IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

VIVIAN FARRIS; trustee for WIRT ADAMS YERGER, JR. LEGACY TRUST; *Individually and on behalf of all those similarly situated*	)	
Plaintiff,	)	**Case No. 1:17-cv-417**
v.	)	**Judge Susan J. Diott**
U.S. FINANCIAL LIFE INSURANCE COMPANY,	)	**JURY TRIAL DEMANDED**
Defendant.	)	

FIRST AMENDED CLASS ACTION COMPLAINT

Plaintiff Vivian Farris, trustee of the Wirt Adams Yerger, Jr. Legacy Trust, individually and on behalf of a class of all those similarly situated, files this First Amended Class Action Complaint pursuant to Fed. R. Civ. P. 15(a)(1)(B), and brings this action against U.S. Financial Life Insurance Company and alleges based upon investigation, experience, and information and belief as follows:

INTRODUCTION

1. U.S. Financial Life Insurance Company ("USFL") is a for-profit life insurer organized under Ohio law. AXA is a French multinational insurance firm headquartered in Paris, France and operating primarily in Europe, North America, the Asia Pacific region, Africa and the Middle East. AXA is USFL's ultimate parent.

2. USFL, AXA, and other AXA entities have engaged in a series of accounting schemes that make USFL appear as a financially strong life insurance company by utilizing captive

reinsurance to offload liabilities, namely life insurance policies, and create the appearance that USFL has adequate assets to back its remaining liabilities.

3. Through what New York's former Superintendent of Financial Services, Benjamin M. Lawksy, called "financial alchemy," USFL painted itself as a supremely healthy insurer, virtually bursting with excess cash, by dumping more than $865,000,000 worth of liabilities into a captive reinsurance company, AXA RE Arizona Company (formerly known as AXA Financial (Bermuda), Ltd.) (hereafter "AXA Arizona"). AXA Arizona, however, is incapable of satisfying its assumed obligations. To recognize the significance of that amount ceded to a captive, it needs to be put in perspective – that is **more than 8 times USFL's reported surplus of $105,000,000**.

4. In 2007, USFL stopped selling new insurance policies and entered into a business runoff. A year later, in 2008, USFL increased Plaintiff's and Class members' Cost of Insurance ("COI") abruptly, blaming changes in future mortality expectations.

5. However, the 2008 COI increase was done in the midst of the Great Recession and the beginning of record-low interest rates. This impacted the relevant policies as they have a minimum guaranteed interest rate of 4 percent and those policies were all dropped to the minimum guaranteed rate in 2008. Despite reducing the interest rate to the minimum guaranteed rate of 4 percent, USFL now faces and continues to face interest rates on its investments that are lower than the guaranteed interest rate on the affected policies.

6. In 2013, the North Carolina Department of Insurance notified USFL that it has been charging COI above the maximum guaranteed rate for a block of 3,000 policies, resulting in policyholders lapsing prematurely. USFL was required to reimburse both lapsed and existing policyholders within the affected policies. Beginning in 2014 and throughout 2015, tens of millions of dollars were set aside and paid out to those affected policyholders.

7. In 2015, the same year USFL finished paying off this costly act, USFL suddenly announced the increase to the COI charged to Plaintiff's and the Class members' universal life insurance policies starting on policy anniversaries after August 31, 2015. This COI increase was as high as 40 percent for many policyholders. *See, e.g.,* "Carrier that Recently Increased Cost of Insurance Charges on In-Force Life Policies," *available at* http://lionstreet.com/media/Lion-Street-COI-Charges-Whitepaper-Carrier-List-11.07.16.pdf.

8. Through mailers, press releases, and myriad other mediums, USFL has told policyholders that dramatic COI increases for Nova and SuperNova UL policies are necessary due to USFL "expecting future mortality experience to be less favorable than was anticipated when the current schedule of COI rates was established." *See, e.g.,* "A Close Look at the Current Universal Life Cost Increases," *available at* https://www.itm21st.com/Content/Documents/Webinar/coi-handbook.pdf; "USFL Nova & SuperNova UL Products: Increase in Cost of Insurance (COI) Rates," *available at* https://www.itm21st.com/Content/Documents/usfl-nova-supernova-ul-09-01-15.pdf.

9. Since August 2015, USFL has systematically raided policyholder accounts, arguing that its actions are permitted by the policies' terms. In reality, USFL's offered justifications are false, and merely a guise to accomplish three objectives: (1) find new cash with which to fund the company, (2) rid itself of near-term liabilities and delay inevitable financial disaster, and (3) recoup for past losses due to: (a) record-low interest rates, (b) miscalculation of the 2008 COI increase on Plaintiff's and Class members' policies, and (c) the tens of millions of dollars paid in 2014 and 2015 to 3,000 policyholders overcharged the maximum COI rate in their respective policies.

PARTIES

10. Plaintiff Vivian Farris is an adult resident of Jackson, Mississippi. Ms. Farris is the trustee of the Wirt Adams Yerger Jr. Legacy Trust (the "Trust") which is a family trust Wirt Yerger, Jr. formed to purchase a Nova policy ("the Policy") from USFL for the benefit of his family.

11. Plaintiff Wirt Adams Yerger, Jr. Family Trust is a trust organized under the laws of Mississippi in Jackson, Mississippi, and for the benefit of Mr. Yerger's children and grandchildren.

12. Defendant USFL is a corporation organized and existing under the laws of Ohio, and according to its annual statements, has its statutory headquarters at 4000 Smith Road, Suite 300 Cincinnati, Ohio 45209.

JURISDICTION AND VENUE

13. This Court has original subject matter jurisdiction over this matter pursuant to 28 U.S.C. § 1332(d), which, under the provisions of the Class Action Fairness Act ("CAFA"), provides federal courts original jurisdiction over any class action in which any member of a class is a citizen of a state different from any defendant, and in which the matter in controversy exceeds in the aggregate the sum of $5 million, exclusive of interest and costs.

14. This Court has personal jurisdiction over USFL because it is the venue where USFL resides, it has systematic and continuous contacts within the state this Court resides by and through the millions in premiums it receives from citizens of this state, the policies issued to citizens in this state, the presence of a registered agent, and its filings with the relevant state regulatory bodies.

15. Venue is proper in this district pursuant to 28 U.S.C. § 1391(c)(2) and (d) because USFL is subject to this Court's personal jurisdiction and has sufficient contacts establishing such.

FACTS

I. Plaintiff and Class Members

16. Mr. Yerger is a resident of Jackson, Mississippi.

17. In order to look after his children and grandchildren Mr. Yerger created the Wirt Adams Yerger Jr. Legacy Trust ("Trust") in November 2005.

18. Mr. Yerger transferred his USFL Nova life insurance policy ("the Policy"), policy number 0000167447, to the Trust for the benefit of his family.

A. The Yerger Policy

19. In March 2001, Mr. Yerger procured the Policy with a death benefit of $1,750,000.

20. Mr. Yerger initially made a premium deposit of $297,087.

21. On or about December 2005, Mr. Yerger changed the owner and beneficiary of the Policy to the Trust.

22. In March 2008, USFL sent the Trust a letter stating it would increase the COI rate on the Policy because "[a] recent review of our mortality experience under this policy form has indicated that the trend in mortality and claims will be less favorable than anticipated when the product was priced." *See* Exhibit 1, March 17, 2008 USFL letter.

23. Indeed, the monthly COI spiked from $4,664.74 in February 15, 2008 to $5,794.46 on March 15, 2008. The yearly COI from policy year 2007-2008 was $55,182.39 and skyrocketed to $70,282.85 in policy year 2008-2009, an increase of over $15,000.

24. Beginning in 2008, the Trust made regular premium payments to support the Policy due to the COI hike.

25. The Trust was informed in August 2015 by USFL that USFL would increase the COI rates on the Policy for a second time because "[w]e anticipate the future mortality experience

for this product to be worse than was anticipated when the current schedule of cost of insurance rates was established." *See* Exhibit 2, August 11, 2015 USFL letter.

26. Apparently, any supposed mortality experience adjustments made during the 2008 COI increase were all for naught.

27. Instead, USFL has not experienced changes in mortality experience, but is merely recouping for prior losses based on a number of factors pleaded later in this Complaint.

28. Regardless, even if the 2008 COI increase was due to a change in mortality experience, the 2015 COI increase is merely a money grab by USFL because it either miscalculated in 2008 and is recouping for prior losses since the 2008 COI increase or USFL is continuing to hide the current COI increase under the guise of changes to "future mortality experience," changes, which is extremely doubtful based on current mortality trends.

29. Indeed, the monthly COI dramatically increased from $9,137.48 on February 15, 2016 to $17,029.35 on March 15, 2016. The yearly COI from policy year 2015-2016 was $111,693.65 and spiked to $191,217.41 in policy year 2016-2017, an increase of nearly $80,000.

30. The Policy's Account Value started on March 15, 2015, with a value of $76,142.02 and a cost of insurance of $9,078.53.

31. By June 2016, USFL warned Plaintiff in a letter that if Plaintiff did not pay an additional premium of $22,354.80 then the Policy would lapse at the end of a grace period due to the Policy Account value being depleted by the COI rate increase.

32. Mr. Yerger contacted USFL and was informed that he also needed to pay $18,000 per month in additional premiums in order to keep the Policy in force. The Trust paid an additional premium of $95,776 after receiving another letter in December 2015 from USFL warning the policy was about to enter a grace period before lapsing. In fact, the cash value had already been

drained by USFL's 2015 COI increase, as the cash value was in the negative by $6,945.99 as of December 15, 2015.

33. Within a period of a mere ten months, USFL had completely acquired Plaintiff's policy cash value of $76,142.02 due to the fraudulent 2015 COI increase.

34. Plaintiff made approximately $151,636.80 in premium payments in 2016 to keep the Policy in force – over $50,000 more in premiums than Plaintiff paid in 2015.

35. By February 15, 2017, the Policy Account was reduced to $17,913.19, and the Policy Account is expected to be at $0 unless Plaintiff continues to make additional premium payments. The monthly COI continues to rise, and is now approximately $17,334.13 per month – nearly double the COI rate paid the previous policy year.

36. By dramatically increasing COI charges, USFL is raiding the Policy Account, and attempting to force Plaintiff to allow the Policy to lapse.

B. Class Members

37. Plaintiff is not alone. USFL has dramatically increased the COI rate on policyholders of the Nova and SuperNova UL policies.

38. The COI rate increases on these policies are drastic and unprecedented in the history of these policies. COI is being increased from 6% to 40%, depending upon the policy block.

39. USFL is increasing the COI to (1) find new cash with which to fund the company, (2) rid itself of near-term liabilities because it is financially unstable – a fact they have hidden through a captive reinsurance scheme – and (3) to recoup past losses related to (a) record-low interest rates, (b) the miscalculation of the 2008 COI increase on Plaintiff's and Class members' policies, and (c) the tens of millions of dollars paid in 2014 and 2015 to 3,000 policyholders overcharged the maximum COI rate in their respective policies.

II. USFL's COI Increases Are Inappropriate Raids on Policy Cash Values

A. USFL's History

40. USFL is an Ohio-incorporated insurance company with its headquarters located in Cincinnati, Ohio. The MONY Group acquired USFL on December 31, 1998, and in turn was acquired by AXA Financial, Inc. during AXA Financial, Inc.'s purchase of The MONY Group on July 8, 2004.

41. AXA is a French multinational insurance firm headquartered in Paris, France and operating primarily in Europe, North America, the Asia Pacific region, Africa, and the Middle East. AXA is USFL's ultimate parent.

