



Valuation Manual

Jan. 1, 2024 Edition

Table of Contents

I. Introduction	1
Authority and Applicability.....	1
Background	1
Description of the <i>Valuation Manual</i>	2
Operative Date of the <i>Valuation Manual</i>	2
PBR Review and Updating Process	2
Process for Updating the <i>Valuation Manual</i>	2
Overview of Reserve Concepts	5
Corporate Governance Requirements for Principle-Based Reserves	6
II. Reserve Requirements	7
Life Insurance Products.....	7
Annuity Products.....	8
Deposit-Type Contracts.....	9
Health Insurance Products.....	9
Credit Life and Disability Products.....	9
Riders and Supplemental Benefits.....	10
Claim Reserves.....	10
III. Actuarial Opinion and Report Requirements	11
IV. Experience Reporting Requirements.....	11
V. <i>Valuation Manual</i> Minimum Standards.....	11
VM-01:Definitions for Terms in Requirements.....	01-1
VM-02:Minimum Nonforfeiture Mortality and Interest	02-1
VM-20:Requirements for Principle-Based Reserves for Life Products	20-1
VM-21:Requirements for Principle-Based Reserves for Variable Annuities	21-1
VM-22:Statutory Maximum Valuation Interest Rates for Income Annuities	22-1
VM-25:Health Insurance Reserves Minimum Reserve Requirements	25-1
VM-26:Credit Life and Disability Reserve Requirements.....	26-1
VM-30:Actuarial Opinion and Memorandum Requirements	30-1
VM-31:PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation	31-1
VM-50:Experience Reporting Requirements.....	50-1
VM-51:Experience Reporting Formats.....	51-1
VM-A: Appendix A – Requirements	A-1
VM-C: Appendix C – Actuarial Guidelines	C-1
VM-G: Appendix G – Corporate Governance Guidance for Principle-Based Reserves	G-1
VM-M: Appendix M – Mortality Tables.....	M-1

VM-50: Experience Reporting Requirements

Table of Contents

Section 1:	Overview	50-1
Section 2:	Statutory Authority and Experience Reporting Agent	50-2
Section 3:	Experience Reporting Requirements	50-2
Section 4:	Data Quality and Ownership	50-5
Section 5:	Experience Data	50-8
Section 6:	Confidentiality of Data	50-9

Section 1: Overview

A. Purpose of the Experience Reporting Requirements

The purpose of this section is to define the requirements pursuant to Section 13 of Model #820 for the submission and analysis of company data. It includes consideration of the experience reporting process, the roles of the relevant parties, and the intended use of and access to the data, and the process to protect the confidentiality of the data as outlined in Model #820.

B. PBR and the Need for Experience Data

The need for experience data includes but is not limited to:

1. PBR may require development of assumptions and margins based on company experience, industry experience or a blend of the two. The collection of experience data provides a database to establish industry experience tables or factors, such as valuation tables or factors as needed.
2. The development of industry experience tables provides a basis for assumptions when company data is not available or appropriate and provides a comparison basis that allows the state insurance regulator to perform reasonableness checks on the appropriateness of assumptions as documented in the actuarial reports.
3. The collection of experience data may assist state insurance regulators, reviewing actuaries, auditors and other parties with authorized access to the PBR actuarial reports to perform reasonableness checks on the appropriateness of principle-based methods and assumptions, including margins, documented in those reports.
4. The collection of experience data provides an independent check on the accuracy and completeness of company experience studies, thereby encouraging companies to establish a disciplined internal process for producing experience studies. Industry aggregate or sub-industry aggregate experience studies may assist an individual company for use in setting experience-based assumptions. As long as the confidentiality of each company's submitted results is maintained, a company may obtain results of a study on companies' submitted experience for use in formulating experience assumptions.
5. The collection of experience data will provide a basis for establishing and updating the assumptions and margins prescribed by regulators in the *Valuation Manual*.
6. The reliability of assumptions based on company experience is founded on reliable historical data from comparable characteristics of insurance policies including, but not limited to, underwriting standards and insurance policy benefits and provisions. As with all forms of experience data analysis, larger and more consistent statistical samples have a greater probability of producing reliable analyses of historic experience than smaller or

inconsistent samples. To improve statistical credibility, it is necessary that experience data from multiple companies be combined and aggregated.

7. The collection of experience data allows state insurance regulators to identify outliers and monitor changes in company experience factors versus a common benchmark to provide a basis for exploring issues related to those differences.
8. PBR is an emerging practice and will evolve over time. Research studies other than those contemplated at inception may be useful to improvement of the PBR process, including increasing the accuracy or efficiency of models. Because the collection of experience data will facilitate these improvements, research studies of various types should be encouraged.
9. The collection of experience data is not intended as a substitute for a robust review of companies' methodologies or assumptions, including dialogue with companies' actuaries.

Section 2: Statutory Authority and Experience Reporting Agent

A. Statutory Authority

1. Model #820 provides the legal authority for the *Valuation Manual* to prescribe experience reporting requirements with respect to companies and lines of business within the scope of the model.
2. The statutes and regulations requiring data submissions generally apply to all companies licensed to sell life insurance, A&H insurance and deposit-type contracts. These companies must submit experience data as prescribed by the *Valuation Manual*.
3. Section 4A(5) of Model #820 defines the data to be collected to be confidential.

B. Experience Reporting Agent

1. For the purposes of implementing the experience reporting required by state laws based on Section 13 of Model #820, an Experience Reporting Agent will be used for the purpose of collecting, pooling and aggregating data submitted by companies as prescribed by lines of business included in VM-51.
2. The NAIC is designated as Experience Reporting Agent for the Statistical Plan for Mortality beginning Jan. 1, 2020, and NAIC expertise in collecting and sorting data from multiple sources into a cohesive database in a secure and efficient manner, but the designation of the NAIC as Experience Reporting Agent does not preclude state insurance regulators from independently engaging other entities for similar data required under this *Valuation Manual* or other data purposes.

Section 3: Experience Reporting Requirements

A. Statistical Plans

1. Consistent with state laws based on Section 13 of Model #820, the Experience Reporting Agent shall collect experience data based on statistical plans defined in the *Valuation Manual*.
2. Statistical plans are detailed instructions that define the type of experience data being collected (e.g., mortality; elective policyholder behavior, such as surrenders, lapses, premium payment patterns, etc.; and company expense data, such as commissions, policy expenses, overhead expenses etc.). The state insurance regulators serving on the Life

Actuarial (A) Task Force and Health Actuarial (B) Task Force, or any successor body, will be responsible for prescribing the requirements for any statistical plan by applicable line of business. For each type of experience data being collected, the statistical plan will define the data elements and format of each data element, as well as the frequency of the collection of experience data. The statistical plan will define the process and the due dates for submitting the experience data. The statistical plan will define criteria that will determine which companies must submit the experience data. The statistical plan will also define the scope of business that is to be included in the experience data collection, such as lines of business, product types, types of underwriting, etc. Statistical plans are defined in VM-51 of the *Valuation Manual*. Statistical plans will be added to VM-51 of the *Valuation Manual* when they are ready to be implemented. Additional data elements and formats to be collected will be added as necessary, in subsequent revisions to the *Valuation Manual*.

3. Data must conform to common data definitions. Standard definitions provide for stable and reliable databases and are the basis of meaningful aggregated insurance data. This will be accomplished through a uniform set of suggested minimum experience reporting requirements for all companies.

