2024 VM-51 DATA DICTIONARY
Last updated July, 2024

Contents

PURPOSE AND SCOPE
- This VM-51 Data Dictionary is intended to aid companies submitting life insurance mortality experience data to the NAIC pursuant to VM-51 of the NAIC Valuation Manual. It provides descriptions and reporting instructions for each data field shown in VM-51 Appendix 4, in the 2024 version of the Valuation Manual.
- VM-51 Section 2.D defines "reporting year" and "observation year", and there is a lag. For the 2024 reporting year, data for the 2022 and 2023 observation years will be submitted. Submissions must be based on the requirements in the 2024 version of the Valuation Manual.
- The Valuation Manual is subject to change from year to year since amendments may be adopted. This data dictionary is only applicable for the 2024 reporting year. NAIC staff plans to provide an updated data dictionary prior to the kick-off of data collection for each reporting year.
- The VM-51 Data Dictionary is not (currently) part of the Valuation Manual and does not supersede any provision of the Valuation Manual. If there is a conflict between the Valuation Manual and the VM-51 Data Dictionary, the terms of the Valuation Manual take precedence, and companies are required to follow the guidance provided in the Valuation Manual. However, there has been noted certain instances where the guidance provided by the Valuation Manual may vary from actual company practices, and this Data Dictionary provides guidance on how companies may comply with the requirements of the Valuation Manual under these circumstances. Companies may rely upon the guidance provided in this VM-51 Data Dictionary in submitting the life insurance mortality experience to the NAIC unless otherwise notified by the Experience Reporting Agent.

GENERAL INSTRUCTIONS
- Data elements that describe the policy segment at issue should remain consistent from one reporting year to the next. For example: Issue Date, Issue Age, Date of Birth, etc. for a specified policy segment should not change. These types of fields are identified below as "Consistent Year Over Year."
- All monetary values should be rounded to the nearest dollar.
- Currently, the VM-51 mortality experience data file excludes coverage for spouse and/or children under family policies or riders.
- Data items #1 - #5 form the unique key for a given record. If multiple records have the same values in these 5 fields, they will be flagged as a duplicate and will be rejected.

Data Item #1
> Name: Submitting Company ID
> Maximum Length: 9
> Format: Left Justified
> Consistent Year over Year
> Description: This field should contain the NAIC company code of the company submitting the data file.
> Reporting Instructions:
> - If a company is reporting their own data, then data items #1 and #2 must be the same.
> - There can only be one Submitting Company ID per data file.
> - If a reinsurer or other third-party administrator is submitting data on behalf of the direct writer, this must be the code for the reinsurer / third party.
> - If the reporting company has an NAIC company code, then that number must be used. If the reporting company does not have an NAIC company code, then the company's Federal Employer Identification Number (FEIN) should be used.

Data Item #2
> Name: NAIC Company Code of the Direct Writer of Business
> Length: 5
> Consistent Year over Year
> Description: This field is the NAIC assigned company code of the company that reports the business as direct written business in their Annual Statement.
> Reporting Instructions:
> - In the case of assumption reinsurance where the assuming company is legally responsible for all benefits and claims paid, the assuming company is considered to be the direct writer.
> - If a company is reporting their own data, then data items #1 and #2 must be the same.

Data Item # 3
> Name: Observation Year
> Length: 4
> Description: The observation year is the calendar year of the experience data that is being reported.
> Reporting Instructions:
> - The observation year is different from the reporting year.
> - The reporting year is the calendar year that the company submits the experience data. The observation year will be prior to the reporting calendar year as defined in VM-51 Section 2.D
> - An amendment was adopted for the 2024 Valuation Manual that changed the lag from two years to one year. As a result of this amendment, the 2024 reporting year will include observation years 2022 and 2023. Going forward, only one observation year will be collected each reporting year.
> - There can only be one observation year per data file.

Data Item # 4

    Name: Policy Number

    Maximum Length: 20

    Consistent Year over Year

    Format: Left Justified

    Description: This field is a unique number that identifies a specific policy.

    Reporting Instructions:

- The policy number may be the actual policy number used internally. However, companies are encouraged to encrypt the policy number for privacy reasons.
- If the policy number is encrypted, then the same encryption process must be used each year so that the policy number is the same for each reporting year.

Data Item # 5

    Name: Segment Number

    Maximum Length: 3

    Format: Left Justified

    Consistent Year over Year

    Description: This field identifies a specific coverage level within the policy.

