Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Line of Business: Disability Income Insurance
Reporting Period: January 1, 2024 through December 31, 2024
Filing Deadline: April 30, 2025

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	
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 above, 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 above, explain:	Comment
1-13	Number of class action lawsuits?	
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

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

Schedule 3—Claims Decisions Processed

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 3-001 through 3-004 (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 3-006 through 3-009 (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 4-001 through 4-004 (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 4-006 through 4-009 (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

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 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

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.

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 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 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).