B. Role and Responsibilities of the Experience Reporting Agent

1. Based on requirements of VM-51, the Experience Reporting Agent may design its data collection procedures to ensure it is able to meet these regulatory requirements. The Experience Reporting Agent will provide sufficient notice to reporting companies of changes, procedures and error tolerances to enable the companies to adequately prepare for the data submission.
2. The Experience Reporting Agent will aggregate the experience of companies using a common set of classifications and definitions to develop industry experience tables.
3. The Experience Reporting Agent will seek to enter into agreements with a group of state insurance departments for the collection of information under statistical plans included in VM-51. The number of states that contract with the Experience Reporting Agent will be based on achieving a target level of industry experience prescribed by VM-51 for each line of business in preparing an industry experience table.
 - a. The agreement between the state insurance department(s) and the Experience Reporting Agent will be consistent with any data collection and confidentiality requirements included within Model #820 and the *Valuation Manual*. Those state insurance departments seeking to contract with the Experience Reporting Agent will inform the Experience Reporting Agent of any other state law requirements, including laws related to the procurement of services that will need to be considered as part of the contracting process.
 - b. Use of the Experience Reporting Agent by the contracting state insurance departments does not preclude those state insurance departments or any other state insurance departments from contracting independently with another Experience Reporting Agent for similar data required under this *Valuation Manual* or other data purposes.
4. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will be responsible for the content and maintenance of the experience reporting requirements. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force or a working group will monitor the data definitions, quality standards, appendices and reports described in the experience reporting requirements to assure that they take advantage of changes in technology and provide for new regulatory and company needs.

5. To ensure that the experience reporting requirements will continue to be useful, the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will seek to review each statistical plan on a periodic basis at least once every five years. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force should have regular dialogue, feedback and discussion of this topic. In seeking feedback and engaging in discussions, the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force shall include a broad range of data users, including state insurance regulators, consumer representatives, members of professional actuarial organizations, large and small companies, and insurance trade organizations.
6. The Experience Reporting Agent will obtain and undergo at least annual external audits to validate that controls with respect to data security and related topics are consistent with industry standards and best practices. The Experience Reporting Agent will provide a copy of any report prepared in connection with such an audit, upon a company's request. In the event of a material deficiency identified in the external audit or in the event of an identified security breach affecting the Experience Reporting Data, the Experience Reporting Agent shall notify the NAIC, and the states that have directed the Experience Reporting Agent to collect this information, of the nature and extent of such an issue. In the event of an identified security breach affecting Experience Reporting Data, the Experience Reporting Agent shall also notify any insurer whose data was affected. Upon good cause shown, the Experience Reporting Agent will take reasonable actions to protect the data under its control, including that the data submission process may be suspended until the security issue has been remediated. If data submission is suspended under this section, the Experience Reporting Agent will work with the states that have directed collection to issue appropriate guidance modifying the requirements of VM 51, Section 2.D. The term "good cause" shall mean that there is the chance of irreparable harm upon continuing the transmission of the data to the Experience Reporting Agent. Once the security issue has been remediated, the Experience Reporting Agent shall notify the NAIC and the states that have directed the Experience Reporting Agent to collect this information. The Experience Reporting Agent shall work in conjunction with the NAIC and the states that have directed the Experience Reporting Agent to collect this information to develop a revised data submission schedule for any deferred submissions. The revised schedule shall provide for reasonable timing for companies to provide such data.

C. Role of Other Organizations

The Experience Reporting Agent may ask for other organizations to play a role for one or more of the following items, including the execution of agreements and incorporation of confidentiality requirements where appropriate:

1. Consult with the NAIC (as appropriate) in the design and implementation of the experience retrieval process;
2. Assist with the data validation process for data intended to be forwarded to the SOA or other actuarial professional organizations to develop industry experience tables;
3. Analyze data, including any summarized or aggregated data, produced by the Experience Reporting Agent;
4. Create initial experience tables and any revised tables;
5. Provide feedback in the development and evaluation of requests for proposal for services related to the reporting of experience requirement;
6. Create statutory valuation tables as appropriate and necessary;

7. Determine and produce additional industry experience tables or reports that might be suggested by the data collected;
8. Work with the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force, in accordance with the *Valuation Manual* governance process, in developing new reporting formats and modifying current experience reporting formats;
9. Support a close working relationship among all parties having an interest in the success of the experience reporting requirement.

Section 4: Data Quality and Ownership

A. General Requirements

1. The quality, accuracy and consistency of submitted data is key to developing industry experience tables that are statistically credible and represent the underlying emerging experience. Statistical procedures cannot easily detect certain types of errors in reporting of data. For example, if an underwriter fails to evaluate the proper risk classification for an insured, then the “statistical system” has little chance of detecting such an error unless the risk classification is somehow implausible.
2. To ensure data quality, coding a policy, loss, transaction or other body of data as anything other than what it is known as is prohibited. This does not preclude a company from coding a transaction with incomplete detail and reporting such transactions to the Experience Reporting Agent, but there can be nothing that is known to be inaccurate or deceptive in the reporting. An audit of a company’s data submitted to the Experience Reporting Agent under a statistical plan in VM-51 can include comparison of submitted data to other company files.
3. When the Experience Reporting Agent determines that the cause of an edit exception could produce systematic errors, the company must correct the error and respond in a timely fashion, with priority given to errors that have the largest likelihood to affect a significant amount of data. When an error is found that has affected data reported to the Experience Reporting Agent, the company shall report the nature of the error and the nature of its likely impact to the Experience Reporting Agent. Retrospective correction of data subject to systematic errors shall be done when the error affects a significant amount of data that is still being used for regulatory purposes and it is reasonably practical to make the correction through the application of a computer program or a procedure applied to the entire data set without the need to manually examine more than a small number of individual records.

B. Specific Requirements

1. Once the data file is submitted by the company, the Experience Reporting Agent will perform a validity check of the data elements within each data record in the data file for proper syntax and verify that required data elements are populated. The Experience Reporting Agent will notify the company of all syntax errors and any missing data elements that are required. Companies are required to respond to the Experience Reporting Agent by submitting a corrected data file. The Experience Reporting Agent will provide sufficient notice to reporting companies of changes, procedures and error tolerances to enable the companies to adequately prepare for the data submission.
2. Each submission of data filed by a company with the Experience Reporting Agent shall be balanced against a set of control totals provided by the company with the data submission. At a minimum, these control totals shall include applicable record counts, claim counts, amounts insured and claim amounts. Any submission that does not balance to the control totals shall be referred to the company for review and resolution.

3. Each company submitting experience data and each company on whose behalf data is being submitted as required in VM-51 will perform a reconciliation between its submitted experience data with its statistical and financial data, and provide an explanation of differences, to the Experience Reporting Agent. The reconciliation must include policy count and insurance amount.
 - a. If a third-party administrator (TPA) that is not an insurance company or an insurance company not required to submit its direct data is submitting data on behalf of an insurance company, the reconciliation will consist of separate lines identifying each insurance company for whom this entity is submitting data.
 - b. If the TPA is an insurance company that is required to submit its direct data, the reconciliation must include separate lines identifying each additional company whose data is being submitted.
 - c. The reconciliation to company statistical and financial data for both the direct writer and the reinsurer or TPA must include lines indicating the amount of business that is being reported by the reinsurer or TPA. The NAIC will use this information to confirm that all in-scope business is reported and that there is no double counting of policies.
4. Validity checks are designed to identify:
 - a. Improper syntax or incomplete coding (e.g., a numeric field that is not numeric, missing elements of a date field);
 - b. Data elements containing codes that are not contained within the set of possible valid codes;
 - c. Data elements containing codes that are contained within the set of possible valid codes but are not valid in conjunction with another data element code;
 - d. Required data elements that are not populated.
5. Where quality would not appear to be significantly compromised, the Experience Reporting Agent may use records with missing or invalid data if such invalid or missing data do not involve a field that is relevant or would affect the credibility of the report. For companies with a body of data for a state, line of business, product type or observation period that fails to meet these standards, the Experience Reporting Agent will use its discretion, with regulatory disclosure of key decisions made, regarding the omission of the entire body of data or only including records with valid data. Completeness of reports is desirable, but not at the risk of including a body of data that appears to have an unreasonably high chance of significant errors.
6. Errors of a consistent nature are referred to as “systematic.” Incorrect coding instructions can introduce errors of a consistent nature. Programming errors within the data processing system of insurer company can also produce systematic miscoding as the system converts data to the required formats for experience reporting. Most systematic errors will produce data that, when reviewed using tests designed to reveal various types of systematic errors, will appear unreasonable and likely to be in error. In addition, some individual coding errors may produce erroneous results that show up when exposures and losses are compared in a systematic fashion. Such checking often cannot, however, provide a conclusive indication that data with unusual patterns is incorrect. The Experience Reporting Agent will perform tests and look at trends using previously reported data to determine if systematic errors or unusual patterns are occurring.
7. The Experience Reporting Agent will undertake reasonability checks that include the comparison of aggregate and company experience for underwriting class and type of