42. Upon AXA Financial, Inc.'s purchase of The MONY Group (and in turn, USFL), all of USFL's term life insurance business issued since January 1, 1999 (net of non-affiliated reinsurance) was reinsured through AXA RE Arizona Company (formerly AXA Financial Bermuda Ltd.), an affiliated company. All policies issued effective 2005 and later earned a level allowance for the policy years and created additional capital strain upon issuance for the company.

43. Starting July 20, 2007, USFL entered into a runoff, *i.e.* terminated issuing new lines of business.

44. The next year, Plaintiff and Class members received a letter dated March 17, 2008, warning, "[a] recent review of our mortality experience under this policy form has indicated that the trend in mortality and claims will be less favorable than anticipated when the product was priced." Therefore, USFL would be increasing the COI rates on their policies – less than a year after USFL stopped issuing new policies.

B. USFL's Justifications for the Nova and SuperNova UL COI Increase Are False

45. USFL marketed and sold Nova and SuperNova UL policies during the turn of the century.

46. These policies were chosen by USFL to receive COI rate increases ranging from 6 percent to upwards of 40 percent.

47. With respect to the manner in which COI rates are purportedly determined, the Policy provides:

> The cost of insurance rate is based on the Insured's sex, attained age and premium class. For the initial specified amount, we will use the premium class on the policy date. For each increase in the specified amount, we will use the premiums class applicable to the increase. As a result, there may be a different cost of insurance rate for each increase.
>
> The guaranteed maximum cost of insurance rates are shown in the Table of Maximum Monthly Costs on page 5. We have the right to use cost of insurance rates that are lower than the guaranteed rates and may change the rates from time to time. Any change in the cost of insurance rates will apply uniformly to all members of the same class.[1]

48. As reflected in the policy language above, USFL can increase COI based solely on reasonable assumptions regarding three enumerated factors: sex, age, and premium class. Moreover, any COI increase must be done on a basis that will "apply uniformly to all members of the same class."

49. In early August 2015, USFL initially notified policyholders via correspondence dated August 11, 2015 that effective the next policy anniversary, USFL would be increasing the monthly COI for Nova and SuperNova UL policyholders. The correspondence stated that the purported basis for the COI increase was:

> We anticipate the future mortality experience for this product to be worse than was anticipated when the current schedule of cost of insurance rates

[1] Plaintiff's USFL Policy, Exhibit 3 at 12.

> was established. We are writing to inform you that beginning on your next policy anniversary after August 31, 2015, the cost of insurance rates will be based on a new schedule that is higher than the current schedule.

50. AXA has repeatedly claimed in its letters to policyholders, and in their 2015-2016 and 2016-2017 policy annual statements, that the only alleged basis for the increase was unfavorable future mortality experience. For example, in both Policy annual statements received by Plaintiff, USFL represented "U.S. Financial Life anticipates the future mortality experience for this product to be worse than was anticipated when the current schedule of cost of insurance rates was established."

51. In reality, future mortality experience fails to support the sheer scale of the COI increase imposed upon the Policy and other Nova and SuperNova UL policyholders.

52. With respect to mortality, USFL asserts that policyholders are dying sooner than was expected when the policies were sold. However, actuarial tables published by the Society of Actuaries throughout the years, and as recently as 2014, demonstrate that mortality expectations **have consistently improved** throughout the years. This trend is even more pronounced with respect to older age insureds.

53. The COI increases range anywhere from 6 percent to 40 percent. If USFL expects this level of COI increase to return the policies to profitability, this reflects a massive investment income shortfall, which could only mean USFL's "expectations" at the issue date were inherently unreasonable, and a violation of the insurance contract.

54. Plaintiff and Class members are now left to face the results of USFL's pillaging of their policies: a lose-lose situation. Plaintiff and Class members are forced to watch their cash value dwindle to lapse and face paying astronomically higher premiums; go into lapse and lose their death benefit and cash value if they cannot afford the draconian COI increase; or take out the

dwindling cash value and attempt to obtain another life insurance policy that will lack the guaranteed interest rate and death benefit of their current policy due to the policyholder's present age and health. Truly a no-win scenario.[2]

55. Meanwhile, USFL absconds with the cash values of Plaintiff and Class members and reaps the benefit of premature policy lapsing due to the artificial and fraudulent 2015 COI increase.

D. USFL's 2015 COI Increase is Recouping Prior Losses

56. In fact, multiple rating agencies and industry analysts in the early 2000's criticized the life insurance industry for selling universal life policies with secondary guarantees like Plaintiff and Class members with unreasonable expectations as to policy performance.[3] USFL refers to the secondary guarantee in Plaintiff's and the Class members' policies as a "Target Premium Guarantee Period."

57. Beginning as early as July 2004, both Moody's and Fitch, which are industry publications, issued special reports and warnings regarding secondary guarantee universal life policies. As two industry analysts noted, "[b]oth Moody's and Fitch are now officially on record

[2] *See* Ron Sussman, *Commentary: Cost of Insurance Increases Keep Coming*, insurancenews.net (Oct. 14, 2016) https://www.insurancenewsnet.com/innarticle/commentary-cost-insurance-increases-keep-coming ("A common theme among the carriers that have, so far, announced these COI increases is that the insureds most affected are 70 and over. Most of them will be unable to replace their coverage due to age, medical conditions and the cost of suitable replacement policies. . . . The actual, and possibly intended, consequence of these COI increases will be a high percentage of lapsed policies, which will surely benefit the carrier.").

[3] *See* David N. Barkhausen, *Universal Life with No Lapse Guarantees: What You Need to Know!*, (2004), http://www.lifeinsuranceadvisorsinc.com/articles/individuals/UniversalLifeNoLapse.pdf ("Recent (June and July 2004) detailed reports from Moody's, Standard & Poor's and Fitch, three of the five insurance company rating agencies, have issued strong warnings about the future impact of these policies on the companies issuing them. They caution that the premium levels for the lowest-priced products appear predicated on possible overly optimistic expectations with regard to future interest rates, mortality experience, reinsurance pricing, and policy lapse rates. Because premium levels and death benefits remain constant for the duration of a guaranteed death benefit policy, with no possible adjustments in policy pricing or benefits in the event of unfavorable future economic developments and insurer experience, these risks are greatly enhanced.").

in notifying companies that there is a new and significant factor in their evaluation of long-term financial strength."[4]

58. Incredibly, USFL and the industry was warned that "**Moody's fears that insurers writing these policies could suffer potentially large losses if aggressive pricing assumptions involving portfolio yield, surrender rates, letter of credit (LOC) costs and mortality rates do not materialize as expected**." (emphasis original).[5]

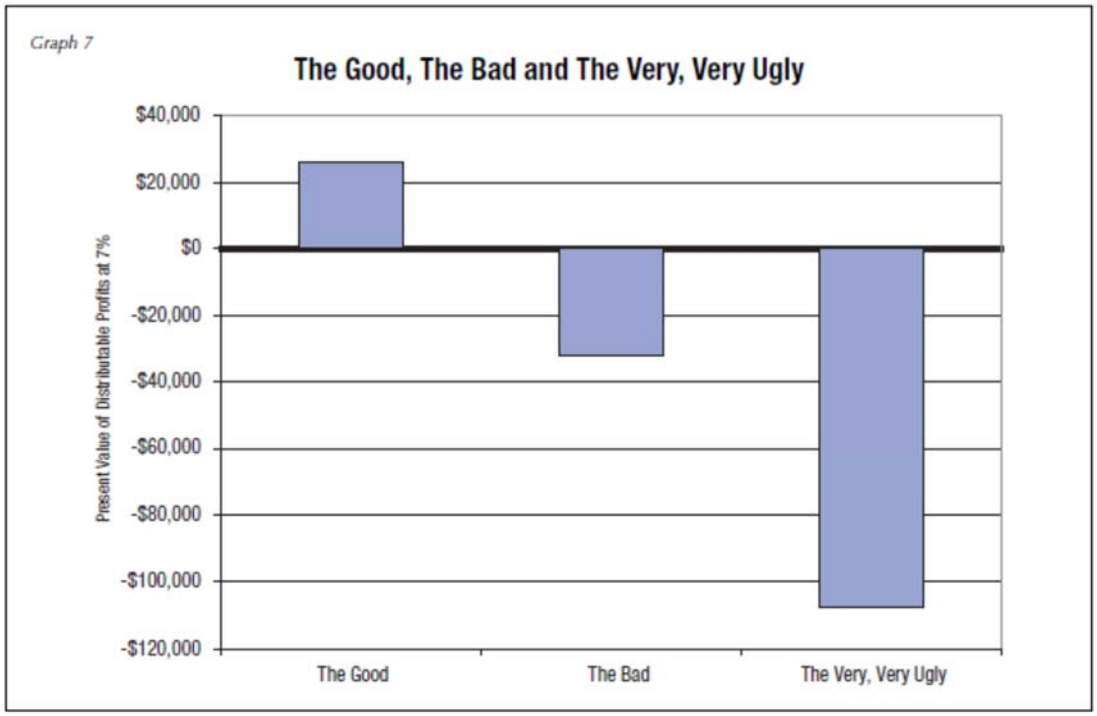
59. The report went on to predict that "The combination of a prolonged low interest rate environment, increasing LOC costs, higher than anticipated mortality rates, and low lapse rates can produce material losses for an insurer with a substantial block of UL policies containing these guarantees."[6] Moody's even went so far as to predict "the worse-case scenario" which is precisely what has occurred as a result of record-low interest rates after the Great Recession: [7]

[4] Lawrence J. Rybka, R. Marshall Jones, *Guesses, Projections, Promises and Guarantees*, Journal of Financial Service Professionals, (July 2005); http://joneslowry.com/articles/Guesses_Projections_Promises_Guarantee.pdf.
[5] Special Comment, *Beware of What You Price For: Credit Implications of UL Secondary Guarantees for U.S. Life Insurers*, Moody's Investors Service, Report No. 87150 at 1 (July 2004).
[6] *Id*. at 2.
[7] *Id*. at 10.

The worst-case scenario for a company is to experience prolonged depressed investment returns combined with high mortality and low lapse rates.[16] As seen below, the combination of low investment yields, low lapse rates and adverse mortality has a dramatic impact on profitability.

Scenario Descriptions

Scenario	Investment Yield	Lapse Rates	Mortality as % Expected
The Good	7%	6%	100%
The Bad	5%	4%	150%
The Very, Very Ugly	3%	2%	200%



60. Only one year later, Moody's noted that "**if interest rates continue moving on a slow upward trend**" then the life insurance industry would be favorably affected, as it "should provide insurers relief from their minimum interest rate guarantees." (emphasis original).[8] Furthermore, Moody's sounded an alarm regarding "no lapse" or secondary guarantee universal life policies, stating "We are concerned about how aggressive some companies are being with respect to their **assumption about higher interest rate levels** and about the **lack of robust analysis** by the companies **on the effects of periods of lower levels of interest rates**. If interest

[8] Special Comment, *2005 Credit Issues and Trends for U.S. Life & Health Insurance*, Moody's Investors Service, Report No. 93143, at 6 (Aug. 2005).

rates do not rise to the levels priced for under these product designs, the company could be subject to lower earnings or even losses." (emphasis added).[9]

61. Simply put, "Low interest rates are a big part of this new pressure on insurers; their earnings are being squeezed."[10] For example, "If, say, an 8 percent bond from the 1990s matures, the cash must be reinvested in something new. But now, a similar bond may pay only 2 percent. The insurance policy sold to a customer back in the 1990s guaranteed a 4 percent return. It adds up to a vexing math problem: how to back a promise of 4 percent in a 2-percent-or-less world."[11]

62. This is precisely the problem USFL faces with Plaintiff and Class members as their policies guarantee a 4 percent interest rate on their policy cash value. USFL lowered Plaintiff's policy interest rate to the 4 percent floor in 2008, the same year USFL promptly increased the COI on their policy for the first time.

