Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Line of Business: Disability Income Insurance
Reporting Period: January 1, 2022 through December 31, 2022
Filing Deadline: April 30, 2023

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?	
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	

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 bT3g4CID 1 >>3 (o)-3.4 (f).3 (t) 6 ((n)5.6 (t)-0.9 (aAT

Schedule 4—Resulting in Closed Without Payment 15uT9

ID	Description
4–35	

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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) Reportinngthognnt0.538 Tw 2.315 0 32283 T0.359(nf)13.4 (o.

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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

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

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 resc

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