coverage data elements for the current reporting period to company and aggregate experience from prior periods for the purpose of identifying potential coding or reporting errors. When reporting instructions are changed, newly reported data elements shall be examined to see that they correlate reasonably with data elements reported under the old instructions.

8. At a minimum, reasonability checks by the Experience Reporting Agent will include:
 - a. An unusually large percentage of company data reported under a single or very limited number of categories;
 - b. Unusual or unlikely reporting patterns in a company's data;
 - c. Claim amounts that appear unusually high or low for the corresponding exposures;
 - d. Reported claims without corresponding policy values and exposures;
 - e. Unreasonable loss frequencies or amounts in comparison to ranges of expectation that recognize statistical fluctuation;
 - f. Unusual shifts in the distribution of business from one reporting period to the next.
9. If a company's unusual pattern under Section 4.B.8.a, Section 4.B.8.b or Section 4.B.8.c is verified as accurate (that is, the reason for the apparent anomaly is an unusual mix of business), then it is not necessary that a similar pattern for the same company be reconfirmed year after year.
10. The Experience Reporting Agent will keep track of the results of the validity and reasonability checks and may adjust thresholds in successive reporting years to maintain a reasonable balance between the magnitude of errors being found and the cost to companies.
11. Results that may indicate a likelihood of critical indications, as defined below, will be reported to the company with an explanation of the unusual findings and their possible significance. When the possible or probable errors appear to be of a significant nature, the Experience Reporting Agent will indicate to the company that this is a "critical indication." "Critical indications" are those that, if not corrected or confirmed, would leave a significant degree of doubt whether the affected data should be used in reports to the state insurance regulator and included in industry databases. It is intended that Experience Reporting Agents will have reasonable flexibility to implement this under the direction of the state insurance regulators. Also, under the direction of the state insurance regulators, the Experience Reporting Agent may grade the severity of indications, or it may simply identify certain indications as critical. While companies are expected to undertake a reasonable examination of all indications provided to them, they are not required to respond to every indication except for those labeled by the Experience Reporting Agent as "critical."
12. The Experience Reporting Agent will use its discretion regarding the omission of data from reports owing to the failure of an insurer company to respond adequately to unusual reasonability indications. Completeness of reports is desirable, but not at the risk of including data that appears to have an unreasonably high chance of containing significant errors.
13. Companies shall acknowledge and respond to reasonability queries from the Experience Reporting Agent. This shall include specific responses to all critical indications provided by the Experience Reporting Agent. Other indications shall be studied for apparent errors,

as well as for indications of systematic errors. Corrections for critical indications shall be provided to the Experience Reporting Agent or, when a correction is not feasible, the extent and nature of the error shall be reported to the Experience Reporting Agent.

C. Ownership of Data

1. Experience data submitted by companies to the Experience Reporting Agent will be considered the property of the companies submitting such data, but the recognition of such ownership will not affect the ability of state insurance regulators or the NAIC to use such information as authorized by state laws based on Model #820 or the *Valuation Manual*, or, in case of state insurance regulators, for solvency oversight, financial examinations and financial analysis.
2. The Experience Reporting Agent will be responsible for maintaining data, error reports, logs and other intermediate work products, and reports for use in processing, documentation, production and reproduction of reports provided to state insurance regulators in accordance with the *Valuation Manual*. The Experience Reporting Agent will be responsible for demonstrating such reproducibility at the request of state insurance regulators or an auditor designated by state insurance regulators.

Section 5: Experience Data

A. Introduction

1. Using the data collected under statistical plans, as defined in the *Valuation Manual*, the Experience Reporting Agent produces aggregate databases as defined by this *Valuation Manual*. The Experience Reporting Agent, and/or other persons assisting the Experience Reporting Agent, will utilize those databases to produce industry experience tables and reports as defined in the *Valuation Manual*. In order to ensure continued relevance of reports, each defined data collection and resulting report structure shall be reviewed for usefulness at least once every five years since initial adoption or prior review.
2. Data compilations are evaluated according to four distinct, and often competing, standards: quality, completeness, timeliness and cost. In general, quality is a primary goal in developing any statistical data report. The priorities of the other three standards vary according to the purpose of the report.
3. The Experience Reporting Agent may modify or enlarge the requirements of the *Valuation Manual*, through recommendation to the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force and in accordance with the *Valuation Manual* governance process for information to accommodate changing needs and environments. However, in most cases, changes to existing data reporting systems will be feasible only to provide information on future transactions. Requirements to submit new information may require that companies change their systems. Also, the Experience Reporting Agent may need several years before it can generate meaningful data meeting the new requirements with matching claims and insured amounts. The exact time frames for implementing new data requirements and producing reports will vary depending on the type of reports.

B. Design of Reports Linked to Purpose

Fundamental to the design of each report is an evaluation of its purpose and use. The Life Actuarial (A) Task Force and Health Actuarial (B) Task Force shall specify model reports responding to general regulatory needs. These model reports will serve the basic informational needs of state insurance regulators. To address a particular issue or problem, a state insurance regulator may have

to request to the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force that additional reports be developed.

C. Basic Report Designs

1. The Life Actuarial (A) Task Force or Health Actuarial (A) Task Force will designate basic types of reports to meet differing needs and time frames. Each statistical plan defined in VM-51 of the *Valuation Manual* will provide a detailed description of the reports, the frequency and time frame for the reports. Statistical compilations are anticipated to be the primary reports.
2. Statistical compilations are aggregate reports that generally match appropriate exposure amounts and transaction event amounts to evaluate the recent experience for a line of business. For example, a statistical compilation of mortality experience would match insurance face amounts exposed to death with actual death claims paid. Here the exposure amount is the total insurance face amount exposed to death, and the transaction event amounts would be the death claims paid. As another example, a statistical compilation of surrender experience would match total cash surrender amounts exposed to surrender with actual surrender amounts paid. Here the exposure amount is the total cash surrender amounts that could be surrendered, and the transaction event amounts would be the total surrender amounts actually paid. Statistical compilations can be performed for the industry or for the state of domicile.
3. In addition to statistical compilations, state insurance regulators can specify additional reports based on elements in the statistical plans in VM-51. State insurance regulators can also use statistical compilations and additional reports to evaluate non-formulaic assumptions.
4. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will specify the reports to be provided to the professional actuarial associations to fulfill their roles as specified in Section 3.C of this VM-50. In general, the reports are expected to include statistical compilation at the industry level.
5. State insurance regulators can use the reports to review long-term trends. Aggregate experience results may indicate areas warranting additional investigation.

D. Supplemental Reports

1. For specific lines of business and types of experience data, state insurance regulators may request additional reports from the Experience Reporting Agent. State insurance regulators also may request custom reports, which may contain specific data or experience not regularly produced in other reports.
2. The regulator and the Experience Reporting Agent must negotiate time schedules for producing supplemental reports. The information in these reports is limited by the amount of data actually available and the manner in which it has been reported.

