4. Received an update from the Working Group chair regarding progress made by the accelerated underwriting regulator subject matter experts on the development of revisions to the Handbook based upon the Accelerated Underwriting (A) Working Group Regulatory Guidance Document, which was adopted by the NAIC at the Summer 2024 NAIC meeting.
5. Discussed the applicability of the NAIC Connect platform to address the Working Group's charge to develop a shared regulator-only collaborative space where state insurance regulators can share tools, such as exam call letter templates, report templates, and other helpful market regulation tools. The Working Group's NAIC Connect site went live on Feb. 11.
6. Discussed the exposure draft of an AI systems evaluation tool currently before the Big Data and Artificial Intelligence (H) Working Group and that Working Group's formal request for comments regarding a proposal to develop a NAIC model law on the use of artificial intelligence in the insurance industry. Discussed that the NAIC Connect page is also an opportunity to address the Working Group's charge to coordinate with the Innovation, Cybersecurity, and Technology (H) Committee in the development of market conduct examiner guidance for the oversight of regulated entities' use of AI.

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REGULATOR-TO-REGULATOR SESSION

Virtual Meeting

MARKET INFORMATION SYSTEMS (D) WORKING GROUP
July 23, 2025

Summary Report

The Market Information Systems (D) Working Group met July 23, 2025, in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group:

1. Discussed its June 25 meeting, which included the following action:
   A. Discussed its May 28 meeting, which included the following action:
      i. Discussed its April 23 meeting, which included the following action:
         a. Discussed its March 4 meeting.
         b. Considered a Uniform System Enhancement Request (USER) form to reactivate the Market Actions Tracking System (MATS) action type of "compliance" or "re-examination."
         c. Received an update on outstanding USER forms and Market Information System (MIS) projects.
         d. Received an update on the State Based Systems (SBS) implementation of MATS.
         e. Discussed plans for revisions to NAIC i-Site+ help sections.
         f. Discussed the MIS data analytics report.
         g. Discussed upcoming Working Group lunch-and-learn sessions.
      ii. Denied the USER form to reactivate the MATS action type of "compliance" or "re-examination." There is already an ability to provide additional information about the type of exam that includes "re-examination."
      iii. Received an update on outstanding USER forms and MIS projects.
      iv. Discussed revisions to the NAIC i-Site+ help section for Market Analysis Review System (MARS) Level 1.
      v. Discussed the MIS data analytics report.
   B. Received an update on outstanding USER forms and MIS projects.
   C. Discussed the NAIC i-Site+ help section for MARS Level 1.
   D. Discussed the June 16 lunch-and-learn session on Snowflake and ThoughtSpot. The next lunch-and-learn session is scheduled for September.

2. Discussed the results of a survey on the value of each of the metrics in the MIS data analytics report.

3. Revised the NAIC i-Site+ help section for MARS Level 1.

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Virtual Meeting

MARKET REGULATION CERTIFICATION (D) WORKING GROUP
August 6, 2025

Summary Report

The Market Regulation Certification (D) Working Group will meet Aug. 6, 2025. During this meeting, the Working Group anticipates it will:

1. Adopt its May 21 minutes, which include the following action:
   A. Discussed its regulator-to-regulator session at the Spring National Meeting.
   B. Discussed a referral from the Market Analysis Procedures (D) Working Group to draft a requirement for conducting Market Analysis Review System (MARS) reviews. Numerous suggestions were discussed, and the chair and vice chair agreed to draft a proposal for further discussion during the Working Group's next meeting.

2. Discuss the draft proposal for a market analysis requirement to be included in the *Voluntary Market Regulation Certification Program*. The proposal would require six MARS and/or Market Action Tracking System (MATS) entries per year per full-time market regulation section employee.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

SPEED TO MARKET (D) WORKING GROUP
June 24, 2025

Summary Report

The Speed to Market (D) Working Group met June 24, 2025. During this meeting, the Working Group:

1. Adopted its March 4 minutes, which included the following action:
   A. Adopted its 2024 Fall National Meeting minutes.
   B. Adopted its Oct. 31, 2024, minutes. During this meeting, the Working Group took the following action:
      i. Discussed its July 20, 2024, minutes. There was not a quorum present; the minutes were emailed to the Working Group for consideration of adoption.
      ii. Received an update on the System for Electronic Rates & Forms Filing (SERFF) modernization project and the SERFF Product Steering Committee (PSC).
      iii. Discussed changes or revisions to the 2024 *Product Filing Review Handbook*.
      iv. Received an update on the 2025 product coding matrix (PCM) on filing solutions.
      v. Received an update on the Interstate Insurance Regulation Commission (Compact).
   C. Discussed its 2025 charges.
   D. Discussed the *Product Filing Review Handbook Annual* review process.
   E. Received an update on the SERFF modernization project and SERFF PSC.
   F. Received an update on filing solutions for the 2025 PCM.
   G. Received an update on the Compact.

2. Discussed suggestions received on the PCM and uniform transmittal document (UTD). There were seven suggestions. Only one suggestion, to either add type of insurance (TOI) codes for Affordable Care Act (ACA)-related non-pediatric dental plans or include the plan in the description of currently available TOIs, generated the interest of the members and interested state insurance regulators. A survey was drafted and distributed to members and interested regulators to gauge which solution is preferred.