    Reporting Instructions:

- A given policy may have one segment or several.
- The base coverage for single life policies must always be distinguished as segment 1.
- In the case where a policy exercised a Non-Forfeiture Option, the original policy data (if available) should be renumbered to a later segment number (we recommend adding 100 to the original segment number) and identified as terminated. The coverage resulting from the non-forfeiture election should be in a separate record and must be identified as segment 1.
- Except for non-forfeiture elections identified above, segment numbers must remain consistent year to year. If a segment terminated, the subsequent segment must not be renumbered.
- Special Consideration for Coverages Purchased with Dividends (PUA or OYT): These coverages should be rolled together into one segment. The issue date, issue age, and underwriting type should be consistent with the base segment of the policy.
- Additional segments should be added for term riders, additional amounts of insurance purchased after original issue, and coverage purchased through dividend options.
- Note that additional amounts of insurance should be reported in a separate policy segment. They should not be added to the base coverage or reported in a new policy number.
- Special Consideration for Joint Life policies: In the case of joint-life policies, the lives should be in segment 1 and segment 2. In the case of second to die, when the first insured dies, that segment should be identified as a death but without a death benefit. The following reporting year, that segment should no longer be in the data file. The segment number for the remaining insured should stay the same for year over year consistency validations.

Commented [AP1]: I put these special considerations in all 4 places (segment, issue date, issue age, underwriting type) so they get the complete picture of what we want them to do.

Data Item # 6

Name: State of Issue

Length: 2

Consistent Year over Year

Description: State in which the policy was issued.

Reporting Instructions:

- Use standard two-letter state abbreviation codes.
- Acceptable values are as follows:

    AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV, WY, AS, GU, MP, PR, NA, OT

Data Item # 7

Name: Gender

Length: 1

Consistent Year over Year

Description: Gender as identified on the policy.

Reporting Instructions:

- Acceptable values are as follows:

    0 = Unknown or unable to subdivide

    1 = Male

    2 = Female

    3 = Unisex – Unknown or unable to identify

    4 = Unisex – Male

    5 = Unisex – Female

- Values 4 or 5 may be used when the policy is issued as unisex but the gender is known.

Data Item # 8

Name: Date of Birth

Length: 8

Format: YYYYMMDD

Consistent Year over Year

Description: Date of Birth for the insured covered in each policy segment.

Reporting instructions:

- If the insured's date of birth is unknown, this field may be left blank.
- The date of birth is used to check the reasonableness of issue age based on calculations using date of birth, age basis, and issue date.

Data Item # 9

Name: Age Basis

Length: 1

Consistent Year over Year

Description: The age basis used to determine issue age for this policy.

Reporting Instructions:

- Acceptable values are as follows:
  - 0 = Age Nearest Birthday
  - 1 = Age Last Birthday
  - 2 = Age Next Birthday

Data Item # 10

Name: Issue Age
Maximum Length: 3
Format: Left Justified
Consistent Year over Year
Description: Age of insured at issue for each segment as identified in the policy contract.

- Special Consideration for Coverages Purchased with Dividends (PUA or OYT): These coverages should be rolled together into one segment. The issue date, issue age, and underwriting type should be consistent with the base segment of the policy.

Data Item # 11

Name: Issue Date
Length: 8
Format: YYYYMMDD
Consistent Year over Year
Description: Date of issue for each policy segment.
Reporting Instructions:

- If the segment number is not 1, this date may be different from the original issue date of the policy contract.
- In the case of a term policy that renewes into a new term period, the original issue date should be used unless underwriting was performed.
- Policies that have elected a non-forfeiture option (Reduced Paid-Up or Extended Term) should retain the original policy issue date.
- Special Consideration for Coverages Purchased with Dividends (PUA or OYT): These coverages should be rolled together into one segment. The issue date, issue age, and underwriting type should be consistent with the base segment of the policy.

Data Item # 12

Name: Smoker Status
Length: 1
Description: This field represents the current smoker status of the coverage.
Reporting Instructions:

- Acceptable values are as follows:
  - 0 = Unknown
  - 1 = No tobacco usage
  - 2 = Nonsmoker
  - 3 = Cigarette smoker
  - 4 = Tobacco user
- If the company cannot distinguish between 1 and 2, then 2 should be used.

- If the company cannot distinguish between 3 and 4, then 4 should be used.
- The smoker status populated in this field should be the smoker status upon which the premium amount is based. Since some companies re-underwrite policies in certain situations after issue (e.g., changing smoker status from smoker to nonsmoker), this field may not always be consistent from one reporting year to the next.

For Data Items #13-17 please refer to the examples in Appendix A

Data Item # 13

    Name: Preferred Class Structure Indicator

    Length: 1

    Consistent Year over Year

    Description: This field is used to indicate whether the policy segment was issued as a product with one or more preferred classes. This class structure has at least one preferred class and a residual standard class.

    Reporting Instructions:
- Acceptable values are as follows:
  0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown.1=If this policy was issued in one of the available multiple preferred and standard classes for this policy segment.
- Records which have a Smoker Status = 0 (Unknown) and Preferred Class Structure Indicator = 1 should have their preferred class information reported along with non-smokers (fields #14 and #15).
- The minimum number of classes in a preferred class structure is 2. For nonsmokers, these would be preferred nonsmoker and standard nonsmoker. For smokers, these would be preferred smoker and standard smoker.
- Standard (residual) smokers and nonsmokers should have a preferred class structure indicator of 1 if the policy was issued in one of the company's available multiple preferred and standard classes.
- VM-51 indicates that records coded as substandard should have a preferred class structure indicator of 0. This is a situation where the guidance provided by the Valuation Manual may vary from actual company practices, since some companies have a practice of issuing a flat extra on an otherwise preferred individual. In this situation, the NAIC will accept a preferred class structure indicator of 1 and a substandard code of 1.
  - Example: As a result of medical underwriting, the insured falls into a preferred risk class, however this individual has a hobby of flying a private plane. The company may choose to add a flat extra due to the risky avocation.
- Please verify records are coded consistent with the examples in Appendix A of this document

Data Item # 14

    Name: Number of Classes in Nonsmoker Preferred Class Structure

    Length: 1

Consistent Year over Year

Description: If the company is offering multiple nonsmoker preferred and standard classes for this product, enter the number of classes available at the time of issue.