E. Reports to State Insurance Departments

The Experience Reporting Agent will periodically provide the following reports to state insurance departments:

1. A list of companies whose data is included in the compilation.

2. A list of companies whose data was excluded from the compilation because it fell outside of the tolerances set for missing or invalid data, or for any other reason.

Section 6: Confidentiality of Data

A. Confidentiality of Experience Data

1. The confidentiality of the experience data, experience materials and related information collected pursuant to the *Valuation Manual* is governed by state laws based on Section 14.A.(5) of Model #820. The following information is considered “confidential information” by state laws based on Section 14A(5) of the Model #820:

Any documents, materials, data and other information submitted by a company under Section 13 of [the Standard Valuation Law] (collectively, “experience data”) and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner (together with any “experience data,” the “experience materials”) and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

2. Nothing in the experience reporting requirements or elsewhere within the *Valuation Manual* is intended to, or should be construed to, amend or supersede any applicable statutory requirements, or otherwise require any disclosure of confidential data or materials that may violate any applicable federal or state laws, rules, regulations, privileges or court orders applicable to such data or materials.

B. Treatment of Confidential Information

1. Confidential information may be shared only with those individuals and entities specified in state laws based on Section 14B(3) of Model #820. Any agreement between a state insurance department and the Experience Reporting Agent will address the extent to which the Experience Reporting Agent is authorized to share confidential information consistent with state law.
2. The Experience Reporting Agent may be required to use confidential information in order to prepare compilations of aggregated experience data that do not permit identification of individual company experience or personally identifiable information. These reports of aggregated information, including those reports referenced in Section 5 of VM-50, are not considered confidential information, and the Experience Reporting Agent may make publicly available such reports. Reports using aggregate experience data will have sufficient diversification of data contributors to avoid identification of individual companies.
3. Consistent with state laws based on Section 14B(3) of the Model #820 and any agreements between a state insurance department and the Experience Reporting Agent, access to the confidential information will be limited to:
 - a. State, federal or international regulatory agencies;
 - b. The company with respect to confidential information it has submitted, and any reports prepared by the Experience Reporting Agent based on such confidential information;

- c. The NAIC, and its affiliates and subsidiaries;
- d. Auditor(s) of the Experience Reporting Agent for purposes of the experience reporting function outlined in this VM-50; and
- e. Other individuals or entities, including contractors or subcontractors of the Experience Reporting Agent, otherwise assisting the Experience Reporting Agent or state insurance regulators in fulfilling the purposes of VM-50. These other individuals or entities may provide services related to a variety of areas of expertise, such as assisting with performing industry experience studies, developing valuation mortality tables, data editing and data quality review. These other individuals and entities shall be subject to the same standards as the Experience Reporting Agent with respect to the maintenance of confidential information.

VM-51: Experience Reporting Formats

Table of Contents

Section 1:	Introduction	51-1
Section 2:	Statistical Plan for Mortality	51-1
Appendix 1:	Preferred Class Structure Questionnaire	51-5
Appendix 2:	Mortality Claims Questionnaire	51-8
Appendix 3:	Additional Plan Code Form	51-10
Appendix 4:	Mortality Data Elements and Format	51-12

Section 1: Introduction

- A. The experience reporting requirements are defined in Section 3 of VM-50. The experience reporting requirements state that the Experience Reporting Agent will collect experience data based on statistical plans that are defined in VM-51 of the *Valuation Manual*. Statistical plans are to be added to VM-51 of the *Valuation Manual* when they are ready to be implemented.
- B. Each statistical plan shall contain the following information:
 1. The type of experience data to be collected (e.g., mortality experience; policy behavior experience, such as surrenders, lapses, conversions, premium payment patterns, etc.; and company expense experience, such as commission expense, policy issue and maintenance expense, company overhead expenses etc.);
 2. The scope of business to be included in the experience data to be collected (e.g., line(s) of business, such as individual or group, life, annuity or health; product type(s), such as term, whole life, universal life, indexed life, variable life, fixed annuity, indexed annuity, variable annuity, LTC or disability income; and type of underwriting, such as medically underwritten, simplified issue (SI), GI, accelerated, etc.);
 3. The criteria for determining which companies or legal entities must submit the experience data to be collected;
 4. The process for submitting the experience data to be collected, which will include the frequency of the data collection, the due dates for data collection and how the data is to be submitted to the Experience Reporting Agent;
 5. The individual data elements and format for each data element that will be contained in each experience data record, along with detailed instructions defining each data element or how to code each data element. Additional information may be required, such as questionnaires and plan code forms that will assist in defining the individual data elements that may be unique to each company or legal entity submitting such experience data elements;
 6. The experience data reports to be produced.

Section 2: Statistical Plan for Mortality

- A. Type of Experience Collected Under This Statistical Plan

The type of experience to be collected under this statistical plan is mortality experience.

B. Scope of Business Collected Under This Statistical Plan

1. The data for this statistical plan is the individual ordinary life line of business. Such business is to include direct written business issued in the U.S. All values should be prior to any reinsurance ceded except for the situation defined in VM-51 Section 2.B.2. Assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan. The ordinary life line of business does not include separate lines of business, such as SI/GI, worksite, individually solicited group life, direct response, final expense, preneed, home service, credit life, and corporate-owned life insurance (COLI)/bank-owned life insurance (BOLI)/charity-owned life insurance (CHOLI).
2. In the event a reinsurer or TPA is responsible for administering a block of business, the reinsurer or TPA may submit that block of business on behalf of the direct writer. In this case, the reinsurer or TPA must be identified in Appendix 4 Item 1 - Submitting Company ID, and the direct writer must be identified in Appendix 4 Item 2 - NAIC Company Code of Direct Writer.
 - a. As defined in VM-50 Section 4.B.3, the reconciliation to company statistical and financial data for both the direct writing company and all reinsurers and/or TPAs must include lines indicating the amount of business that is being reported by the reinsurers and/or TPAs. The Experience Reporting Agent will compare the reconciliations for all business submitted by the direct writer and any reinsurers and/or TPAs to ensure that all business is included and that there is no double counting of policies.
 - b. If an insurance company is required to submit its direct written business and it also has reinsurance assumed business, it should only submit the assumed business if asked to do so by the ceding company since some ceding companies may not have been selected for data submission.
3. The direct writing company is ultimately responsible for all the data submitted for its company.

C. Criteria to Determine Companies That Are Required to Submit Experience Data

Companies with less than \$50 million of direct individual life premium shall be exempted from reporting experience data required under this statistical plan. This threshold for exemption shall be measured based on aggregate premium volume of all affiliated companies and shall be reviewed annually and be subject to change by the Experience Reporting Agent. At its option, a group of nonexempt affiliated companies may exclude from these requirements affiliated companies with less than \$10 million direct individual life premium provided that the affiliated group remains nonexempt.

Additional exemptions may be granted by the Experience Reporting Agent where appropriate, following consultation with the domestic insurance regulator, based on achieving a target level of approximately 85% of industry experience for the type of experience data being collected under this statistical plan.

D. Process for Submitting Experience Data Under This Statistical Plan

Data for this statistical plan for mortality shall be submitted on an annual basis. Each company required to submit this data shall submit the data using the Regulatory Data Collection (RDC) online software submission application developed by the Experience Reporting Agent. For each data file submitted by a company, the Experience Reporting Agent will perform reasonability and

completeness checks, as defined in Section 4 of VM-50, on the data. The Experience Reporting Agent will notify the company within 30 days following the data submission of any possible errors that need to be corrected. The Experience Reporting Agent will compile and send a report listing potential errors that need correction to the company.