63. Remarkably, USFL provided the exact same reason for increasing Plaintiff's and Class members' COI rate in both 2008 and in 2015: "mortality experience."

64. Either USFL's actuarial team greatly miscalculated the 2008 COI increase and USFL is now trying to recoup past losses from 2008 to present or, more likely, USFL is merely increasing the COI starting in 2015 in another attempt to raid the policies' cash values and force policyholders into lapse in order to minimize USFL's liabilities. Regardless, both scenarios are attempts to recoup prior losses and/or fail to have justification based on any future mortality expectations.

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[9] *Id*. at 8.
[10] Mary Williams Walsh, *Why Some Life Insurance Premiums Are Skyrocketing*, The New York Times (Aug. 13, 2016), https://www.nytimes.com/2016/08/14/business/why-some-life-insurance-premiums-are-skyrocketing.html?_r=1.
[11] *Id*.

65. Furthermore, as outlined in Section II(B), mortality rates are improving and could not be the reason for the COI increases in 2008 or 2015.

66. USFL is also desperately in need of cash due to their overcharging COI above the maximum rate for 3,000 policyholders with policies dating back to 1993.

67. USFL was caught in August 2013 by the North Carolina Department of Insurance in charging a COI exceeding the contractual minimum rate for 3,000 policyholders. Because of this fraudulent increase and breach of contract, many policyholders lapsed or surrendered their policies. USFL reported that this excess COI remediation resulted in a cost of $14 million related to the affected policyholders.

68. Unsurprisingly, 2015 also saw the announcement and beginning of the COI hike at issue in this Complaint.

69. Finally, all insurance companies that are increasing COI rates have at least one thing in common: the use of captive and affiliate reinsurance companies to hide liabilities.[12] USFL is no exception as detailed further below.

70. Moody's also predicted the problems of using captive reinsurance transactions in 2004, predicting that over the "next five to 10 years" problems would develop and could "pose significant negative credit consequences, particularly for business subject to XXX/AXXX reserves"[13] like USFL.[14] Since 2004, Moody's, along with other notable commentators, has

[12] Walsh, *supra* n. 3. ("But in recent years, even as low interest rates ate into the industry's profits, some companies engaged in complex financial maneuvers that enabled them to pay hefty shareholder dividends. Normally, life insurers cannot pay shareholder dividends unless their balance sheets are flush. These maneuvers involve shifting a company's future obligations to policyholders into special financial vehicles that do not appear on the insurer's balance sheets."); Sussman, *supra* n. 2. ("[T]hese rate increases are being instituted to boost the return on investment on these older blocks of business. Of the carriers that have already instituted COI increases, two in particular (that we know of) have participated in complex captive reinsurance transactions that freed up significant capital that was then up-streamed as dividends to their European corporate parents.").

[13] "AXXX" reserves are for universal life insurance policies while "XXX" reserves are for term life policies.

[14] Special Comment, *Hidden Credit Risks of Regulation XXX/Guideline AXXX Reinsurance Programs*, Moody's Investors Service, Report No. 80935 at 1 (2004).

continued to monitor and criticize the life insurance industry regarding the use of captive reinsurance.[15]

71. USFL's parent, AXA, and its captive reinsurance company, AXA Arizona, have both been under the eye of the federal government's Office of Financial Research.[16]

E. USFL Is Increasing COI Because It Is Under Reserved

72. The death benefits USFL will pay on the Nova and SuperNova UL policies represent a huge liability for the company, which has seen a steady increase in death benefit payments over the last several years as policyholders naturally age.

73. Because of the reinsurance scheme described below, USFL does not have sufficient reserves to pay the death benefits coming due in the near future.

74. Faced with the unprecedented death benefit obligations, and a significant reserve shortfall, USFL chose to increase the COI charges on the Nova and SuperNova UL policies, believing that the owners of these policies either (a) had the resources to pay exorbitant COI charges, or (b) would allow their policies to lapse, thus relieving USFL of its payment obligations.

75. Under the terms of the Nova and SuperNova UL policies with the Death Benefit Maturity Extension Endorsement, "Starting at attained age 100, the following changes will be made to this policy:" namely "No new premiums will be accepted" and "The Monthly Deduction [based upon the COI rate] will stop." *See* Ex. A at 16.

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[15] Special Comment, *The Captive Triangle: Where Life Insurers' Reserve and Capital Requirements Disappear*, Moody's Investor Services, Report No. 156495 (Aug. 23, 2013) (analyzing AXA's captive reinsurance in Appendix III); Sector Comment, *Affiliated Certified Reinsurers: A Growing Risk for Life Industry*, Moody's Investors Service, Report No. 1028905 (Jun. 30, 2016); Sector In-Depth, *Lifting the Veil on XXX/AXXX Captives: Better Disclosure Reveals Sizable Exposures*, Moody's Investor Services, Report No. 1052633 at 15 (Jan. 20, 2017) (recognizing in Appendix 4 AXA as number 13 in the Top 20 XXX/AXXX Captive Exposures of Moody's Rated Universe).

[16] *Mind the Gaps: What Do New Disclosure Tell Us About Life Insurers' Use of Off-Balance-Sheet Captives?*, Office of Financial Research, Brief Series 16-02 at 4, 9 (Mar. 17, 2016) (analyzing AXA at Figure 5 and AXA Arizona at Figure A-2).

76. If the owners of the Nova and SuperNova UL policies were to pay the increased COI charges until attaining age 100, they would end up paying more than the death benefits USFL is obligated to pay.

77. As discussed above, Mr. Yerger funded the Policy initially with a $297,087 payment and has subsequently made regular premium payments since 2009. The 2015 increased COI charges require the Trust to pay over $17,000 a month, or over $204,000 annually.

78. If Mr. Yerger lives to age 100, the Trust would end up paying total premiums and COI monthly deductions in excess of the $1,750,000 death benefit.

III. General Background Allegations Regarding Reinsurance Scheme

79. Life insurance policies are unique financial obligations: long-term commitments where the life insurer promises to be a faithful steward of policyholders' money and to give a sum-certain to policyholders' loved-ones after their death.

80. To induce people to enter into these decades-long agreements, life insurers tout their longevity, long-standing commitment to policyholders and their families, and their financial strength. For example, AXA's website markets prominently the organization's roots beginning as early as 1859, to encourage the public to purchase its policies. *See* https://us.axa.com/about-axa/ ("A history of dependability").

81. Because life insurance companies promise to pay death benefits far into the future, a company's financial condition is particularly important to potential purchasers. Life insurers understand this and market themselves as financially strong and prudent. For example, USFL's website, in part, brags about both AXA's and USFL's financial strength and reads: "In addition, Fitch Ratings has affirmed an Insurer Financial Strength rating of "AA" for the major insurance entities of AXA Group, which includes U.S. Financial Life Insurance. The long-term and short-

term ratings of AXA Group are also affirmed at 'A+' and 'F1' respectively. The Outlooks on the ratings remain Stable." *See* http://www.usfli.com/c_about.html.

82. The National Association of Insurance Commissioners (the "NAIC") also specifically acknowledges that a company's financial condition is an essential tool used to protect policyholders. NAIC Statement of Statutory Accounting Principles (the "SSAP"), Preamble, ¶ 27 ("The ability to effectively determine financial condition using financial statements is of paramount importance to the protection of policy holders.").

83. So, too, is a life insurer's accounting information acknowledged as a factor consumers use to determine which entity they will trust with their money. *Id*. at Preamble at ¶ 6 ("Customers . . . may use accounting information to make choices as to the entity with which they engage in a business transaction.").

84. The SSAP governs the way in which financial information is accumulated and reported to users. *Id.*, Preamble, ¶ 6.

A. SSAP Is Designed to Protect Policyholders and Requires Accurate Financial Condition Disclosure

85. NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from each of the 50 states, the District of Columbia, and five U.S. territories. One of NAIC's goals is to "[p]rotect the public interest" and to "[p]romote the reliability, solvency and financial solidity of insurance institutions." "Our Mission," About the NAIC, *available at* http://www.naic.org/index_about.htm.

86. The SSAP are found in the NAIC Accounting Practices and Procedures Manual ("AP&P Manual"). The SSAP's objectives are specifically spelled out:

> The conceptual framework used in developing and maintaining statutory accounting principles for insurance companies is summarized in the Statutory Accounting Principles Statement of Concepts. The application of ***conservatism,***

> ***consistency and recognition*** assure that guidance developed and codified as part of this project is consistent with the underlying objectives of statutory accounting.

(emphasis added).

87. The SSAP Preamble: Conclusion, further states:

> Application of [SSAP], either contained in the [Statements on Standards for Accounting and Review Services] SSARs or defined as GAAP and adopted by NAIC, to unique circumstances or individual transactions should be consistent with the concepts of ***conservatism, consistency, and recognition***.

(emphasis added).

88. The SSAP differs from other financial accounting methods because the focus is on solvency for the protection of policyholders.

89. To protect policyholders, the applicable statutory accounting principles promote conservativism: "Conservative valuation procedures provide protection to policyholders against adverse fluctuations in financial condition or operating results. Statutory accounting should be reasonably conservative over the span of economic cycles and in recognition of the primary responsibility to regulate for financial solvency." AP&P Manual, ¶ 30. This emphasis—determining an insurer's ability to satisfy obligations years in the future—is much different than other financial accounting methods, such as Generally Accepted Accounting Principles ("GAAP").

90. The NAIC requires all fifty states to adopt the AP&P Manual and Annual Statement Instructions, and all fifty states have in fact adopted them.

91. Codified by every state, the SSAP "provide examiners and analysts with uniform accounting rules against which companies' financial statements can be evaluated," thereby providing "more complete disclosures and more comparable financial statements," in which surplus and RBC "will be reported more consistently . . . ." SSAP Preamble, ¶ 14.

92. To that end, Ohio, USFL's state of domicile, and all other states, require all Annual Statements conform to the annual statement instructions and manuals promulgated by NAIC.

93. Therefore, every year USFL is required to prepare and file a sworn Annual Statement, based on the convention blank form adopted by NAIC, that accurately reports its financial condition with the Ohio Department of Insurance.

94. An Annual Statement is a detailed statement of an insurance company's finances. It must be prepared according to SSAP, to the extent they are not in conflict with applicable state statutes or regulations. Quarterly Statements, which contain less detail than the Annual Statement, are also prepared using the same accounting methodology.

95. States can, by law, regulation, or rule, specifically require accounting practices (which may differ from NAIC SSAP) or they can permit accounting practices that differ from SSAP, however, both the deviation and its financial effect must be specifically disclosed in an insurance company's Annual Statement. SSAP No. 1. While "[s]tatutory requirements vary from state to state ... to the extent that they exist it is the objective of NAIC statutory accounting principles to provide the standard against which the expectations will be measured and disclosed if material." Statement of Concepts, ¶ 26.

96. Therefore, if an insurer's use of a state accounting practice departs from SSAP, and the deviation affects its surplus or Risk Based Capital ratio ("RBC ratio"), the insurer must disclose both the accounting practice and explain the financial impact to the insurance company in Note 1 of its Annual Statement:

> [I]f a reporting entity employs accounting practices that depart from the NAIC accounting practices and procedures, disclosure of the following information about those accounting practices that affect statutory surplus or risk-based capital shall be made at the date each financial statement is presented:
>
> (a) A description of the accounting practice;

> (b) A statement that the accounting practice differs from NAIC statutory accounting practices and procedures;
>
> (c) The monetary effect on net income and statutory surplus of using an accounting practice which differs from NAIC statutory accounting practices and procedures;
>
> (d) If the insurance enterprise's risk-based capital would have triggered a regulatory event had it not used a prescribed or permitted practice, that fact should be disclosed in the financial statements.