Reporting Instructions:

- The number of classes in a preferred class structure must be at least 2 (preferred and standard) and can be as many as 9.
- For this data item, "nonsmoker" implies either "Nonsmoker" or "No Tobacco Usage."
- Records which have a Smoker Status = 0 (Unknown) and Preferred Class Structure Indicator = 1 should be included in this field.
- If the Preferred Class Structure Indicator (Item #13) is 0, this field should be blank.
- If Smoker Status (Item #12) indicates Cigarette Smoker (3), or Tobacco User (4) then this field should be blank.
- Please verify records are coded consistent with the examples in Appendix A of this document

Data Item # 15

Name: Nonsmoker Preferred Class

Length: 1

Consistent Year over Year

Description: If this policy segment was issued as one of multiple nonsmoker preferred and standard classes, then identify which preferred or standard class was assigned to the policy segment.

Reporting Instructions:

- Classes are numbered 1 through 9 with 1 being the best preferred class. This number cannot be greater than the number identified in Data Item #14.
- For this data item, "nonsmoker" implies either "Nonsmoker" or "No Tobacco Usage."
- Records which have a Smoker Status = 0 (Unknown) and Preferred Class Structure Indicator = 1 should be included in this field.
- If the Preferred Class Structure Indicator (Item #13) is 0 then this field should be blank.
- If Smoker Status (Item #12) indicates Cigarette Smoker (3), or Tobacco User (4) then this field should be blank.
- Please verify records are coded consistent with the examples in Appendix A of this document

Data Item # 16

Name: Number of classes in Smoker Preferred Class Structure

Length: 1

Consistent Year over Year

Description: If the company is offering multiple smoker preferred and standard classes for this product, enter the number of classes available at the time of issue.

Reporting Instructions:

- The number of classes in a preferred class structure must be at least 2 (preferred and standard) and can be as many as 9.
- For this data item, "smoker" implies either "Cigarette smoker" or "Tobacco User."

- If the Preferred Class Structure Indicator (Item #13) is 0 then this field should be blank.
- If Smoker Status (Data Item #12) indicates Unknown (0), No tobacco usage (1), or Nonsmoker (2) then this field should be blank.
- Please verify records are coded consistent with the examples in Appendix A of this document

Data Item # 17

Name: Smoker Preferred Class

Length: 1

Consistent Year over Year

Description: If this policy segment was issued as one of multiple smoker preferred and standard classes, then identify which preferred class.

Reporting Instructions:

- Classes are numbered 1 through 9 with 1 being the best preferred class. This number cannot be greater than the number identified in Data Item #16.
- For this data item, "smoker" implies either "Cigarette smoker" or "Tobacco User."
- If the Preferred Class Structure Indicator (Item #13) is 0 then this field should be blank.
- If Smoker Status (Item #12) indicates Unknown (0), No tobacco usage (1), or Nonsmoker (2) then this field should be blank.
- Please verify records are coded consistent with the examples in Appendix A of this document

Data Item #18

Name: Type of Underwriting Requirements

Length: 2

Consistent Year over Year

Description: Indicate the type of underwriting that was performed at the issue of this policy segment.

Reporting Instructions:

- Acceptable values are as follows:
  01 = Underwritten but unknown whether fluid was collected
  02 = Underwritten with no fluid collection (this would include accelerated underwriting)
  03 = Underwritten with fluid collected
  06 = Term Conversion
  07 = Group Conversion
  09 = Not Underwritten99 = Unknown or Unable to Subdivide
- This field **must contain leading zeros** where applicable.
- If the company believes that underwriting was performed but lacks information regarding the type of underwriting, then the record should be coded as 01. Coding records as 99 will result in them being rejected in the aggregated file that is sent to the SOA.
- Special Consideration for Coverages Purchased with Dividends (PUA or OYT): These coverages should be rolled together into one segment. The issue date, issue age, and underwriting type should be consistent with the base segment of the policy.

- Please note the following types of business are currently excluded from this data collection: Simplified issue, guaranteed issue, worksite, individually solicited group life, direct response, final expense, pre-need, home service, and COLI/BOLI/CHOLI.

