	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	

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

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

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

ID	Description
7–67	Number of policies in force at the beginninggithe begnNumber itN 3.12itp(s)]TJo.3 ((h)0.

Sales, closures and movement of DI business—(1-11 and 1-12) Described instances in

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)
2iriial-5.2 (r)i26 2 To10.4 ( )]TJ-0.003 Tc 0.19028.0.6 (7.060 (i)-do)-3.1.5 (l)-3.5 (n)0.6 (al-5.9 (r)a-2.
A median is the middle value in a distribution arranged in numerical order (either lowest tono(e)1.0.6 ( )

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

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.

d[n)0.6 (( )0.9 ((t)-6 (l)-2.2 ffi)-2.( )0.9 (c)1.5 ()0.53.5 a)-9 ((g)6.5 ((v)5.9 ( )0.8 (i)-2.2 (

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

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.

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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 p

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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 acti.6 (i)-2.3 (o).to(t)heend46(.5)-(3)0.8)(0)(-535)-f2t.5hine orto(i)-4.3 ni -11.7 (p)69.4 (e)ri

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