SSAP No. 1.

97. Essential to SSAP principles, and inherent in all of its requirements, is the concept of ***adequate disclosure***:

> Statutory reporting applies to all insurers authorized to do business in the United States and its territories, and ***requires sufficient information to meet the statutory objectives.*** However, statutory reporting as contained in this guide is not intended to preempt state legislative and regulatory authority. The SSAP financial statements include the balance sheet and related summary of operations, changes in capital and surplus, and cash flow statements. Because these basic financial statements cannot be expected to provide all the information necessary to evaluate an entity's short-term and long-term stability, ***management must supplement the financial statements with sufficient disclosures*** (e.g., notes to the financial statements, management's discussion and analysis, and supplementary schedules and exhibits) to assist financial statement users in evaluating the information provided.

SSAP Preamble: Objectives of Statutory Financial Reporting (emphasis added).

98. Consistent with these objectives, life insurance companies must fully and accurately disclose the nature of their financial transactions. If they do not, regulators, rating agencies, and policyholders will not have sufficient information with which to accurately evaluate the insurance companies' ability to satisfy policy obligations.

99. Accurate Annual Statement reporting is critically important because it is one of the few publicly available financial disclosure documents. Consumers, agents, ratings agencies, and others rely on the Annual Statements to assess companies' financial strength and ability to pay

future claims as they come due. In short, Annual Statements are essential for the ultimate customer—the policyholder—to evaluate whether to put his or her trust in the insurance company.

100. An insurance company's Annual Statement, statutory surplus, and RBC ratios are also the key variables A.M. Best, a rating agency that focuses on the insurance industry, uses to evaluate life insurers' financial strength.

101. For example, A.M. Best issues financial strength ratings that provide opinions about an insurer's financial strength and ability to meet its ongoing obligations to policyholders. Among other things, the financial strength rating is based on an insurance company's reported surplus and RBC ratio because this data is "the foundation for policyholder security." A.M. Best Methodology, Criteria – Insurance, May 2, 2012, at page 1.

102. According to A.M. Best, financial strength ratings are important "to assess the creditworthiness of an insurer's operations, to evaluate prospective reinsurance accounts, to compare company performance and financial condition." Moreover, a "rating can influence an agent's selection of plans to market." *Id*. Likewise, "[a] rating also is an important factor in the consumer's decision-making process to purchase insurance," and it "can provide consumers with the information necessary for an educated buying decision." *Id*.

B. Surplus and RBC Are The Two Main Ways Insurance Companies Are Measured for The Ability to Meet Long-Term Obligations

103. The two primary metrics used to measure whether an insurance company is adequately capitalized to meet future obligations are surplus and RBC. Both metrics reflect life insurance's conservative nature.

i. *Surplus as a measure of solvency.*

104. An insurance company's solvency is critical to policyholders. It "ensure[s] that the policyholder, contract holder and other legal obligations are met when they come due and ***that the***

companies maintain capital and surplus at all times and in such forms as required by statute to provide an adequate margin of safety." SSAP Preamble, ¶ 27 (emphasis added).

105. The consumer can only assess an insurance company's ability "to provide an adequate margin of safety" if the life insurance company accurately discloses its financial condition because "the cornerstone of solvency measurement is financial reporting." *Id*.

106. Surplus is the company's ***admitted assets*** minus its liabilities, including its current and projected future policyholders' obligations.

107. ***Admitted assets*** are an insurer's assets that are available to satisfy the obligations owed to policyholders. Assets that cannot be readily liquidated due to encumbrances or other third party interests cannot be reported as ***admitted assets***. SSAP No. 4.

108. A contingent letter of credit is an example of an asset that cannot be an admitted asset.

109. The following example of a simplified balance sheet demonstrates how surplus is calculated:

Admitted Assets			**Liabilities**	
Bonds	$13 Billion		All Reserves	$14 Billion
Stock	$ 1 Billion		Expenses Due	$2 Billion
Cash	$ 1 Billion		Debt	$0
All Other	$2 Billion			
Total Admitted Assets	**$17 Billion**		**Total Liabilities**	**$16 Billion**

	Surplus = $1 Billion	

110. If a life insurance company's statutory surplus falls below the minimum legal levels, or if the company operates at an annual loss, it is not permitted to pay dividends to shareholders and may not be able to continue operations.

111. Management of every U.S.-based life insurer swears, under penalty of perjury, that the financial condition of their company, as reported in the Annual Statements, is completely true. That means that assets must be valued truthfully, and liabilities calculated in accordance with the law, specifically SSAP.

112. State laws and SSAP requirements create a framework by which an insurer's financial condition is externally reported to, among others, consumers.

113. For a life insurer, liabilities are almost entirely promises made to policyholders—such as death benefits—and those promises are most often very long-term commitments. The nature of insurance business requires insurance company management engage actuaries to calculate the total commitments associated with a company's annuities and life policies for the Annual Statement. To account for future events that would trigger claims the company is bound to pay under the policies, actuaries must calculate the present value of all of those future promises.

114. The projected amount due under life insurance policies is a very static figure because the calculation is relatively stable and predictable due to long-term trends, involving far fewer unknowns than property and casualty risks, which would include such events as hurricanes and fires.

115. The actuary performs mathematical calculations to determine the present value of

future liability, which is the liability figure used on a life insurer's balance sheet. If the value of the admitted assets exceeds that liability figure, the company enjoys surplus. If, however, admitted assets are insufficient to cover the liability figure, the company suffers from a deficit and the state regulator must take action to protect policyholders by, for example, putting the company in receivership.

116. Accurate reporting of assets and liabilities is necessary to measure a life insurer's solvency—as measured through surplus—and rating agencies, regulators, and consumers rely on companies to fulfill their obligation to report their true financial condition.

ii. *RBC as a measure of ability to meet future obligations*.

117. RBC is another measure of insurance company solvency and is one of the most important factors examined in determining an insurance company's ability to meet future obligations.

118. RBC is a ratio used to limit the risk a company can acquire. RBC requires a company that has greater risk to hold more capital, thereby giving the company a cushion against insolvency. Stated another way, RBC is a ratio that ensures a company can meet its future obligations.

119. To assure policyholders that the benefits they purchased are available when needed, NAIC began regulating insurer capital through the Risk-Based Capital Model Act ("the RBC Model Act.").

120. The RBC Model Act provides a method of measuring the minimum capital necessary for an insurer to support its overall business operations when considering its size and risk profile.

121. Under the RBC Model Act, insurance companies calculate and self-report their total

adjusted capital (in general, the amount by which a company's assets exceed liabilities) and an RBC figure which reflects the riskiness of the company's activities. Although the insurance company reports the results of those calculations on its Annual Statement, the calculations themselves are not part of the Annual Statement.

122. RBC is intended to be a ***minimum*** capital standard, and is not necessarily a measure of the total capital an insurer would want to meet its safety and competitive objectives. Additionally, RBC is not designed as a stand-alone tool to determine financial solvency of an insurance company; rather it is one of the tools used to assess the ability of insurance companies to meet its risk obligations both now and in the future.

123. Before RBC was created, fixed capital standards were a primary tool used to monitor insurance companies' financial solvency. Under fixed capital standards, insurers were required to supply the same minimum amount of capital, regardless of the financial condition of the company. Capital requirements varied by state, ranged from $500,000 to $6 Million, and were dependent upon the state and the lines of business the insurance carrier wrote. Companies were required to meet minimum capital and surplus requirements to be licensed and to write business in the state. As insurance companies changed and grew, it became clear that the fixed capital standards were no longer effective in providing a sufficient cushion for many insurers.

124. Following a string of large company insolvencies in the late 1980s and 1990s, the NAIC implemented its RBC regime, intending it to be an early warning system that alerted regulators to potential insolvencies.

125. The RBC regime's intent was to provide a capital adequacy standard directly related to risk that (a) provided a safety net for insurers, (b) was uniform among the states, and (c) provided regulatory authority for timely action.

126. The NAIC RBC regime has two main components: (1) the risk-based capital formula, that established a hypothetical *minimum* capital level that is compared to a company's actual capital level, and (2) a risk-based capital model law that gives state insurance regulators authority to take specific actions based on the level of impairment if an insurer's RBC drops below the minimum threshold.

127. Under the RBC system, regulators have statutory authority to take preventive and corrective measures, which vary depending on the capital deficiency indicated by the RBC result. These preventive and corrective measures are intended to enable regulatory intervention that will correct problems before insolvencies become inevitable, thereby minimizing the number and adverse impact of insolvencies.

128. On their Annual Statements, insurance companies must report two RBC-related numbers: (1) Total Adjusted Capital, and (2) their Authorized Control Level Capital.

129. Frequently, the comparison between a company's Total Adjusted Capital and the Authorized Control Level Capital is expressed as a ratio—the RBC Ratio. The ratio is:

$$\frac{Total\ Adjusted\ Capital}{Capital\ Reserved\ In\ Accordance\ Pursuant\ to\ RBC\ Model\ Act}$$

130. When the NAIC RBC system is tripped, one of two things happen: (1) a company must take action to increase its capital as compared to its risk (meaning increase its surplus), or (2) regulators can exercise their statutory authority and intervene in the business affairs of the insurer. If a company's financial reporting is accurate, reported RBC alerts regulators to undercapitalized companies, giving them sufficient time to act and minimize overall costs associated with insolvency.

131. The RBC ratio is also used by consumers to evaluate the likelihood an insurer will become insolvent given its capital, surplus, and liabilities because it is a significant factor rating

agencies use to measure a company's financial strength.

132. If RBC is misstated, a company not only improperly avoids regulatory intervention, but it also misleads ratings agencies and consumers about its financial stability and the sufficiency of its capitalization.

C. Transactions with Affiliates Can Manipulate Surplus and RBC.

133. "An 'affiliate' . . . is a [company] that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the [company] specified." Insurance Holding Company System Regulatory Act §1A.

134. Historically, companies have used affiliated entities to hide their distressed financial condition, á la Enron. Accounting machinations and off-balance sheet liability transfers are easily executed when the company that assumes liabilities is wholly owned or affiliated with the ceding company, and has every incentive to act for a common benefit, rather than its own benefit.

135. Surplus and RBC are good predictors of an insurer's solvency only if all the company's transactions regarding the transfer of liabilities, assets, and risk are legitimate and arm's-length. When, however, such transactions are not arm's-length, surplus and RBC can be easily manipulated.

136. Obviously, some affiliated transactions achieve meaningful purposes, for example, consolidating certain lines of business into an affiliate that specializes in that line. Affiliated transactions, however, can also be used for nefarious purposes, such as shuffling liabilities between entities, artificially "transferring" risk, inflating valueless assets, or merely generating phantom assets.

137. Insurance companies legitimately use reinsurance, coinsurance, and modified

coinsurance transactions to spread risk to third-party companies that are solvent and capable of meeting policyholder obligations. This allows insurance companies to obtain surplus relief, as well as improve their risk-based capital ratios.

138. When an insurer "cedes" risks of a block of life insurance policies or annuities through a bona fide reinsurance transaction, the assuming company is obliged by the governing reinsurance contract—a "treaty"—to set up reserve liabilities for that block. Once ceded, the ceding company can drop those liabilities from its own financial statements because the assuming company becomes responsible for paying those liabilities.