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be one year prior to the reporting calendar year. For example, if the current calendar year is 2024 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2023, which is the observation calendar year. For the 2024 reporting calendar year, companies who are required to submit data for this statistical plan for mortality will be required to submit two observation calendar years of data, namely observation calendar year 2022 and observation calendar year 2023. For reporting calendar years after 2024, companies who are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.

Given an observation calendar year of 20XX, the calendar year method requires reporting of experience data as follows:

- i. Report policies in force during or issued during calendar year 20XX.
- ii. Report terminations that were incurred in calendar year 20XX and reported before April 1, 20XX+1. Companies may report terminations reported after April 1, 20XX+1 if they choose to do so. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Feb. 28 of the year following the reporting calendar year. The NAIC may extend either of these deadlines if it is deemed necessary.

E. Experience Data Elements and Formats Required by This Statistical Plan

Companies subject to reporting pursuant to the criteria stated in Section 2.C are required to complete the data forms in Appendix 1, Appendix 2 and Appendix 3 as appropriate, and also complete the Experience Data Elements and Formats as defined in Appendix 4.

The data should include policies issued as standard, substandard (optional) or sold within a preferred class structure. Preferred class structure means that, depending on the underwriting results, a policy could be issued in classes ranging from a best preferred class to a residual standard class. Policies issued as part of a preferred class structure are not to be classified as substandard.

Policies issued as conversions from term or group contracts should be included. For these converted policies, the issue date should be the issue date of the converted policy, and the underwriting field will identify them as issues resulting from conversion.

Generally, each policy number represents a policy issued as a result of ordinary underwriting. If a single life policy, the base policy on a single life has the policy number and a segment number of 1. On a joint life policy, each life has separate records with the same policy number. The base policy on the first life has a segment number of 1, and the

base policy on the second life has a segment number of 2. Policies that cover more than two lives are not to be submitted.

Term/paid up riders or additional amounts of insurance purchased through dividend options on a policy issued as a result of ordinary underwriting are to be submitted. Each rider is on a separate record with the same policy number as the base policy and has a unique segment number. The details on the rider record may differ from the corresponding details on the base policy record. If underwriting in addition to the base policy underwriting is done, the coverage is given its own policy number.

Terminations (both death and non-death) are to be submitted. Terminations are to include those that occurred in the observation year and were reported by June 30 of the year after the observation year.

Plans of insurance should be carefully matched with the three-digit codes in item 19, Plan. These plans of insurance are important because they will be used not only for mortality experience data collection, but also for policyholder behavior experience data collection. It is expected that most policies will be matched to three-digit codes that specify a particular policy type rather than select a code that indicates a general plan type.

Each company is to submit data for in-force and terminated life insurance policies that are within the scope defined in Section 2.B except:

- i. For policies issued before Jan. 1, 1990, companies may certify that submitting data presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.
- ii. For policies issued on or after Jan. 1, 1990, companies must:
 - a) Document the percentage that the face amount of policies excluded are relative to the face amount of submitted policies issued on or after Jan. 1, 1990; and
 - b) Certify that this requirement presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.

F. Experience Data Reports Required by This Statistical Plan

1. Using the data collected under this statistical plan, the Experience Reporting Agent will produce an experience data report that aggregates the experience data of all companies whose data have passed all of the validity and reasonableness checks outlined in Section 4 of VM-50 and has been determined by the Experience Reporting Agent to be acceptable to be used in the development of industry mortality experience.
2. The Experience Reporting Agent will provide to the SOA or other actuarial professional organizations an experience data report of aggregated experience that does not disclose a company's identity, which will be used to develop industry mortality experience and valuation mortality tables.

3. As long as a company is licensed in a state, that state insurance regulator will be given access to a company's experience data that is stored on a confidential database at the Experience Reporting Agent. Access by the state insurance regulator will be controlled by security credentials issued to the state insurance regulator by the Experience Reporting Agent.

Appendix 1: Preferred Class Structure Questionnaire

PREFERRED CLASS STRUCTURE QUESTIONNAIRE

Fill out this preferred class structure questionnaire based on companywide summaries, such as underwriting guideline manuals, compilations of issue instructions or other documentation.

The purpose of this preferred class structure questionnaire is to gather information on different preferred class structures. This questionnaire varies between nonsmoker/non-tobacco and smoker/tobacco users and provides for variations by issue year, face amount and plan. If the company has the standard Relative Risk Score (RR Score) information available, the company should map its set of preferred class structure to sets of RR Scores. **Except for new preferred class structures or new sets of RR Scores applied to existing preferred class structure(s), the response to the questionnaire should remain the same from year to year.**

If a company has determined sets of RR Scores for its preferred class structures, it should provide separate preferred class structure responses for each set of RR Scores applied to a preferred class structure. If a company has not determined sets of RR Scores for its preferred class structures, it should fill out this questionnaire with its preferred class structures and update the preferred class structure questionnaire at such future time that sets of RR Scores for the preferred class structures are determined. When sets of RR Scores are used, there is to be a one-to-one correspondence between a preferred class structure and a set of RR Scores.

The information given in this questionnaire will be used both to map a set of RR Scores to policy level data and as a check on the policy-level data submission. Submit this questionnaire along with the initial data submission to the Experience Reporting Agent.

Each preferred class structure must include at least two classes (e.g., one preferred class and one standard class). Make as many copies of this preferred class structure questionnaire as necessary for your individual life business and submit in addition to policy-level detail information.

Company	NAIC Company Code
Name	Date

PREFERRED CLASS STRUCTURE – Part 1 Nonsmokers/Non-Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for nonsmokers/non-tobacco users

Number of Nonsmoker/Non-Tobacco User Risk Classes

- Issue Date Range Date through Date
- Issue Age Range Age through Age
- Face Amount Range Amount through Amount
- Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

- Issue Date Range Date through Date
- Issue Age Range Age through Age
- Face Amount Range Amount through Amount
- Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Age through Age
- c) Face Amount Range Amount through Amount
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Age through Age
- c) Face Amount Range Amount through Amount
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Age through Age
- c) Face Amount Range Amount through Amount
- d) Plan Types (use three-digit codes from item 19, Plan)

PREFERRED CLASS STRUCTURE – Part 2 Smokers/Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for smokers/tobacco users

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Age through Age
- c) Face Amount Range Amount through Amount
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Age through Age
- c) Face Amount Range Amount through Amount
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Age through Age
- c) Face Amount Range Amount through Amount
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Age through Age
- c) Face Amount Range Amount through Amount
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Age through Age
- c) Face Amount Range Amount through Amount
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Age through Age
- c) Face Amount Range Amount through Amount
- d) Plan Types (use three-digit codes from item 19, Plan)

Appendix 2: Mortality Claims Questionnaire**MORTALITY CLAIMS QUESTIONNAIRE**

The purpose of this mortality claims questionnaire is for a company to respond to the questions whether or not it is submitting death claim data as specified. If the company is not submitting death claim data as specified, provide the additional detail requested.

Fill out this questionnaire for your individual life business and submit in addition to policy-level information.

Company	NAIC Company Code
Name	Date

MORTALITY CLAIMS

1. If the data is provided using a reporting run-out that is other than six months, what run-out period was used? mm/dd/yyyy
2. The death claim amounts are to be for the total face amount and on a gross basis (before reinsurance). The data is based on:
 - a. Total face amount (for policies that include the cash value in addition to the face amount as a death benefit, use only the face amount) as specified OR
 Other (describe):
 If not as specified, indicate time period for which this occurred _____ - _____
 - b. Gross basis (before reinsurance) as specified OR ☐ Other (describe):
 If not as specified, indicate time period for which this occurred: _____ - _____
 Is this the same basis used for face amounts included in the study data? ☐ Yes ☐ No
3. The date that the termination is reported is to be used for the termination reported date. The date that the termination actually occurred is to be used for the actual termination date. What dates are used for death claims in the study data with respect to?
 - a) Termination reported date
 If not reported date, indicate ☐ Reported date ☐ Other (describe):
 basis for dates provided
 - b) Actual termination date for death claims: ☐ Date of death ☐ Other (describe):
 If not date of death, indicate
 basis for dates provided
4. Death claims pending at the end of the observation period but paid during the subsequent six months following the observation year are to be included in the data submission. Claims that are still pending at the end of the six-month run out are ~~to~~ be included.