Data Item # 19
    Name: Substandard Indicator
    Length: 1
    Consistent Year over Year
    Description: This field identifies whether the policy segment was issued as substandard.
    Reporting Instructions:
- Acceptable values are as follows:
    0 = Policy segment is not substandard
    1 = Policy segment is substandard
    2 = Policy segment is uninsurable
- Per VM-51 Section 2.E, submission of substandard policy segments is optional.
- If substandard coverages are included in the data file, they must be identified as substandard or uninsurable.
- If substandard coverages are excluded from the data file, they will need to be identified in the reconciliation between the data file and the company's Annual Statement data.

Data Item # 20
    Name: Plan
    Length: 3
    Consistent Year over Year (Except in the case of Extended Term or Reduced Paid Up)
    Description: This field is used to identify the type of coverage represented by each policy segment.
    Reporting Instructions:
- There is an extensive list of plans to choose from (see file layout for defined values).
- All values **must contain a leading zero** where appropriate.
- If none of the pre-defined plans is appropriate, the company can define a custom plan code. If a custom plan code is used, the questionnaire in VM-51 Appendix 3 (Additional Plan Code Form) must be filled out and submitted.
- In the event the policy segment was issued with a secondary guarantee that is now expired or no longer in force, the plan should reflect how the policy segment was originally issued.
- Please note that the 2024 VM-51 specifically excludes spouse and/or children covered under family policies or riders.
- Starting with the 2023 reporting year, VM-51 identified plan codes to be used for coverages purchased with dividends. These plan codes are: *196 – Paid Up Additions; 197 – One Year Term.*

Data Item # 21
    Name: In-force Indicator
    Length: 1

Description: This field identifies whether the policy segment was in-force at the end of the calendar year of observation.
Reporting Instructions:
- Acceptable values are as follows:
    0 = Policy segment was <u>not</u> in force
    1 = Policy segment was in force

Data Item # 22
Name: Face Amount of Insurance at Issue
Maximum Length: 12
Format: Round to nearest dollar
Consistent Year over Year
Description: This field is the original face amount of each policy segment at the time of issue **of that segment**.
Reporting Instructions:
- For plans where the death benefit provides payment of cash value in addition to the face amount (e.g., UL option B), do not include the cash value.
- In the event the face amount at issue is unavailable (due to acquisition, legacy system, etc.) the face amount at beginning of year should be used.
- Special Consideration for Coverages Purchased with Dividends (PUA or OYT):
    o These coverages should be rolled together into one segment.
    o The face amount at issue should be the face amount that was issued for the first of these coverages.
    o If the first face amount issued is unavailable, the face amount at beginning of year may be used.

Data Item # 23
Name: Face Amount of Insurance at the Beginning of Observation Year
Maximum Length: 12
Format: Round to nearest dollar
Description: This field represents the face amount of the policy segment on January 1 of the observation year.
Reporting Instructions:
- If the policy was issued during the observation year, this field should be blank.
- If the policy was issued prior to the observation year, this field should be populated.
- For plans where the death benefit provides payment of cash value in addition to the face amount (e.g., UL option B), do not include the cash value.
- Do not include extra amounts attributable to 7702 corridors.

Data Item # 24
Name: Face Amount of Insurance at the End of the Observation Year
Maximum Length: 12
Format: Round to nearest dollar

Description: If the policy segment is in force at December 31st of the observation year then this field represents the face amount of the policy segment on that date. If the policy segment is terminated, then this represents the face amount of the policy segment at termination.

Reporting Instructions:
- If the face amount of the policy segment at termination is unavailable, this field may be left blank.
- For plans where the death benefit provides payment of cash value in addition to the face amount (e.g., UL option B), do not include the cash value.
- Do not include extra amounts attributable to 7702 corridors.

Data Item # 25

Name: Death Claim Amount

Maximum Length: 12

Format: Round to nearest dollar

Description: If the policy segment is terminated and the cause of termination is death or death due to Covid-19, this field represents the face amount that was paid out as death benefit.

Reporting Instructions:
- If the policy segment is in force, this field should be blank.
- If the policy segment is terminated but the cause of termination is not death, this field should be blank.
- Death claim amounts should reflect the portion of the death claim attributable to the given segment. Do not report the total death claim amount on multiple segments.
- Death claims that are pending as of the end of the observation year and/or on April 1 of the following year should be included.
- For plans where the death benefit provides payment of cash value in addition to the face amount (e.g., UL option B), do not include the cash value.
- Do not include extra amounts attributable to 7702 corridors.
- Special Consideration for Joint Life Policies:
  - For first to die policies, code both insureds as terminated due to death (or death due to covid-19) for Data Item #28.
  - For first to die policies, enter the death claim amount only on the insured who died. If the company cannot determine which insured died, then code the death claim amount on segment 1 only.
  - For second to die policies, in the event both insureds died in the same year, only populate the death claim amount on the second insured to die.

Data Item # 26

Name: Termination Reported Date

Length: 8

Format: YYYYMMDD

Description: If the policy segment is terminated, this represents the date the company was notified of the termination.

Reporting Instructions:
- If the policy segment is in force, this field should be blank.

- If the cause of termination is lapse due to non-payment of premium, enter the last premium paid to date.
- If the cause of termination is death or death due to COVID-19, the Termination Reported Date cannot be prior to the Actual Termination Date.