139. By way of example, assume that Company A originally sold 100 insurance policies to customers (policyholders), each with a death benefit of $100,000. Although extremely unlikely, the worst-case scenario for the insurer is that all 100 policyholders suddenly die the very next day. Doing the math, a $100,000 death benefit multiplied by 100 policies equals a $10 Million liability. However, it is virtually impossible that all 100 policyholders will die after just one day. Applying mathematical tables, formulas, and the "Law of Large Numbers," actuaries can predict with remarkable accuracy when an insured, within a given band, will die. Accordingly, Company A is not required to hold reserves equal to a policy's ultimate death benefit. However, between the policy's issue date and the policyholder's death, the insurance company is expected to collect premiums and earn interest on those funds which will, over time, equal more than the $100,000 benefit. For this reason, the initial reserve liability for a very young, healthy, non-smoker will be much lower than it would be for an elderly smoker. This assessment, keyed to the present value of the obligation, is done through annual cash flow testing and reserve calculations.

140. In insurance parlance, the total needed to fulfill all contractual obligations (in this example $10 Million) is referred to as the "Gross In-Force"—the sum of all ultimate death benefit

payments. Because it is extremely likely that the deaths will be staggered across many ensuing years, the insurance company only needs to hold in reserve the present value of that ultimate $10 Million. For this example, assume that the actuarially required immediate reserve liability is $1 Million for the entire block.

141. When Company A cedes this block of policies to Company B in a reinsurance transaction, Company A drops the present value amount of $1 Million from its liabilities and Company B sets up the $1 Million liability on its books. Company B is essentially standing in Company A's shoes, and must pay Company A $100,000 for each death claim as it is made. The terminology used to describe Company A's reduction of the $1 Million liability is a "reserve credit." In other words, because Company B is now "on the hook" to pay the claims as they come due, Company A is allowed to reduce its reserve liability (called a "reserve credit") by $1 Million. In this way, Company A reduces its liabilities by $1 Million and Company B adds $1 Million to its liabilities.

142. Because this is a business transaction between two independent companies, Company B will not acquire the reserve liabilities without sufficient payment; therefore, Company A must also send sufficient assets to cover the reserve liabilities. In an arm's-length transaction, those assets are cash or cash-equivalents that have sufficient face value to cover the assuming company's obligations.

143. RBC assumes that all reinsurance agreements are reached at arm's-length with reinsurers financially capable of performing the ceded reinsurance obligations; therefore, the RBC formulas do not account for reinsurance *quality*. As a result, reinsurance with a highly solvent third-party reinsurer and reinsurance with an undercapitalized wholly owned captive shell company are treated the same.

144. Coinsurance or modified coinsurance similarly spreads risk. However, the assets and liabilities for the block of business that is coinsured stay on the balance sheet of the ceding company for surplus calculation purposes, but are considered transferred to the assuming company for RBC purposes. In other words, the ceding company's RBC is calculated as if the company had transferred that block of business off its books.

145. Historically, insurance companies reinsure or coinsure their risks with highly capitalized and independent—non-affiliated—companies. Legitimate reinsurers are used for their strong financial support and their valuable expertise and advice. A knowledgeable, well-capitalized, and honest reinsurer helps a company spread its risks and shares knowledge of good underwriting practices and economic expectations. The independent reinsurer has its own set of experienced executives, actuaries, and other experts that help the ceding company achieve shared goals. With well-capitalized and independent reinsurers, the valid purpose for reinsuring or coinsuring risks is achieved.

146. In arm's-length transactions between unaffiliated entities, both companies are independently incentivized to ensure that liabilities transferred mirror liabilities assumed, and that the transferred assets are real and sufficient to cover the assumed liabilities.

147. In fact, for the ceding company to enjoy a reserve credit, the reinsurance agreements must transfer risk from the ceding entity to the reinsurer. SSAP 61R, ¶ 17.

148. When insurance companies engage in reinsurance, coinsurance, and modified coinsurance transactions with affiliated entities, the companies can manipulate their balance sheets or risk profiles. Such transactions can foist large liabilities or risky assets onto an affiliated entity that is not subject to the strict capital and surplus requirements imposed on life insurance companies for the policyholders' benefit.

149. Such transactions between affiliates, especially shell entities, often have no valid economic purpose. Indeed, pretending to transfer risk to an affiliate or captive is similar to a husband handing off a debt he owes a bank to his wife, purportedly to improve the family's financial condition. It simply does nothing.

150. These types of sham liability transfers have recently become prevalent in the life insurance industry: insurance companies create, and enter into transactions with, wholly owned captive subsidiaries whose finances are secret and free from regulatory scrutiny. These entities provide a vehicle for financial alchemy that serves to mask a ceding company's dire financial condition, or even insolvency. *See, e.g.,* Jill Cetina, et al., Mind the Gaps: What Do New Disclosures Tell Us About Life Insurers' Use of Off-Balance-Sheet Captives, Office of Financial Research, March 17, 2016, *available at* https://www.financialresearch.gov/briefs/files/OFRbr_2016-02_Captive-Insurers.pdf.

D. The Danger of Financial Alchemy Through Transactions with Affiliates Worsens Through the Use of Wholly Owned Captives

151. A legitimate captive insurance company is a very specific kind of risk financing wherein a non-insurance company, such as Exxon, creates an insurance subsidiary for which it is the sole policyholder. The captive insurer is a regulated entity designed to provide a form of self-insurance. Through a captive reinsurer, a company creates a self-insurance vehicle and tax deductions because it can write off the premiums. Companies typically form captives when they are either so large that they have more resources than the insurers who would be covering their risk, or when it is simply less expensive to start and run one's own insurance company than it is to pay the market value for certain kinds of insurance.

152. A captive insurer is "an insurance or reinsurance entity created and owned, directly or indirectly, by one or more industrial, commercial or financial entities, other than an insurance

or reinsurance group entity, the purpose of which is to provide insurance or reinsurance cover for risks of the entity or entities to which it belongs, or for entities connected to those entities and only a small part if any of its risk exposure is related to providing insurance or reinsurance to other parties." International Association of Insurance Supervisors, Issues Paper on the Regulation and Supervision of Captive Insurance Companies, October 2006, *available at* https://www.iaisweb.org/file/34279/issues-paper-on-regulation-and-supervision-of-captive-insurance-companies-october-2006.

153. Nevertheless, insurance companies have begun to create "captive" reinsurance subsidiaries primarily to hide liabilities, thereby falsely inflating RBC.

154. Arguably, the impetus for captive reinsurance subsidiaries was the NAIC's Regulation XXX reserving methodology. The XXX reserving methodology is the product of the NAIC's March 1999 adoption of the revised Valuation of Life Insurance Policies Model Regulation.

155. Becoming effective in January 2000, Regulation XXX significantly increased the U.S. statutory reserve requirements for term life insurance writers.

156. Regulation XXX was a response to life insurer's attempt to drive down reserves by creating products that had excessively late-duration guaranteed premiums. Regulation XXX was intended to foreclose this practice, which was generally regarded as a loophole exploitation. Regulation XXX addressed this practice by necessitating that each level of a premium be calculated separately in order to ensure sufficient reserve requirements.

157. The insurance industry pushed back against increased reserves requirements imposed by Regulation XXX. Insurance companies alleged that the reserve requirements were overly stringent and, in response, began pursuing workarounds.

158. Ultimately, companies began to evade the increased reserve requirements by using captive reinsurers. More specifically, many companies began ceding their policy liabilities to offshore or out-of-state reinsurers where local statutory reserving requirements were less onerous, such as allowing the use of U.S. GAAP rather than SSAP.

159. Universal life ("UL") policies with secondary guarantees are subject to Regulation AXXX (also known as Actuarial Guideline 38). Reserves under AXXX demonstrate a similar "hump-backed" pattern as XXX with longer tails since universal life typically has a longer average policy life than term life products. The reinsurance market for the AXXX reserve is very limited and most insurers retain the risk.

160. To address the looming capital needs associated with XXX and AXXX reserves, many for-profit life insurance companies turned to so called "alternate capital-funding solutions," among which securitization is considered the more elegant solution.

161. Securitization is the process of repackaging certain assets or cash flows for sale in the capital markets as debt securities that pay periodic coupons as well as the eventual repayment of principal. Investors buying these securities will assume the risks inherent in the underlying cash flow.

162. A common and well-known type of securitization in the asset world is a mortgage-backed security ("MBS"), where the cash flows from a pool of mortgages are sold as debt. Insurance securitizations follow a very similar process, except that the cash flows are derived from liabilities instead of assets, and the risks are related to insurance risks such as mortality and lapse rates instead of prepayment.

163. A simple hypothetical illuminates how these securitizations function in practice: suppose a block of term insurance reserves under XXX is being securitized. Similar concepts

would apply to UL reserves under AXXX as well. The original company is either a direct writer or a reinsurer looking to finance its mounting XXX reserve. The company typically would set up a captive reinsurer and cede off its block of term policies under a coinsurance treaty. Many companies choose to set up captives either offshore or in states that offer favorable regulatory accounting treatment, such as allowing the use of GAAP reserves for the captive's regulatory reporting. A holding company may be set up as the parent to the captive reinsurer. Many prefer this type of holding company structure, since the original company does not directly own the captive reinsurer, and it is less likely that the original company will need to reflect the captive reinsurer on its statutory financial statement.

164. Special Purpose Vehicles ("SPVs") are often used in securitization. An SPV is set up to serve a specific purpose, such as raising capital and servicing investors in a securitization. It performs little or no other activities. The investors have claims to assets only in the SPV and have no recourse to the original company. Similarly, the creditors of the original company have no claims to any assets in the SPV. The equity holder of the SPV is often the original company, an affiliate or an investment bank, and controls the SPV's activities, including the issuing of debt or equity securities, as well as selling notes to the investors. The SPV pays the financial guarantor a premium to compensate for the risks the guarantor assumes.

165. For years, insurance companies like USFL's parent company, AXA, created these captive entities in offshore countries, such as Bermuda. Because the offshore captives are not subject to U.S. regulation, they provide a means to hide balance sheet and RBC problems from United States regulators.

166. In the last decade, several states, including Arizona, encouraged the formation of the "special purpose financial captives" ("SPFCs")—a specific type of SVP—in their states,

hoping to spur a cottage industry that would generate fee revenues and create jobs. Such state programs feature confidentiality protections that, despite the required transparency of the ceding company's financial condition, shield the SPFCs' financial condition from the view of consumers (and even from other state regulators that would be unwilling to offer SPFCs the same degree of secrecy).

167. Arizona, for example, clothes domestic SPFCs in secrecy, only permitting its Commissioner of the Department of Insurance to disclose captive formation and financial information to non-governmental entities under discreet circumstances, for example, in response to a subpoena, but only if certain specific requirements are met. *See* AZ. STAT. ANN. § 20-1098.23(3).

168. The same strict confidentiality restrictions apply to examinations and investigations by the commissioner into a captive insurance company's financial condition:

> Section 20-1098.23 [confidentiality provisions] applies to all examination reports, preliminary examination reports or results, working papers, recorded information, documents and copies of any of those reports, results, papers, information or documents produced by, obtained by or disclosed to the director in the course of an examination made under this section.

Id. at § 20-1098.08(B).

169. In short, Arizona and certain other states now allow insurance companies to create U.S. subsidiaries whose balance sheets are secret. This is precisely why USFL's parent company, AXA, transferred AXA Arizona (formerly known as, AXA Financial (Bermuda), Ltd.) from Bermuda to Arizona.

170. Simply stated, AXA and USFL can shuttle financial statement problems onto captive SPFCs, like AXA Arizona, and away from regulation and public scrutiny.