Are such pending claims included in the study data? ☐ Yes ☐ No

If no indicate time period for which this occurred: _____

5. The face amounts and death claim amounts are to be included without capping by amount. Are the face amounts and death claims/exposures included without capping by amount?

☐ Yes ☐ No

If No, describe how face amounts and death claims are capped and at what amount the capping is being done.

6. For death claims on policies issued before 1990:

Are death claims matched up to a corresponding in-force policy? ☐ Yes ☐ No

If no, indicate approach used:

7. Please briefly describe any other unique aspects of the death claims data that are not covered above.

Appendix 3: Additional Plan Code Form

If you need an additional plan code(s) for a product(s) in addition to those plan codes in Item 19, Plan, of the statistical plan for life insurance mortality, fill in this form using plan codes in the range 300 to 999. Your data submission should reflect the plan codes in this form. Make as many copies as necessary for your individual life business and submit in addition to policy-level information. When this form is used, it must be sent to the Experience Reporting Agent at the time that data is submitted.

Completed by: _____ Title: _____

Company: _____ NAIC Company Code: _____ Date: _____

Phone Number: _____ Email: _____

Add comments or attachments where necessary.

Enter unique three-digit plan codes for each product.

Plan Code For Product I	Plan Code for Product II	Plan Code for Product III
-------------------------	--------------------------	---------------------------

Enter specific plan names for each product.

--	--	--

A. General Product Information

	Product I	Product II	Product III
1. In what year was each product introduced?			
2. Briefly describe the product.	_____ _____	_____ _____	_____ _____
3. Enter three-digit plan code in the range 300 to 999.			

B. For the products listed, please fit each product into one of the categories below.

Categories for Product I		Categories for Product II		Categories for Product III	
1	Traditional Whole Life Plans	1	Traditional Whole Life Plans	1	Traditional Whole Life Plans
2	Term Insurance Plans	2	Term Insurance Plans	2	Term Insurance Plans
3	Universal Life Plans (excl. Variable and excl. Secondary Guarantees)	3	Universal Life Plans (excl. Variable and excl. Secondary Guarantees)	3	Universal Life Plans (excl. Variable and excl. Secondary Guarantees)
4	Universal Life Plans with Secondary Guarantees (excl. Variable)	4	Universal Life Plans with Secondary Guarantees (excl. Variable)	4	Universal Life Plans with Secondary Guarantees (excl. Variable)
5	Variable Life Plans (without Secondary Guarantees)	5	Variable Life Plans (without Secondary Guarantees)	5	Variable Life Plans (without Secondary Guarantees)
6	Variable Life Plans with Secondary Guarantees	6	Variable Life Plans with Secondary Guarantees	6	Variable Life Plans with Secondary Guarantees
7	Nonforfeiture	7	Nonforfeiture	7	Nonforfeiture
8	Other	8	Other	8	Other

Appendix 4: Mortality Data Elements and Format

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
1	9	Submitting Company ID	<p>ID number representing the company submitting this file.</p> <p>If the company has an NAIC Company Code, then that code must be used.</p> <p>If the company does not have an NAIC Company Code, the company's Federal Employer Identification Number (FEIN) must be used.</p> <p>If the direct writer is the company submitting the data, items 1 and 2 must contain the same value.</p>
2	5	NAIC Company Code of the Direct Writer of Business	<p>The NAIC Company Code of the company that wrote the business being reported.</p> <p>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.</p> <p>If the direct writer is the company submitting the data file, items 1 and 2 must contain the same value.</p>
3	4	Observation Year	Enter Calendar Year of Observation
4	20	Policy Number	Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.
5	3	Segment Number	<p>If only one policy segment exists, enter segment number '1.' For a single life policy, the base policy is to be put in the record with segment number '1.' Subsequent policy segments are in separate records with information about that coverage and differing segment numbers.</p> <p>For joint life policies, the base policy of the first life is to be put in a record with segment number '1,' and the base policy of the second life is to be put in a separate record with segment number '2.' Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers.</p> <p>Policy segments with the same policy number are to be submitted for:</p> <ul style="list-style-type: none"> a) Single life policies; b) Joint life policies; c) Term/paid up riders; or d) Additional amounts of insurance including purchase through dividend options.
6	2	State of Issue	Use standard, two-letter state abbreviation codes (e.g., NY for New York)

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
7	1	Gender	0 = Unknown or unable to subdivide 1 = Male 2 = Female 3 = Unisex – Unknown or unable to identify 4 = Unisex – Male 5 = Unisex – Female
8	8	Date of Birth	Enter the numeric date of birth in YYYYMMDD format
9	1	Age Basis	0 = Age Nearest Birthday 1 = Age Last Birthday 2 = Age Next birthday Drafting Note: Professional actuarial organization will need to develop either age next birthday mortality tables or procedure to adapt existing mortality tables to age next birthday basis.
10	3	Issue Age	Enter the insurance Issue Age
11	8	Issue Date	Enter the numeric calendar year in YYYYMMDD format.
12	1	Smoker Status	Smoker status should be submitted where reliable. 0 = Unknown 1 = No tobacco usage 2 = Nonsmoker 3 = Cigarette smoker 4 = Tobacco user
13	1	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 for this policy segment. Note: If Preferred Class Structure Indicator is 0, or if preferred information is unknown, leave next four items blank.
14	1	Number of Classes in Nonsmoker Preferred Class Structure	If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue.