Data Item # 27

Name: Actual Termination Date
Length: 8
Format: YYYYMMDD
Description: This field represents the date coverage ended.
Reporting Instructions:

- If the policy segment is in force, this field should be blank.
- If the policy segment is terminated and the cause of termination is death or death due to COVID-19, this represents the date of death.
- If the cause of termination is lapse due to non-payment of premium, enter the last premium paid to date.

Data Item # 28

Name: Cause of Termination
Length: 2
Description: This field indicates the reason coverage terminated.
Reporting Instructions:

- Acceptable values are as follows:
  00 = Termination cause unknown
  01 = Reduced paid-up
  02 = Extended term
  03 = Voluntary termination (unable to distinguish between 01, 02, 07, 09, 10, 11, 13)
  04 = Death
  05 = Death Due to COVID-19
  07 = 1035 exchange
  09 = Term conversion – unknown whether attained age or original age
  10 = Term conversion – attained age
  11 = Term conversion – original age
  12 = Coverage expired or contract reached end of mortality table
  13 = Surrendered for full cash value
  14 = Lapse (other than to Reduced Paid Up or Extended Term)
  15 = Termination via payment of a discounted face amount while still alive, pursuant to an accelerated death benefit provision

- If the policy segment is in force, this field should be blank.
- If the policy segment is terminated, indicate the cause of termination from the list of acceptable values.
- Note: this field **must contain leading zeros** where applicable.

- If the death certificate identifies COVID-19 as either the primary or secondary cause of death, the policy should be coded as Death Due to COVID-19.
- Special Consideration for term riders attached to permanent plans:
  In the case where the base coverage is surrendered for cash value, the term rider should be coded as a lapse. Similarly, if the base coverage terminates due to death and the rider is on a different insured, the rider should be coded as a lapse.

Data Item # 29
    Name: Annualized Premium at Issue
    Maximum Length: 10
    Format: Round to nearest dollar
    Consistent Year over Year
    Description: This field represents the annualized premium as of the policy issue date.
    Reporting Instructions:
- In the case of single premium policies, enter the single premium.
- For all other modes this field is calculated as the modal or billed premium at issue multiplied by the number of modes in the year.
- This field should only be populated on the base segment of the policy except in the case of some specific level term segments.
- For segments with plan codes 021 – 027, 041 – 045, or 211 – 271, populate this premium even if it is not the base segment.
- The billed premium should include any policy fees and modal loads.
- The amount populated on the base segment should be the total premium for the policy less the premium for any term segment identified separately.

Data Item # 30
    Name: Annualized Premium at the Beginning of Observation Year
    Maximum Length: 10
    Format: Round to nearest dollar
    Description: This field represents the annualized premium as of the beginning of the observation year.
    Reporting Instructions:
- This field is calculated as the modal or billed premium at the beginning of the observation year multiplied by the number of modes in the year.
- This field should only be populated on the base segment of the policy except in the case of some specific level term segments.
- For segments with plan codes 021 – 027, 041 – 045, or 211 – 271, populate this premium even if it is not the base segment.
- The billed premium should include any policy fees and modal loads.
- The amount populated on the base segment should be the total premium for the policy less the premium for any term segment identified separately.
- If the policy segment was issued in the observation year, this field should be blank.

Data Item # 31
Name: Annualized Premium at the End of Observation Year, if available. Otherwise Annualized
Premium as of Actual Termination Date
Maximum Length: 10
Format: Round to nearest dollar
Description: If the policy is in-force, this field represents the annualized premium as of the end of
the observation year. If the policy is terminated, this field represents the annualized
premium as of the actual termination date.
Reporting Instructions:
- This field is calculated as the modal or billed premium multiplied by the number of modes
in the year.
- This field should only be populated on the base segment of the policy except in the case of
some specific level term segments.
- For segments with plan codes 021 – 027, 041 – 045, or 211 – 271, populate this premium
even if it is not the base segment.
- The billed premium should include any policy fees and modal loads.
- The amount populated on the base segment should be the total premium for the policy
less the premium for any term segment identified separately.

Data Item # 32
Name: Premium Mode
Length: 2
Description: This field represents the frequency of premium payments.
Reporting Instructions:
- Acceptable values are as follows:
  01 = Annual
  02 = Semiannual
  03 = Quarterly
  04 = Monthly Bill Sent
  05 = Monthly Automatic Payment
  06 = Semimonthly
  07 = Biweekly
  08 = Weekly
  09 = Single Premium
  10 = Other / Unknown
- This field **must contain a leading zero** where applicable.

*Data items 33 – 46 are only to be populated if the policy segment is ULSG (plan codes 071 – 078) or VLSG
(plan codes 090 – 096) and only for the base segment of the policy. These fields should be left blank if
unknown.*

Data Item # 33
Name: Cumulative Premium Collected as of the Beginning of Observation Year
Maximum Length: 10

Format: Round to nearest dollar

Description: This field is the cumulative premium collected since issue as of the beginning of the observation year. For policy segments issued in the observation year, this field should be blank.