171. For this reason, many people consider captive SPFCs the "black hole" of insurance

company financial analysis.

172. As captives have become more prevalent, the NAIC has begun to examine and advise the insurance industry on their potential abuse. In fact, the NAIC has expressly stated that these entities should not be used to manipulate company finances: "Commercial insurer-owned captives and [SPFCs] ***should not be used to avoid statutory accounting***." NAIC, The Captive and Special Purpose Vehicles: An NAIC White Paper (hereinafter "NAIC White Paper"), at 3 (emphasis added); *see also id.* at 20 ("the general opinion of the Subgroup was that it is inappropriate for captives and [SPFCs] to be used as a means to avoid statutory accounting."); *id.* at 23 (recognizing "a consensus view that captives and special purpose vehicles should not be used by commercial insurers to avoid statutory accounting prescribed by states."); *id.* at 30 ("The practice of using a different entity or different structure outside of the commercial insurer to engage in a particular activity because of a perception that the regulatory framework does not accurately account for such activity should be discouraged. The Subgroup held a consensus view that captives and [SPFCs] should not be used by commercial insurers to avoid statutory accounting prescribed by the states.").

173. The NAIC White Paper also stated that conditional letters of credit ("LOC"), which cannot be admitted assets pursuant to SSAP, were not appropriate means for capitalizing captive SPFCs:

> The transactions involving conditional LOCs or parental guarantees effectively permit assets to support reinsurance recoverables, either as collateral or as capital, in forms that are otherwise inconsistent with requirements under Model #785 and Model #786 or other financial solvency requirements applicable to U.S.-domiciled commercial assuming insurers. The Subgroup held a consensus view that these types of transactions may not be consistent with the NAIC credit for reinsurance requirements.

NAIC White Paper, at 23.

174. The draft White Paper was more blunt:

> The transactions involving conditional LOCs or parental guarantees effectively permit assets to support reinsurance recoverables, either as collateral or as capital, in forms that are otherwise inconsistent with requirements under the credit for reinsurance models or other financial solvency requirements applicable to U.S.-domiciled commercial assuming insurers. The subgroup held a consensus view that these types of transactions were not consistent with the NAIC credit for reinsurance requirements. ***It is not financially sound to provide credit for reinsurance when the assuming insurer's solvency depends on a parental guaranty, while the parent's surplus that supports that guaranty includes credit for the very reinsurance whose performance depends on the guaranty. Similar bootstrapping problems arise if reinsurance is directly secured by an LOC, or is indirectly secured when an LOC is used to capitalize the assuming insurer, and the ceding insurer itself, or one of its affiliates, is the LOC applicant, which becomes liable to reimburse the bank if the LOC is drawn.***

Draft White Paper (setting out Maine comments), at 18 (emphasis added).

175. In short, an otherwise regulated commercial insurer, like USFL, cannot do through an SPFC what it is prohibited from doing by SSAP. Liabilities originating with, and retained by, the ceding insurer cannot be granted favorable treatment merely by reporting that those liabilities are on the books of an affiliated captive. *See, e.g.*, NAIC White Paper, at 28 ("allowing a captive or [SPFC] to account for LOCs or parental guarantees as assets [is] something not permitted in the current statutory accounting framework."). Likewise, risky assets that would normally affect a company's RBC ratio cannot simply be transferred to a wholly owned captive entity to make the insurance company look financially stable when it is not.

176. As alleged with particularity below, and precisely as feared by the NAIC, USFL has used SPFCs and other affiliated entities to facilitate a fraudulent scheme to avoid statutory accounting rules and principles to make USFL appear financially stable and inflate statutory surplus, and magically improve its RBC ratios. As shown below, USFL used the "black box" confidentiality afforded by Arizona to evade SSAP principles, to misstate its true surplus, and

mask its troubled financial condition to regulators, rating agencies, and ultimately, its life insurance customers.

E. Rules Prohibiting Financial Alchemy Through Affiliated Transactions

177. Because the risk that insurance companies will alter their balance sheet through affiliate transactions is so grave, the NAIC drafted the Model Holding Company Act, adopted in all 50 states, to govern such transactions. The Act's primary objective is to ensure that insurance companies' transactions with affiliates are "fair and reasonable," and done at "arm's-length."

178. Those requirements, mainly contained in SSAP 25, prohibit companies from recording non-arm's-length or non-economic transactions with affiliates in such a way that they seem to "create" assets, falsely inflate assets, or mask liabilities.

179. SSAP No. 25 governs accounting for transactions with affiliates and other related parties. SSAP No. 25 in pertinent part provides:

> [1] Related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the reporting entity or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny. This statement establishes statutory accounting principles and disclosure requirements for related party transactions.
>
> ***
>
> [9] Loans or advances by a reporting entity to all other related parties shall be evaluated by management and nonadmitted if they do not constitute arm's length transactions as defined in paragraph 12.
>
> ***
>
> [12] An arm's-length transaction is defined as a transaction in which willing parties, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell, or loan, would be willing to participate. A transaction between related parties involving the exchange of assets or liabilities shall be designated as either an economic transaction or non-economic transaction. An economic transaction is defined as an arm's-length transaction which results in the transfer of the risks and

rewards of ownership and represents a consummated act thereof, i.e., "permanence." The appearance of permanence is also an important criterion in assessing the economic substance of a transaction. In order for a transaction to have economic substance and thus warrant revenue (loss) recognition, it must appear unlikely to be reversed. If subsequent events or transactions reverse the effect of an earlier transaction prior to the issuance of the financial statements, the reversal shall be considered in determining whether economic substance existed in the case of the original transaction.

***

An economic transaction must represent a bona fide business purpose demonstrable in measurable terms. ***A transaction which results in the mere inflation of surplus without any other demonstrable and measurable betterment is not an economic transaction. The statutory accounting shall follow the substance, not the form of the transaction.***

***

[13] In determining whether there has been a transfer of the risks and rewards of ownership in the transfer of assets or liabilities between related parties, the following – and any other relevant facts and circumstances related to the transaction – shall be considered:

[a] Whether the seller has a continuing involvement in the transaction or in the financial interest transferred, such as through the exercise of managerial authority to a degree usually associated with ownership;

***

[15] A non-economic transaction is defined as any transaction that does not meet the criteria of an economic transaction. Similar to the situation described in paragraph 13, ***transfers of assets from a parent reporting entity to a subsidiary, controlled or affiliated entity shall be treated as a non-economic transactions at the parent reporting level because the parent has continuing indirect involvement in the assets***.

***

[16] When accounting for a specific transaction, reporting entities shall use the following valuation method:

[a] Economic transactions between related parties shall be recorded at fair value at the date of the transaction. To the extent that the related parties are affiliates under

common control, the controlling reporting entity shall defer the effects of such transactions that result in gains or increases in surplus (*see* paragraph 13);

[b] Non-economic transactions between reporting entities, which meet the definitions of related parties above, shall be recorded at the lower of existing book values or fair values at the date of the transaction;

[c] Non-economic transactions between a reporting entity and an entity that has no significant ongoing operations other than to hold assets that are primarily for the direct or indirect benefit or use of the reporting entity or its affiliates, shall be recorded at the fair value at the date of the transaction; however, to the extent that the transaction results in a gain, that gain shall be deferred until such time as permanence can be verified;

[d] ***Transactions which are designed to avoid statutory accounting practices shall be reported as if the reporting entity continued to own the assets or to be obligated for a liability directly instead of through a subsidiary***.

SSAP 25, ¶¶ 1, 9, 12, 13, 15 & 16 (emphasis added).

180. The Model Act also addresses transactions with affiliates and prohibits self-interested transactions with affiliates:

(A) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(1) The terms shall be fair and reasonable.

(2) Charges or fees for services performed shall be reasonable.

(3) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices that are consistently applied.

(4) The books, accounts, and records of each party shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

(5) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

OHIO REV. CODE ANN. § 3901.34.

F. Captives And Offshore Affiliates Help Companies Break The Rules

181. While SSAP 25 clearly prohibits the use of affiliated transactions to manipulate a company's financial picture and give the appearance of stability and strength, it still relies on insurance companies to accurately disclose and report their financials.

182. Companies that are motivated to cheat have found a perfect vehicle for financial alchemy in domestic and offshore captive subsidiaries and affiliates. Because the captives' finances are largely secret and not subject to the same regulations, parent insurance companies can, and do, hide liabilities through affiliated transactions.

183. Life insurance companies are now using captive SPFCs to misuse reinsurance and coinsurance as methods of masking their troubled financial condition.

184. They do this by causing their affiliates to enter into what appears to be reinsurance or coinsurance transactions, but that are in reality simply means of shuffling the insurance company's worst liabilities and assets off its books. In reality, however, liabilities are not transferred because they never left the holding company system or the insurance company where it started.

F. Affiliated Transactions Help Hide Liabilities.

185. A company that wishes to disguise its troubled financial condition can hide some of its liabilities through affiliated transactions, allowing it to report positive surplus and RBC ratios.

186. By creating captive reinsurers and offshore affiliated entities, life insurers can enter into non-economic, non-arm's-length transactions in which the ceding company can "cede" more liabilities than the assuming company reports it "assumes," or the ceding company can "send"

significantly liabilities, while sending insufficient assets to cover these liabilities.

187. Because surplus is a component of the insurance company's RBC ratio (it is part of the denominator in the RBC ratio calculation), artificially inflating surplus also artificially inflates RBC.

188. In a normal arm's-length reinsurance transaction, an independent reinsurance company would not assume liabilities without also receiving real assets to cover those liabilities. Because life insurance involves such predicable risk factors, as compared to other forms of insurance, the actuary working for the ceding company will independently arrive at a number that should reasonably track the number arrived at by the assuming company's actuary.

189. If the ceding actuary arrives at $2 Billion, for example, the assuming actuary should be in the same ballpark, substantially "mirroring" his counterpart. Because different and independent executives and actuaries are involved in arm's-length reinsurance transactions, there is no great concern if the liability to asset ratio is minimally different because it simply reflects the subtle differences in each companies' management and actuarial approach. Such a transaction could, for example, look like this:

Reserve Liabilities Should "*Mirror*"

190. When, however, the ceding company chooses to "cede" the $2 billion to an affiliated company (or wholly owned captive), no independent actuary calculations occur. Because the ceding parent and assuming captive share management and actuaries, the amount

ceded and the amount assumed should be ***exactly*** the same.

191. If the terms of the transaction can be concealed, however, there is a powerful incentive for the assuming affiliated company to set its reserves much lower. Specifically, and as seen with USFL's reinsurance with AXA's captive affiliate AXA Arizona (discussed herein *infra* Section III(B)), such a transaction could look like this:

192. In this example, the difference is neither subtle nor reasonable. The two parties are not independent; instead, the same management is intentionally creating the disparity, which gives the appearance that $3.2 Billion in surplus for the ceding company resulted from the reinsurance deal. Such manufacturing of phony surplus can be accomplished only because the captive does not file public financial statements revealing the lack of mirroring.

193. The Model Holding Company Act expressly prohibits this sort of "reserve discounting" scheme. In the insurance industry it is called "window dressing." The Act mandates that when a ceding company transacts with an affiliate, the deal terms must be fair and reasonable; one party cannot benefit to the other party's detriment. If such transactions were permitted, no regulator, rating agency, or life insurance purchaser could possibly know the true condition of the ceding insurer.