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
15	1	Nonsmoker Preferred Class	<p>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank.</p> <p>For nonsmoker policy segments that could have been issued as one of multiple preferred and standard classes:</p> <p>1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8</p> <p>Note: The policy segment with the highest nonsmoker Preferred Class number should have that number equal to the Number of Classes in Nonsmoker Preferred Class Structure.</p>
16	1	Number of Classes in Smoker Preferred Class Structure	<p>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank.</p> <p>For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.</p>
17	1	Smoker Preferred Class	<p>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank.</p> <p>For smoker policy segments that could have been issued as one of multiple preferred and standard classes:</p> <p>1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8</p> <p>Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the Number of Classes in Smoker Preferred Class Structure.</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
18	2	Type of Underwriting Requirements	<p>If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, preneed, home service and COLI/BOLI/CHOLI.</p> <p>01 = Underwritten, but unknown whether fluid was collected</p> <p>02 = Underwritten with no fluid collection</p> <p>03 = Underwritten with fluid collected</p> <p>06 = Term Conversion</p> <p>07 = Group Conversion</p> <p>09 = Not Underwritten</p> <p>99 = For issues where underwriting requirement unknown or unable to subdivide</p>
19	1	Substandard Indicator	<p>0 = Policy segment is not substandard</p> <p>1 = Policy segment is substandard</p> <p>2 = Policy segment is uninsurable</p> <p>Note:</p> <ul style="list-style-type: none"> a. All policy segments that are substandard need to be identified as substandard or uninsurable. b. Submission of substandard policies is optional. c. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard.
20	3	Plan	<p>Exclude from contribution: spouse and children under family policies or riders. If Form for Additional Plan Codes was submitted for this policy, enter unique three-digit plan number(s) that differ from the plan numbers below:</p> <p>000 = If unable to distinguish among plan types listed below</p> <p>100 = Joint life plan unable to distinguish among joint life plan types listed below</p> <p>Permanent Plans:</p> <p>010 = Traditional fixed premium fixed benefit permanent plan</p> <p>011 = Permanent life (traditional) with term</p> <p>012 = Single premium whole life</p> <p>013 = Econolife (permanent life with lower premiums in the early durations)</p> <p>014 = Excess interest whole life</p> <p>015 = First to die whole life plan (submit separate records for each life)</p> <p>016 = Second to die whole life plan (submit separate records for each life)</p> <p>017 = Joint whole life plan – unknown whether 015 or 016 (submit separate records for each life)</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
			<p>018 = Permanent products with non-level death benefits</p> <p>019 = Permanent plans 010, 011, 012, 013, 014, 015, 016, 017, 018 combined (i.e. unable to separate)</p> <p>Term Insurance Plans:</p> <p>020 = Term (traditional level benefit and attained age premium)</p> <p>021 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for five years)</p> <p>211 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 10 years)</p> <p>212 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 15 years)</p> <p>213 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 20 years)</p> <p>214 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 25 years)</p> <p>215 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 30 years)</p> <p>022 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)</p> <p>221 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)</p> <p>222 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)</p> <p>223 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)</p> <p>224 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 30 years)</p> <p>023 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 15 years)</p> <p>231 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)</p> <p>232 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)</p> <p>233 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)</p> <p>024 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
			<p>241 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)</p> <p>242 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 year)</p> <p>025 = Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)</p> <p>251 = Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 year)</p> <p>026 = Term (level death benefit with guaranteed level premium for 30 years and anticipated level term period for 30 years)</p> <p>027 = Term (level death benefit with guaranteed level premium period equal to anticipated level term period where the period is other than five, 10, 15, 20, 25 or 30 years)</p> <p>271 = Term (level death benefit with guaranteed level premium period not equal to anticipated level term period, where the periods are other than five, 10, 15, 20, 25 or 30 years)</p> <p>028 = Term (decreasing benefit)</p> <p>040 = Select ultimate term (premium depends on issue age and duration)</p> <p>041 = Return of Premium Term (level death benefit with guaranteed level premium for 15 years)</p> <p>042 = Return of Premium Term (level death benefit with guaranteed level premium for 20 years)</p> <p>043 = Return of Premium Term (level death benefit with guaranteed level premium for 25 years)</p> <p>044 = Return of Premium Term (level death benefit with guaranteed level premium for 30 years)</p> <p>045 = Return of Premium Term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)</p> <p>046 = Economatic term</p> <p>059 = Term plan, unable to classify</p> <p>101 = First to die term plan (submit separate records for each life)</p> <p>102 = Second to die term plan (submit separate records for each life)</p> <p>103 = Joint term plan – unknown whether 101 or 102 (submit separate records for each life)</p> <p>Universal Life Plans (Other than Variable), issued without a Secondary Guarantee:</p> <p>061 = Single premium universal life</p> <p>062 = Universal life (decreasing risk amount)</p> <p>063 = Universal life (level risk amount)</p> <p>064 = Universal life – unknown whether code 062 or 063</p> <p>065 = First to die universal life plan (submit separate records for each life)</p> <p>066 = Second to die universal life plan (submit separate records for each life)</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
			<p>067 = Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)</p> <p>068 = Indexed universal life</p> <p>Universal Life Plans (Other than Variable) with Secondary Guarantees:</p> <p>071 = Single premium universal life with secondary guarantees</p> <p>072 = Universal life with secondary guarantees (decreasing risk amount)</p> <p>073 = Universal life with secondary guarantees (level risk amount)</p> <p>074 = Universal life with secondary guarantees – unknown whether code 072 or 073</p> <p>075 = First to die universal life plan with secondary guarantees (submit separate records for each life)</p> <p>076 = Second to die universal life plan with secondary guarantees (submit separate records for each life)</p> <p>077 = Joint life universal life plan with secondary guarantees unknown whether code 075 or 076 (submit separate records for each life)</p> <p>078 = Indexed universal life with secondary guarantees</p> <p>Variable Life Plans issued without a Secondary Guarantee:</p> <p>080 = Variable life</p> <p>081 = Variable universal life (decreasing risk amount)</p> <p>082 = Variable universal life (level risk amount)</p> <p>083 = Variable universal life – unknown whether code 081 or 082</p> <p>084 = First to die variable universal life plan (submit separate records for each life)</p> <p>085 = Second to die variable universal life plan (submit separate records for each life)</p> <p>086 = Joint life variable universal life plan – unknown whether 084 or 085 (submit separate records for each life)</p> <p>Variable Life Plans with Secondary Guarantees:</p> <p>090 = Variable life with secondary guarantees</p> <p>091 = Variable universal life with secondary guarantees (decreasing risk amount)</p> <p>092 = Variable universal life with secondary guarantees (level risk amount)</p> <p>093 = Variable universal life with secondary guarantees –unknown whether code 091 or 092</p> <p>094 = First to die variable universal life plan with secondary guarantees (submit separate records for each life)</p> <p>095 = Second to die variable universal life plan with secondary guarantees (submit separate records for each life)</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
			<p>096 = Joint life variable universal life plan with secondary guarantees – unknown whether code 094 or 095 (submit separate records for each life)</p> <p>Coverage purchased with dividends: 196 = Paid Up Additions 197 = One-Year Term</p> <p>Nonforfeiture: 098 = Extended term 099 = Reduced paid-up 198 = Extended term for joint life (submit separate records for each life) 199 = Reduced paid-up for joint life (submit separate records for each life)</p>
21	1	In-force Indicator	<p>0 = If the policy segment was not in force at the end of the calendar year of observation</p> <p>1 = If the policy segment was in force at the end of the calendar year of observation</p>
22	12	Face Amount of Insurance at Issue	<p>Face amount of the policy segment at its issue date rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. If the policy was issued during the observation year, the Face Amount of Insurance at the Beginning of the Observation Year should be blank.</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
23	12	Face Amount of Insurance at the Beginning of the Observation Year	Face amount of the policy segment at the beginning of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If the policy was issued during the observation year, the Face Amount at the Beginning of the Observation Year should be blank.
24	12	Face Amount of Insurance at the End of the Observation Year	<p>Face amount of the policy segment at the end of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value. Exclude extra amounts attributable to 7702 corridors.</p> <p>If In-force Indicator is 0, enter face amount of the policy segment at the time of termination, if available; otherwise, leave blank.</p>
25	12	Death Claim Amount	<p>If In-force Indicator is 1, leave blank.</p> <p>Death claim amount rounded to the nearest dollar.</p> <p>If In-force Indicator is 0 and Cause of Termination is 04, then enter the face amount.</p> <p>If In-force Indicator is 0 and Cause of Termination is not 04, then leave blank.</p> <p>If the policy provides payment of cash value in addition to face amount, report face amount, and do not include cash value.</p>
26	8	Termination Reported Date	<p>If In-force Indicator is 1, leave blank.</p> <p>Enter in the format YYYYMMDD the eight-digit calendar date that the termination was reported.</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
27	8	Actual Termination Date	<p>If In-force Indicator is 1, leave blank.</p> <p>Enter in the format YYYYMMDD the eight-digit calendar date when the termination occurred.</p> <p>If termination is due to death (Cause of Termination is 04), enter actual date of death.</p> <p>If termination is lapse due to non-payment of premium (Cause of Termination is 01 or 02 or 14), enter the last day the premium was paid to.</p>
28	2	Cause of Termination	<p>If Inforce Indicator is 1, leave blank.</p> <p>00 = Termination type unknown or unable to subdivide</p> <p>01 = Reduced paid-up</p> <p>02 = Extended term</p> <p>03 = Voluntary; unable to subdivide among 01, 02, 07, 09, 10, 11 or 13</p> <p>04 = Death</p> <p>05 = Death due to COVID-19</p> <p>07 = 1035 exchange</p> <p>09 = Term conversion – unknown whether attained age or original age</p> <p>10 = Attained age term conversion</p> <p>11 = Original age term conversion</p> <p>12 = Coverage expired or contract reached end of the mortality table</p> <p>13 = Surrendered for full cash value</p> <p>14 = Lapse (other than to Reduced Paid Up or Extended Term)</p> <p>15 = Termination via payment of a discounted face amount while still alive, pursuant to an accelerated death benefit provision</p>
29	10	Annualized Premium at Issue	<p>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium set at issue.</p> <p>Except for level term segments specified above, leave blank for non-base segments.</p> <p>For the base segments for ULSG, and Variable Life with Secondary Guarantees (VLSG) with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium set at issue.</p> <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
30	10	Annualized Premium at the Beginning of Observation Year	<p>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium for the policy year that includes the beginning of the observation year.</p> <p>Except for level term segments specified above, leave blank for non-base segments.</p> <p>For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium for the policy year that includes the beginning of the observation year.</p> <p>Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank.</p> <p>If unknown, leave blank.</p>
31	10	Annualized Premium at the End of Observation, if available. Otherwise Annualized Premium as of Year/Actual Termination Date	<p>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, for each segment that has Item 20, with the In-force Indicator = 1, enter the annualized premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).</p> <p>Except for level term segments specified above, leave blank for non-base segments.</p> <p>For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, use the annualized billed premium. For base segments that have Item 20, with the Inforce Indicator =1, enter the annualized billed premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized billed premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).</p> <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
32	2	Premium Mode	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
33	10	Cumulative Premium Collected as of the Beginning of Observation Year	If not ULSG or VLSG, leave blank. For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 1) For non-base segments, leave blank. 2) For base segments, enter the cumulative premium collected since issue, as of the beginning of the observation year. Round to the nearest dollar. For policies issued in the observation year, leave blank. If unknown, leave blank.
34	10	Cumulative Premium Collected as of the End of Observation Year if available. Otherwise Cumulative Premium Collected as of Actual Termination Date	If not ULSG or VLSG, leave blank. For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 1) For non-base segments, leave blank. 2) For base segments inforce at the end of the observation year, enter the cumulative premium collected as of the end of the observation year. 3) For base segments terminated during the observation year, enter the cumulative premium collected since issue, as of the Actual Termination Date (Item 26). Round to the nearest dollar. If unknown, leave blank.