Data Item # 34

Name: Cumulative Premium Collected as of the End of Observation Year if available. Otherwise Cumulative Premium collected as of Actual Termination Date

Maximum Length: 10

Format: Round to nearest dollar

Description: If the policy segment is in force, this field is the cumulative premium collected since issue as of the end of the observation year. If the policy segment is terminated, this field is the cumulative premium collected since issue as of the actual termination date.

Data Item # 35

Name: ULSG / VLSG Premium Type

Length: 2

Description: This field represents the type of premium that is supporting the secondary guarantee on this policy segment.

Reporting Instructions:

- Acceptable values are as follows:
  00 = Unknown
  01 = Single Premium
  02 = ULSG / VLSG whole life level premium
  03 = Lower premium (term like)
  04 = Other

Data Item # 36

Name: Type of Secondary Guarantee

Length: 2

Consistent Year over Year

Description: This field represents the type of secondary guarantee on this policy segment.

Reporting Instructions:

- Acceptable values are as follows:
  00 = Unknown
  01 = Cumulative Premium without Interest (Single Tier)
  02 = Cumulative Premium without interest (Multiple Tier)
  03 = Cumulative Premium without Interest (Other)
  04 = Cumulative Premium with Interest (Single Tier)
  05 = Cumulative Premium with interest (Multiple Tier)
  06 = Cumulative Premium with Interest (Other)
  11 = Shadow Account (Single Tier
  12 = Shadow Account (Multiple Tier)
  13 = Shadow Account (Other)

21 = Both Cumulative Premium without Interest and Shadow Account
22 = Both Cumulative Premium with Interest and Shadow Account
23 = Other, not involving either Cumulative Premium or Shadow Account
- This field **must contain a leading zero** where applicable.

Data Item # 37
Name: Cumulative Minimum Premium as of the Beginning of Observation Year
Maximum Length: 10
Format: Round to nearest dollar
Description: For policy segments with a cumulative minimum premium secondary guarantee, this field is the cumulative minimum premium including applicable interest for all policy years as of the beginning of the observation year.
Reporting Instructions:
- For policy segments where the secondary guarantee is unknown or is a shadow account, this field should be blank.
- If the policy segment was issued during the observation year, this field should be blank.

Data Item # 38
Name: Cumulative Minimum Premium as of the End of Observation Year / Actual Termination Date
Maximum Length: 10
Format: Round to nearest dollar
Description: For policy segments with a cumulative premium secondary guarantee, this field is the cumulative minimum premium including applicable interest for all policy years as of the end of the observation year.
Reporting Instructions:
- For policy segments where the secondary guarantee is unknown or is a shadow account, this field should be blank.
- For in force policy segments, this field is the cumulative minimum premium for all policy years as of the end of the observation year.
- For terminated policy segments with, this field is the cumulative minimum premium for all policy years as of the actual termination date.

Data Item # 39
Name: Shadow Account Amount at the Beginning of Observation Year
Maximum Length: 10
Format: Round to nearest dollar
Description: For policy segments with a shadow account, this field is the value of the shadow account as of the beginning of the observation year.
Reporting Instructions:
- For policy segments where the secondary guarantee is unknown or is a cumulative premium guarantee, this field should be blank.
- The value of the shadow account can be positive, zero, or negative.
- If the policy segment was issued during the observation year, the field should be blank.

Data Item # 40
Name: Shadow Account Amount at the End of Observation Year / Actual Termination Date
Maximum Length: 10
Format: Round to nearest dollar
Description: For policy segments with a shadow account, this field is the value of the shadow account as of the end of the observation year.
Reporting Instructions:
- For policy segments where the secondary guarantee is unknown or is a cumulative premium guarantee, this field should be blank.
- For in-force policy segments, this field is the value of the shadow account as of the end of the observation year.
- For terminated policy segments, this field is the value of the shadow account as of the actual termination date.
- The value of the shadow account can be positive, zero, or negative.

Data Item # 41
Name: Account Value at the Beginning of Observation Year
Maximum Length: 10
Format: Round to nearest dollar
Description: This field is the policy account value, gross of any loan, at the beginning of the observation year.
Reporting Instructions:
- The policy account value can be positive, zero, or negative.
- For policy segments issued during the observation year, this field should be blank.

Data Item # 42
Name: Account Value at the end of Observation Year / Actual Termination Date
Maximum Length: 10
Format: Round to nearest dollar
Description: This field is the policy account value, gross of any loan, at the end of the observation year.
Reporting Instructions:
- For in force policy segments, this field is the policy account value at the end of the observation year.
- For terminated policy segments, this field is the policy account value at the actual termination date.
- The policy account value can be positive, zero, or negative.

Data Item # 43
Name: Amount of Surrender Charge at the Beginning of Observation Year
Maximum Length: 10
Format: Round to nearest dollar

Description: This field is the policy surrender charge value at the beginning of the observation year.

Reporting Instructions:

- For policy segments issued during the observation year, this field should be blank.