194. Through such affiliated reinsurance transactions, insurers generate false surplus by sending significant liabilities and likewise decreasing reserves, all the while sending far fewer

assets than necessary to establish the assuming company reserves. Because the reinsurer is often an offshore entity or wholly owned domestic captive without regulated finances, the acquiring entity has no corresponding obligation to certify that its reserves meet statutorily mandated levels, or are adequate to cover the transferred liabilities. In short, the offshore affiliate or wholly owned captive is not subject to the same reserve scrutiny by regulators.

195. By transferring reserve liabilities off a company's books, and onto an affiliate's books through sham or non-arm's-length "reinsurance" transactions, the "ceding" company is able to significantly reduce the cash reserves it is required to hold to pay future claims, thereby improving the company's risk profile in the process. This, of course, allows the company's surplus and capital picture to appear much healthier than it actually is, permitting stockholder dividend payouts while, at the same time, lulling policyholders into a false sense of security.

III. USFL's Captive Insurance Scheme

196. As discussed more fully below, since as early as 2004, AXA and USFL, and AXA's subsidiaries have engaged in numerous sham reinsurance transactions with the sole purpose of raiding cash reserves from USFL. To that point, the sham reinsurance transactions allowed USFL and AXA to misrepresent their financial health by hiding liabilities and inflating assets, thereby improving their risk profile and reducing the amount of cash reserves they were required to maintain.

197. AXA RE Arizona Company ("AXA Arizona") is one of AXA Equitable Financial Services, LLC's ("AXA Financial") wholly owned captive reinsurers, reinsuring USFL's life insurance liabilities. AXA Arizona and USFL are both wholly owned by and share the same immediate parent company, AXA Financial. AXA Arizona has been organized under the laws of

Arizona since 2012, with its principal place of business at 322 West Roosevelt, Phoenix, Arizona 85003. AXA Arizona was formerly domesticated in Bermuda.

B. Captive Reinsurance Scheme Weakens USFL

198. Following the NAIC's adoption of Regulation XXX, USFL was now required to increase its policy reserve liabilities to levels much higher than in previous years. As discussed above, the entire purpose of Regulation XXX was to inject more conservatism into the reserving methodologies to better protect policyholders.

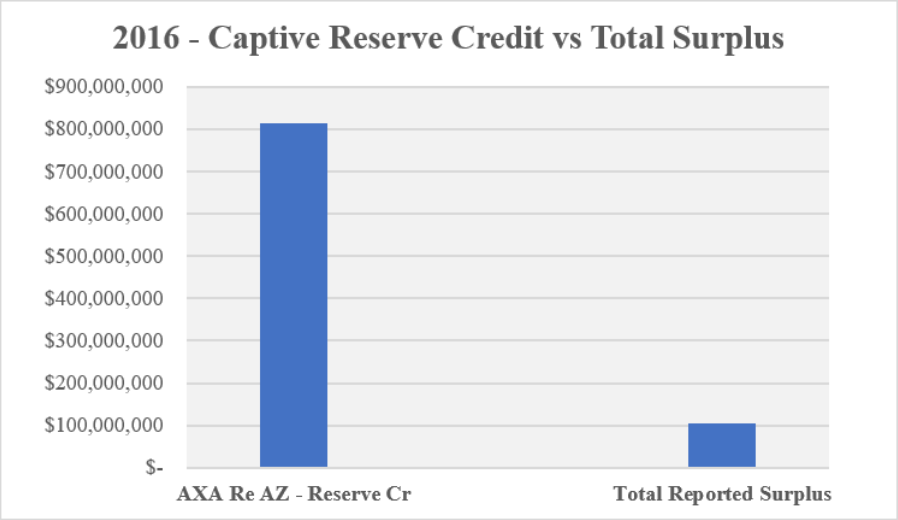
199. Choosing to disregard NAIC's concerns for policyholders, USFL began, as early as 2004, engaging in a series of "captive reinsurance" schemes to sidestep these higher reserve requirements imposed by Regulation XXX. The captive scheme began in 2004 when AXA took control of USFL. That first year, 2004, USFL took reserve credit for reinsurance transferred to AXA Arizona for $491 Million. By 2016, it had snowballed to $870 Million, more than 8 times total reported surplus.

200. In 2003, AXA Financial (USFL's immediate parent) created the foreign special purpose financial captive reinsurer, AXA Financial (Bermuda) Ltd. ("AXA Bermuda" now known as AXA Arizona). In 2004, USFL began ceding large amounts of life insurance business to AXA Bermuda, in an attempt to sidestep the increased reserves Regulation XXX required it to hold. Because USFL "ceded" these liabilities to AXA Bermuda, as of 2016 it reports a "reserve credit" of $813 million. In simplified terms, Equitable Life "reduced" its reported policy liabilities by $813 million, thereby reducing the amount of assets it needed to hold to match the policy liabilities.

201. To be allowed to recognize that $813 million reserve credit, traditional standards of statutory accounting require USFL to send to AXA Bermuda assets commensurate with the

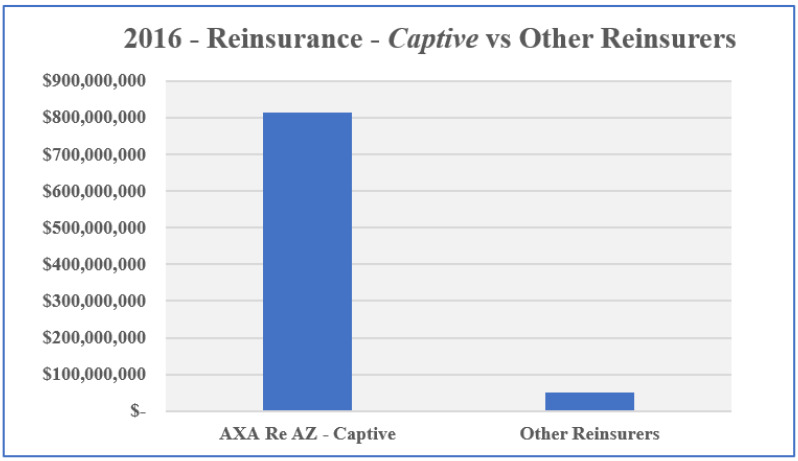
policy liabilities ceded. However, USFL's own financial records indicate that $225 million of the "assets" used by USFL's affiliate AXA Bermuda (now known as AXA Arizona) was a "Letter of Credit."

202. From the captive scheme's inception in 2004, USFL's total reserve credits nearly doubled in amount, from $490 million to $870 million. The graph below represents the growth of USFL's reserve credit taken from inception to 2016. The graph is based upon information that was taken directly from USFL's sworn statutory annual statements, Schedule S - Part 3 for those respective years.



203. At the core of fundamental strength for large life insurance companies is the quality and breadth of its reinsurance portfolio. Independent and well-capitalized reinsurers help life insurers spread risk. However, shockingly, USFL placed $870 million with its OWN CAPTIVE while only placing $50 million with independent reinsurers as shown below:

	Reserve Credit
AXA Re AZ - Captive	$ 812,835,248
Other Reinsurers	$ 50,245,517
	$ 863,080,765



204. It is difficult to explain the sheer magnitude of USFL's "reinsurance" abuse. The "reinsurance" transactions are imprudent and have no legitimate business purpose.

205. To put this in perspective, USFL reported only $105 million in Total Surplus for 2016. However, USFL has significantly "reduced" its policy liabilities through $860 million of affiliated captive reinsurance, which equals approximately 800% of reported surplus.

206. What USFL has done is simply wrong– shoving its liabilities onto affiliated and undercapitalized captives.

207. All 50 states incorporated the NAIC Model Holding Company Act into their insurance statutes. Specific to these affiliated transactions, those statutes require, as previously stated, the following:

> (A) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:
>
> (1) The terms shall be fair and reasonable.
>
> (2) Charges or fees for services performed shall be reasonable.

> (3) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices that are consistently applied.
>
> (4) The books, accounts, and records of each party shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.
>
> (5) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

OHIO REV. CODE ANN. § 3901.34.

208. The manner in which USFL effected and reported its transactions with affiliated captives failed to comply with SSAP, AP&P Manual and Annual Statement Instructions, and the Model Holding Company Act (as adopted by each state):

- Transferring policy liabilities to **captives** does not qualify as risk transfer sufficient to support the related reserve credits;
- Transferring policy liabilities to **captives** without transferring commensurate admitted assets cannot qualify as "fair and **reasonable**;"
- Because the captives (both onshore and offshore) do not file statements with the NAIC and do not even make financial statements available to the public, none of the material transactions with the captives comply with the requirement that "the books, accounts and records . . . shall be so maintained as to clearly and accurately disclose the nature and details of the transactions . . .;"
- Because USFL does not transfer admitted assets commensurate with the policy liabilities, the transactions are deemed "window dressing." If such lopsided transactions were permitted, no one would ever be able to determine the insurer's true financial condition;
- Because USFL has not actually shed the policy liabilities, they are, in essence, reinsuring themselves, a circular transaction;
- Although it cannot be determined without access to discovery if USFL is "discounting" its policy liabilities in the captive jurisdiction, it has been

reported that some life insurers have discounted the reserves both offshore and onshore;

- Because the captives (both onshore and offshore) do not file statements with the NAIC and do not even make financial statements available to the public, it cannot be determined if the captive is merely "fronting" for another reinsurer to whom the captive has retroceded the same business, through which that reinsurer merely retrocedes the same business back to a USFL affiliate, completing a different circular flow; and

- USFL has failed to disclose in its Note 1 of the Notes to Financial Statements the fact that USFL has received, on its own balance sheet, very material benefits from sham transactions that are being booked at the captives' level.

209. The affiliated transactions used by USFL and its captive affiliates had a massive impact on USFL's finances, yet crucial aspects of the shell game AXA, AXA Financial, and USFL played with its captives and affiliated entities went undisclosed in the sworn financial statements USFL filed annually under penalty of perjury. The incomplete disclosures by USFL paint a picture of "form" only that might appear proper on the surface. But it is the *substance*—the true nature and details of the transaction—that is missing.

210. Indeed, USFL's annual financial statements falsely portrayed a stable company with ample capital and assets on hand to meet its long-term obligations.

211. USFL captive reinsurance has placed significant downward pressure on USFL's liquidity and benchmark ratios. Simply put, USFL has downward pressure on solvency and liquidity. Without any other options, USFL has decided to take that cash from policyholders through a fraudulent COI increase.

CLASS ALLEGATIONS

212. Plaintiff brings this action pursuant to Rule 23 of the Federal Rules of Civil Procedure, on her own behalf and as a representative of the following class ("Class members" or "Class"):

> All persons or entities that purchased, contributed to, participated in the purchase, or own the Nova and SuperNova UL policies at issue and who received coverage from those named insurance policies issued by USFL that experienced a cost of insurance increase beginning on their policy anniversary after August 31, 2015.

213. The members of the Class are so numerous that joinder of all Class members in this action is impracticable. Plaintiff believes that there are over thousands of members of the Class.

214. There are questions of fact and law common to the Class, including but not limited to the following:

a. whether Defendant engaged in a scheme to defraud Plaintiff through misrepresentations regarding USFL's financial strength and by failing to disclose deviations from NAIC SSAP and the financial ramifications resulting from said deviations;

b. whether the Plaintiff's and Class members' policies described above were defective by virtue of their being underfunded;

c. whether the Defendant knew that the Life Policies were underfunded at the time it marketed and sold the policies to Plaintiff and Class members;

d. whether the Defendant conspired to market and did market the Plaintiff's and Class members' Policies for the purposes of defrauding members of the class;

e. the actual financial health of USFL after accounting for its proper financial valuation;

f. the true economic justification for raising the cost of insurance under the Plaintiff's and Class members' Policies;

g. whether USFL failed to maintain statutorily required reserve amounts;

h. whether USFL breached its contractual obligations to Plaintiff and Class members by raising the cost of insurance for improper purposes;

i. whether Defendant was unjustly enriched by its actions towards Plaintiff and Class members;

j. whether Defendant converted the premiums and policy values of Plaintiff and Class members;

k. whether Defendant defrauded Plaintiff through their communications, acts, and/or omissions;

l. the extent of injuries sustained by members of the class; and

m. the appropriate type and/or measure of damages.