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
35	2	ULSG/VLSG Premium Type	<p>For non-base segments, leave blank. If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 00 = Unknown 01 = Single premium 02 = ULSG/VLSG Whole life level premium 03 = Lower premium (term like) 04 = Other</p>
36	2	Type of Secondary Guarantee	<p>For non-base segments, leave blank. If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 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</p>
37	10	Cumulative Minimum Premium as of the Beginning of Observation Year	<p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p> <p>If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:</p> <p>1) Leave non-base segments, blank. 2) For base segments:</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
			<p>Enter the cumulative minimum premiums, including applicable interest, for all policy years up to the beginning of the observation year.</p> <p>Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank.</p> <p>If unknown, leave blank.</p>
38	10	Cumulative Minimum Premium as of the End of Observation Year/ Actual Termination Date	<p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:</p> <ol style="list-style-type: none"> 1) For non-base segments, leave blank. 2) For base segments inforce at the end of the observation year, enter the cumulative minimum premiums, including applicable interest, up to the end of the observation year. 3) For base segments terminated during the observation year, enter the cumulative minimum premiums, including applicable interest, up to the Actual Termination Date (Item 26) <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>
39	10	Shadow Account Amount at the Beginning of Observation Year	<p>If not ULSG, or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22:</p> <ol style="list-style-type: none"> 1) Leave non-base segments blank. 2) For base segments: Enter total amount of the Shadow Account at the beginning of the observation year. The Shadow Account can be positive, zero or negative. <p>Round to the nearest dollar.</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
			<p>For policies issued in the observation year, leave blank.</p> <p>If unknown, leave blank.</p>
40	10	Shadow Account Amount at the End of Observation Year/ Actual Termination Date	<p>If not ULSG, or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22:</p> <ol style="list-style-type: none"> 1) For non-base segments, leave blank. 2) For base segments inforce at the end of the observation year, enter the total amount of the Shadow Account at the end of the observation year. The Shadow Account can be positive, zero or negative. 3) For base segments terminated during the observation year, enter the total amount of the Shadow Account as of the Actual Termination Date (Item 26). The Shadow Account can be positive, zero or negative. <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>
41	10	Account Value at the Beginning of Observation Year	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, the policy Account Value (gross of any loan) at the Beginning of the Observation Year. The policy Account Value can be positive, zero or negative.</p> <p>Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank.</p> <p>If unknown, leave blank.</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
42	10	Account Value at the End of Observation Year/Actual Termination Date	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p> <p>1) If policy is in force at the end of observation year, enter the policy Account Value (gross of any loan) at the end of the Observation Year. The policy Account Value can be positive, zero or negative.</p> <p>2) If policy terminated during the observation year, enter the policy Account Value (gross of any loan) as of the Actual Termination Date (Item 26). The policy Account Value can be positive, zero or negative.</p> <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>
43	10	Amount of Surrender Charge at the Beginning of Observation Year	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan, enter the dollar Amount of the Surrender Charge as of the Beginning of the Observation Year.</p> <p>Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank.</p> <p>If unknown, leave blank.</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
44	10	Amount of Surrender Charge at the End of Observation Year/Actual Termination Date	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSC, leave blank.</p> <p>For ULSG and VLSC policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p> <p>1) If policy is in force at the end of observation year, enter the dollar amount of the Surrender Charge at the end of the Observation Year.</p> <p>2) If policy terminated during the observation year, enter the dollar amount of the Surrender Charge as of the Actual Termination Date (Item 26).</p> <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>
45	2	Operative Secondary Guarantee at the Beginning of Observation Year	<p>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the beginning of the Observation Year.</p> <p>If Item 35, Type of Secondary Guarantee is blank, leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 00 through 23:</p> <p>1) For non-base segments, leave blank.</p> <p>2) For base segments:</p> <p>00 = If unknown whether the secondary guarantee is in effect</p> <p>01 = If secondary guarantee is not in effect</p> <p>02 = If secondary guarantee is in effect</p> <p>03 = If all secondary guarantees have expired</p>
46	2	Operative Secondary Guarantee at the End of Observation Year/Actual Termination Date	<p>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the end of the Observation Year/Actual Termination Date.</p> <p>If Item 35, Type of Secondary Guarantee is blank, leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 00 through 23:</p> <p>1) For non-base segments, leave blank.</p> <p>2) For base segments in force at the end of observation year, enter the appropriate value below as of the end of observation year:</p> <p>00 = If unknown whether the secondary guarantee is in effect</p> <p>01 = If secondary guarantee is not in effect</p> <p>02 = If secondary guarantee is in effect</p> <p>03 = If all secondary guarantees have expired</p> <p>3) For base segments terminated during the observation year, enter the appropriate value</p>

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
			<p>below as of the Actual Termination Date (Item 26):</p> <p>00 = If unknown whether the secondary guarantee is in effect</p> <p>01 = If secondary guarantee is not in effect</p> <p>02 = If secondary guarantee is in effect</p> <p>03 = If all secondary guarantees have expired</p>
47	2	Owner's State of Residence	<p>Use standard, two-letter state abbreviations codes (e.g., FL for Florida) for the policy owner's state of residence.</p> <p>If unknown or outside of the U.S., leave blank.</p>