Data Item # 44

Name: Amount of Surrender Charge at the End of Observation Year / Actual Termination Date

Maximum Length: 10

Format: Round to nearest dollar

Description: This field is the policy surrender charge value at the end of the observation year.

Reporting Instructions:

- For in force policy segments, this field is the policy surrender charge value at the end of the observation year.
- For terminated policy segments, this field is the policy surrender charge value at the actual termination date.

Data Item # 45

Name: Operative Secondary Guarantee at the Beginning of Observation year

Length: 2

Description: This field identifies whether a secondary guarantee is in effect for a policy at the beginning of the observation year.

Reporting Instructions:

- Acceptable values are as follows:
  - 00 = Unknown whether the secondary guarantee is in effect
  - 01 = Secondary guarantee is not in effect
  - 02 = Secondary guarantee is in effect
  - 03 = All secondary guarantees have expired
- The term "in effect" is defined as whether the policy is being supported by the secondary guarantee (i.e. the policy would have lapsed without the secondary guarantee).
- For policies issued in the observation year, this field should be blank.

Data Item # 46

Name: Operative Secondary Guarantee at the End of Observation Year / Actual Termination Date

Length: 2

Description: This field identifies whether a secondary guarantee is in effect for a policy at the end of the observation year.

Reporting Instructions:

- Acceptable values are as follows:
  - 00 = Unknown whether the secondary guarantee is in effect
  - 01 = Secondary guarantee is not in effect
  - 02 = Secondary guarantee is in effect
  - 03 = All secondary guarantees have expired

- For terminated policy segments that were issued with a secondary guarantee, this field represents whether that secondary guarantee was in effect as of the actual termination date.
- The term "in effect" is defined as whether the policy is/was being supported by the secondary guarantee (i.e. the policy would have lapsed without the secondary guarantee).

Data Item # 47
    Name: State of Domicile
    Length: 2
    Description: This field represents the **resident state of the policy owner**.
    Reporting Instructions:
- Use standard two-letter state abbreviation codes.
- Acceptable values are as follows:
  AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV, WY, AS, GU, MP, PR, NA, OT
- If the policy owner resides outside the US then this field should be blank.

Appendix A

Multiple Preferred Class Structure Examples

There have been different company interpretations on how preferred class structure data elements should be handled. The following examples are intended to clarify how to code VM-51 Appendix 4 data elements #12-#17 under various situations.

Excerpts of definitions from VM-51 Appendix 4 and links to definitions in this Data Dictionary are provided below for convenience.

Data Item #12 - Smoker Status:
- 0 = Unknown, 1 = No tobacco usage, 2 = Nonsmoker, 3 = Cigarette smoker, 4 = Tobacco user
- If the company cannot distinguish between 1 and 2, then 2 should be used. If the company cannot distinguish between 3 and 4, then 4 should be used.

For simplicity in the examples below Smoker Status=4 was used for smoker and Smoker Status=2 was used for nonsmokers.

Data Item #13 - Preferred Class Structure Indicator:
- 0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown.
- 1 = If this policy was issued in one of the available multiple preferred and standard classes

Data Item #14 - Number of Classes in Nonsmoker Preferred Class Structure: Integer between 2-9. If the company is offering multiple nonsmoker preferred and standard classes for this product, enter the number of classes available at the time of issue. This data item must be left blank if there is no nonsmoker preferred class structure.

Data Item #15 - Nonsmoker Preferred Class: Integer between 1-9. Classes are numbered 1 through 9 with 1 being the best preferred class. This number cannot be greater than the number identified in Data Item #14. This data item must be left blank if there is no nonsmoker preferred class structure.

Data Item #16 - Number of Classes in Smoker Preferred Class Structure: Integer between 2-9. If the company is offering multiple smoker preferred and standard classes for this product, enter the number of classes available at the time of issue. This data item must be left blank if there is no smoker preferred class structure.

Data Item #17 - Smoker Preferred Class: Integer between 1-9. Classes are numbered 1 through 9 with 1 being the best preferred class. This number cannot be greater than the number identified in Data Item #16. This data item must be left blank if there is no smoker preferred class structure.

Example 1 – Nonsmokers have a preferred class structure but Smokers do not

The company issued policies under a structure where there is a preferred nonsmoker class, standard nonsmoker class and a standard smoker class. In this circumstance, there is a preferred class structure for nonsmokers (i.e. preferred class structure indicator = 1) but there is no preferred class structure for smokers (i.e. preferred class structure indicator = 0). Where the preferred class structure indicator is 0, Data Elements #14-17 must be left blank. Do not code these Data Elements with a 0 or 1. The minimum number of classes in a preferred class structure is 2.

	Data Item 12- Smoker Status	Data Item 13- Preferred Class Structure Indicator	Data Item 14- Number of Classes in Nonsmoker Preferred Class Structure	Data Item 15- Nonsmoker Preferred Class	Data Item 16- Number of Classes in Smoker Preferred Class Structure	Data Item 17- Smoker Preferred Class
Standard smoker	4	0	Leave Blank	Leave Blank	Leave Blank	Leave Blank
Preferred nonsmoker	2	1	2	1	Leave Blank	Leave Blank
Standard nonsmoker	2	1	2	2	Leave Blank	Leave Blank

Example 2 – Nonsmoker preferred class structure has 3 classes

The company issued policies under 3 classes in the nonsmoker preferred class structure: Super preferred nonsmoker class, preferred nonsmoker class, and standard nonsmoker class. This should be coded in the data submission as a 3-class nonsmoker preferred class structure with the best class as Class 1 and the standard class as Class 3.

