Property & Casualty Market Conduct Annual Statement
Travel Insurance Data Call & Definitions

Line of Business: Travel
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	Response
1-01	Were there policies/certificates in force during the reporting period that provide travel insurance coverage?	Yes/No
1-02	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
1-03	If yes, add additional comments	Comment
1-04	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
1-05	If yes, add additional comments	Comment
1-06	How does the company treat subsequent supplemental or additional payments on previously closed claims?	Comment
1-07	Does the company use third party administrators (TPAs) for purposes of supporting the travel insurance business being reported?	Yes/No
1-08	If yes, provide the names and functions of each TPA.	Comment
1-09	Does the company use managing general agents (MGAs) for purposes of supporting the travel insurance business being reported?	Yes/No
1-10	If yes, provide the names and functions of each MGA.	Comment
1-11	Does the company use travel administrators for purposes of supporting the travel insurance business being reported?	Yes/No
1-12	If yes, provide the names and functions of each travel administrator.	Comment

1-13	Number of Travel Retailers offering and disseminating Travel Insurance on behalf of the Company at the end of the reporting period.	Comment
1-14	Additional state specific Claims comments (optional)	Comment
1-15	Additional state specific Lawsuit and Complaints comments (optional)	Comment
1-16	Additional state specific Underwriting comments (optional)	Comment

Coverages

Trip Cancellation
Trip Interruption
Trip Delay
Baggage Loss/Delay
Emergency Medical/Dental
Emergency Transportation/Repatriation
Other

Other Breakouts:

1) Each coverage listed is also broken out by Domestic vs. International coverage
2) Emergency Medical/Dental coverage is also broken out by Primary vs. Excess/Secondary coverage

Schedule 2—Travel Claims Activity, Counts Reported by Claimant, by Coverage

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

ID	Description
2-17	Number of claims open at the beginning of the period
2-18	Number of claims opened during the period
2-19	Number of claims closed during the period, with payment
2-20	Number of claims closed during the period, without payment
2-21	Number of claims open at the end of the period
2-22	Median days to final payment
2-23	Number of claims closed with payment within 0-30 days
2-24	Number of claims closed with payment within 31-90 days
2-25	Number of claims closed with payment beyond 90 days
2-26	Number of claims closed without payment within 0-30 days
2-27	Number of claims closed without payment within 31-90 days
2-28	Number of claims closed without payment beyond 90 days
2-29	Dollar amount of claims closed with payment

Schedule 3 – Lawsuits and Complaints

ID	Description
3-30	Number of lawsuits open at the beginning of the period

3-31	Number of lawsuits opened during the period
3-32	Number of lawsuits closed during the period
3-33	Number of lawsuits open at the end of the period
3-34	Number of lawsuits closed with consideration for the consumer
3-35	Number of complaints received directly from the DOI
3-36	Number of complaints received directly from any person or entity other than the DOI

Schedule 4 – Underwriting

ID	Description
4-37	Number of individual policies in force at the beginning of the period
4-38	Number of group policies (other than blanket policies) in force at the beginning of the period
4-39	Number of blanket policies in force at the beginning of the period
4-40	Number of policies/certificates in force during the reporting period
4-41	Number of individuals insured under all policies at the beginning of the period
4-42	Number of individual policies and certificates from group policies cancelled by the consumer during the period
4-43	Number of individual policies and certificates from group policies expired during the period
4-44	Number of individual policies and certificates from group policies in force at end of the period
4-45	Dollar amount of direct premium written during the period for individual policies
4-46	Dollar amount of direct premium written during the period for group policies (other than blanket)
4-47	Dollar amount of direct premium written during the period for blanket policies

Schedule 5 – Travel 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
5-48	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
5-49	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
5-50	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 travel insurance within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Definitions:

Travel Insurance - Means insurance coverage for personal risks incident to planned travel.

Include:

- Interruption or cancellation of trip or event;
- Loss of baggage or personal effects;
- Damages to accommodations or rental vehicles;
- Sickness, accident, disability or death occurring during travel;
- Emergency evacuation;
- Repatriation of remains; or

- Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

Exclude:

- major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six (6) months, including for example, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license.

Blanket Travel Insurance - Means a policy of Travel Insurance issued to any Eligible Group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the Eligible Group without a separate charge to individual members of the Eligible Group.

Coverages - For the following terms, the NAIC asks that the insurer use definitions that meet industry standards. To the extent the insurer's definitions differ from industry standards, the NAIC asks that the insurer provide those definitions.

- Trip Cancellation
- Trip Interruption
- Trip Delay
- Baggage Loss/Delay
- Emergency Medical / Dental
- Emergency Transportation/Repatriation
- Primary Coverage
- Excess/Secondary Coverage

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.

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.
- Claims closed because primary coverage was available elsewhere.

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

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

- As identified by the DOI as a complaint.
- 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.

Domestic Coverage - Coverage for travel originating and contained within the United States including travel directly to and from mainland United States to Hawaii, Alaska and United States territories.

Group Travel Insurance - Means Travel Insurance issued to any Eligible Group as defined by state law.

International Coverage - Coverage for any travel other than Domestic.

Premium Written During Period – The total premium written before any reductions for refunds for travel insurance during the reporting period.

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

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 Travel MCAS blank:

- Include only lawsuits brought by an applicant for insurance or 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 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.

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.

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.

Travel Retailer - Means a business entity that makes, arranges or offers planned travel and may offer and disseminate Travel Insurance as a service to its customers on behalf of and under the direction of a Limited Lines Travel Insurance Producer.