	Data Item 12- Smoker Status	Data Item 13- Preferred Class Structure Indicator	Data Item 14- Number of Classes in Nonsmoker Preferred Class Structure	Data Item 15- Nonsmoker Preferred Class	Data Item 16- Number of Classes in Smoker Preferred Class Structure	Data Item 17- Smoker Preferred Class
Super Preferred nonsmoker	2	1	3	1	Leave Blank	Leave Blank
Preferred nonsmoker	2	1	3	2	Leave Blank	Leave Blank
Standard nonsmoker	2	1	3	3	Leave Blank	Leave Blank

Example 3 – There is no preferred class structure for Nonsmokers or Smokers

The company issued policies as either smoker or nonsmoker (i.e., no preferred classes were offered). In this instance, this is not considered a multiple preferred class structure. The preferred class structure indicator should be 0 and Data Elements #14-17 must be left blank.

	Data Item 12- Smoker Status	Data Item 13- Preferred Class Structure Indicator	Data Item 14- Number of Classes in Nonsmoker Preferred Class Structure	Data Item 15- Nonsmoker Preferred Class	Data Item 16- Number of Classes in Smoker Preferred Class Structure	Data Item 17- Smoker Preferred Class
Nonsmoker	2	0	Leave Blank	Leave Blank	Leave Blank	Leave Blank
Smoker	4	0	Leave Blank	Leave Blank	Leave Blank	Leave Blank

Example 4 – Preferred class structure has minimum qualifying face amounts

The company issued policies under 2 nonsmoker classes in a multiple preferred class structure and 2 smoker classes in a multiple preferred class structure. The product offers preferred classes starting at a minimum face amount of 100K.

	Data Item 12- Smoker Status	Data Item 13- Preferred Class Structure Indicator	Data Item 14- Number of Classes in Nonsmoker Preferred Class Structure	Data Item 15- Nonsmoker Preferred Class	Data Item 16- Number of Classes in Smoker Preferred Class Structure	Data Item 17- Smoker Preferred Class
Smoker with 50K face amount	4	0	Leave Blank	Leave Blank	Leave Blank	Leave Blank
Preferred smoker with 150K face amount	4	1	Leave Blank	Leave Blank	2	1
Standard smoker with 150K face amount	4	1	Leave Blank	Leave Blank	2	2
Preferred nonsmoker with 200K face amount	2	1	2	1	Leave Blank	Leave Blank
Standard nonsmoker with 100K face amount	2	1	2	2	Leave Blank	Leave Blank
Nonsmoker with 75K face amount	2	0	Leave Blank	Leave Blank	Leave Blank	Leave Blank

Example 5 – Policies were issued with no smoker/nonsmoker distinction
The company issued policies prior to 1980 when there was no difference in premium between smokers and nonsmokers (i.e., there were no smoker or nonsmoker classes). In this case the smoker status should be coded as 0 (Unknown), and the preferred class structure indicator should be coded as 0 since there were no multiple preferred and standard classes available for this policy segment.

	Data Item 12- Smoker Status	Data Item 13- Preferred Class Structure Indicator	Data Item 14- Number of Classes in Nonsmoker Preferred Class Structure	Data Item 15- Nonsmoker Preferred Class	Data Item 16- Number of Classes in Smoker Preferred Class Structure	Data Item 17- Smoker Preferred Class
Records issued without smoker/nonsmoker distinction	0	0	Leave Blank	Leave Blank	Leave Blank	Leave Blank

Appendix B

Face Amount Capping vs. Rounding

VM-51 Appendix 2, item 5 states that the face amounts and death claim amounts are to be included without capping by amount. "Capping" an amount may also be described as censoring an amount or that an amount is subject to a ceiling.

This situation may arise when a company has some very high death benefits and sets a ceiling on the face amount in a data set used for experience analysis. This practice is sometimes used in experience studies to eliminate/reduce the impact of outliers that may skew results or where the excess above that value is reinsured. We want to ensure companies are not providing data from a database or system where the face amount has been capped. As illustrated below, the practice of capping may result in a material understatement of exposure and impact the actual to expected analysis.

Example of Capping:

Policy	Face Amount (Expected to be reported in NAIC data submission)	Capped Face Amount (cap = 10M)	
A	25M	10M	Capped
B	5M	5M	
C	100M	10M	Capped
TOTAL	130M	25M	

In these examples, policies A and C are considered capped because the company only reported 10M in face amount for each large policy when the policyholder had a much larger death benefit amount.

Please note, VM-51 Appendix 4, Items 22-25 state that face amounts and death claim amounts should be rounded to the nearest dollar. Rounding is not considered capping.