215. Plaintiff's claims are typical of the claims of all Class members because Plaintiff and all Class members have been damaged by the same unlawful/improper uniform misconduct by the Defendant alleged herein.

216. Plaintiff will fairly and adequately protect the interests of the Class members. In addition, Plaintiff is represented by counsel who are experienced and competent in the prosecution of complex litigation, including class action litigation. Finally, the interests of Plaintiff are coincident with, and not antagonistic to, those of the Class.

217. Class action treatment is superior to the alternatives, if any, for the fair and efficient adjudication of the controversy alleged herein. Such treatment will permit a large number of similarly situated persons to prosecute their common claims in a single forum simultaneously, efficiently, and without the unnecessary duplication of effort and expense that could result from individualized litigation. Further, individualized litigation would create the danger of inconsistent or contradictory judgments arising from the same set of facts. Class action treatment will also permit the adjudication of relatively small claims by the Class members, as measured against the effort and expense required to individually litigate these complex claims against Defendant.

218. Plaintiff knows of no difficulties that are likely to be encountered in the management of this action that would preclude its maintenance as a class action.

219. The Class satisfies the requirements of Rule 23 of the Federal Rules of Civil Procedure in that (1) the Class is so numerous that joinder of all members is impracticable; (2) there are questions of law and fact common to the class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; (4) the Plaintiff will fairly and adequately protect the interests of the class; (5) individualized litigation would create the danger of inconsistent or contradictory judgments arising from the same set of facts and increase the delay and expense to all parties and the court system from the issues raised by this action; and (6) the questions of law or fact common to the Class members predominate over any questions affecting any individual members.

COUNTS

COUNT ONE

BREACH OF CONTRACT

220. Plaintiff incorporates the allegations of Paragraphs 1 through and including 219 as if fully set forth herein.

221. Plaintiff and Class members entered into a contract with USFL when their respective Policy was purchased.

222. Plaintiff and Class members paid to USFL all premiums and charges due under their Policy as set forth at the time of execution of the Policy, and Plaintiff and Class members have performed all obligations and conditions under their Policy.

223. Under the Policy, USFL owed and continues to owe duties and obligations to the Plaintiff and Class members. Among these duties is the duty to properly administer their Policy

consistent with the terms and obligations set forth within the life insurance policy. This includes the duty to determine the correct monthly deduction from a policyholder's account; the duty to notify the policyholder in a timely manner whenever USFL believed a policy's COI expenses increased; and the duty to refrain from increasing the COI except under very specific conditions.

224. USFL materially breached the terms of the life insurance policy and its duties to Plaintiff and Class members under the policy when it:

a. instituted unreasonable COI increases for purposes not authorized under the life insurance policy;

b. failed to determine the correct monthly deduction from the life insurance policy's account in accordance with the policy's terms and conditions;

c. failed to notify Plaintiff as soon as USFL determined that its "expectations" for the Policy were inaccurate and that the policy was not performing sufficiently and required an increase in COI;

d. failed to determine in a reasonably timely manner that the life insurance policy was not charged the appropriate COI; and

e. failed to maintain adequate reserves in order to perform on its obligations under their Policy.

225. As a direct and proximate result of USFL's conduct, Plaintiff and Class members have been damaged in an amount to be determined at trial. The aforementioned damages include, but are not limited to, the diminished value in Plaintiff's and Class members' life insurance policies; the improper increased cost of insurance premiums; and any damages suffered by Plaintiff and Class members from not having the opportunity to pursue and secure alternatives to the

diminished life insurance policy at issue that occurred due to their reliance on the representations of financial solubility of the life insurance policy by USFL.

COUNT TWO

BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING

226. Plaintiff incorporates the allegations of Paragraphs 1 through and including 219 as if fully set forth herein.

227. Plaintiff and Class members entered into a contract with USFL when their respective Policy was purchased.

228. Plaintiff and Class members did all, or substantially all, of the significant things that the contract required them to do; namely, throughout the life of the life insurance policy, Plaintiff and Class members have paid to USFL all premiums and charges due under their Policy as set forth at the time of execution of their Policy, and Plaintiff has performed all obligations and conditions under their Policy.

229. Under the life insurance policy, USFL owed and continues to owe duties and obligations to Plaintiff and Class members. Among these duties is the duty to properly administer their Policy consistent with the terms and obligations set forth within the life insurance policy. This includes the duty to determine the correct monthly deduction from a policyholder's account; the duty to notify policyholders in a timely manner whenever USFL believed a policy's COI expenses increased; and the duty to refrain from increasing the COI except under very specific conditions.

230. USFL materially breached the terms of the life insurance policy and its duties to Plaintiff and Class members under their Policy when it:

a. instituted unreasonable COI increases for purposes not authorized under the life insurance policy;

b. failed to determine the correct monthly deduction from the life insurance policy's accounts in accordance with their Policy's terms and conditions;

c. failed to notify Plaintiff and Class members as soon as USFL determined that its "expectations" for the life insurance policy was inaccurate and that the policy was not performing sufficiently and required an increase in COI;

d. failed to determine in a reasonably timely manner that the life insurance policy was not charged the appropriate COI;

e. failed to maintain adequate reserves to perform on its obligations under their Policy; and

f. failed to administer and/or maintain said policies consistent with USFL's duty of good faith and fair dealing implied in the performance of every contract.

231. USFL's actions unfairly interfered with the Plaintiff's and Class members' receipt of their Policy's benefits.

232. USFL's conduct did not comport with Plaintiff's and Class members' reasonable contractual expectations under their Policy with respect to potential COI increases.

233. As a direct and proximate result of USFL's conduct, Plaintiff and Class members have been damaged in an amount to be determined at trial. The aforementioned damages include, but are not limited to, the diminished value in Plaintiff's and Class members' life insurance policies; the improper increased COI premiums; and any damages suffered by Plaintiff and Class members from not having the opportunity to pursue and secure alternatives to the diminished life insurance policy at issue that occurred due to their reliance on the representations of financial

solubility of the life insurance policy by USFL. Plaintiff and Class members are entitled to damages for all premiums paid or, in the alternative, the unlawful and artificially inflated COI charges that USFL has paid itself from the policy's cash value. Plaintiff and Class members are entitled to punitive damages and all other relief this Court orders in the interest of justice whether in law or equity.

COUNT THREE

UNJUST ENRICHMENT

234. Plaintiff incorporates the allegations of Paragraphs 1 through and including 219 as if fully set forth herein.

235. Plaintiff and Class members conferred benefits upon USFL; specifically, paid money in the form of premiums to fund their life insurance policy.

236. USFL knew that they were enjoying such benefits from the Plaintiff's and Class members' premium and excess premium payments.

237. USFL misused the benefits Plaintiff and Class members conferred on them by engaging in the above described schemes.

238. USFL chose not to inform Plaintiff and Class members that USFL's "expectations" for the subject universal life insurance policies were not being met as soon as they knew such information, causing Plaintiff and Class members to continue to make premium and excess premium payments to the Plaintiff's and Class members' detriment.

239. USFL has unlawfully raided Plaintiff's and Class members' cash value accounts under the guise of a justified contractually mandated increase in COI.

240. USFL's actions have caused policyholders to abandon their universal life insurance policies without receiving the benefit of said policies.

241. USFL's actions have caused policyholders to rely on false statements USFL has made and, as a result, permit USFL to raid their policies' cash value.

242. It is unjust for USFL to retain the benefits they have enjoyed from Plaintiff's and Class members' premium payments and excess premium payments.

243. As a direct and proximate result of USFL's conduct, Plaintiff and Class members have been damaged in an amount to be determined at trial. The aforementioned damages include, but are not limited to, the diminished value in Plaintiff's and the Class members' life insurance policies; the improper increased COI premiums; and any damages suffered by Plaintiff and Class members from not having the opportunity to pursue and secure alternatives to the diminished life insurance policies at issue that occurred due to their reliance on the representations of financial solubility of the life insurance policies by USFL. Plaintiff and the Class members are entitled to restitution for all premiums paid or, in the alternative, the unlawful and artificially inflated COI charges that USFL has paid itself from the policies' cash value. Plaintiff and Class members are entitled to damages and all other relief this Court orders in the interest of justice whether in law or equity.

COUNT FOUR

CONVERSION

244. Plaintiff incorporates the allegations of Paragraphs 1 through and including 219 as if fully set forth herein.

245. On and before their 2015 policy anniversary, Plaintiff and the Class members had acquired significant cash values as part of their universal life insurance policies.

246. Plaintiff's and Class members' policy cash values were specific and identifiable, and were the Plaintiff's and Class members' personal property.

247. Beginning on their policy anniversary after August 31, 2015, and continuing every month thereafter, USFL caused money to be withdrawn from the Plaintiff's and Class members' cash value accounts and deposited into USFL and/or AXA accounts.

248. In so doing, USFL has exerted ownership and dominion over the Plaintiff's and Class members' personal property in denial of the Plaintiff's and Class members' rights.

249. As a direct and proximate result of USFL's conduct, Plaintiff and members of the putative Class have been damaged in an amount to be determined at trial. Plaintiff and Class members are entitled to punitive damages and all other relief this Court orders in the interest of justice whether in law or equity.

COUNT FIVE

FRAUDULENT MISREPRESENTATION

250. Plaintiff incorporates the allegations of Paragraphs 1 through and including 219 as if fully set forth herein.

251. USFL has falsely stated to Plaintiff and Class members on a uniform basis that USFL was justifiably and lawfully increasing the COI charged to their universal life policies, based on "future mortality expectations."

252. USFL also falsely represented to the Plaintiff and Class members that it was a well-funded company, operating efficiently, increasing profits and cash flows, and reducing costs.

253. At the time USFL made these material statements, it knew them to be false.

254. USFL made these statements with the express intention of defrauding the Plaintiff and Class members.

255. Plaintiff and members of the putative Class relied on USFL's statements and were entitled to rely on such statements. In reliance on those statements, Plaintiff and Class members

continued to pay premiums long after they otherwise would have; Plaintiff and Class members did not attempt to obtain alternative life insurance policies at an earlier date when they either could have obtained an alternate policy and/or could have obtained one at a lesser charge than they can now.

256. If USFL had not made such false statements, Plaintiff and Class members would not have taken the above-described actions.

257. As a direct and proximate result of USFL's conduct, Plaintiff and members of the putative Class have been damaged in an amount to be determined at trial. The aforementioned damages include, but are not limited to, the diminished value in Plaintiff's and the members of the Class' life insurance policies; the improper increased COI premiums; and any damages suffered by Plaintiff and members of the Class from not having the opportunity to pursue and secure alternatives to the diminished life insurance policies at issue that occurred due to their reliance on the representations of financial solubility of the life insurance policies by USFL. Plaintiff and the members of the putative Class are entitled to damages for all premiums paid or, in the alternative, the unlawful and artificially inflated COI charges that USFL has paid itself from the policies' cash value. Plaintiff and Class members are entitled to punitive damages and all other relief this Court orders in the interest of justice whether in law or equity.

COUNT FIVE

FRAUDULENT SUPPRESSION

258. Plaintiff incorporates the allegations of Paragraphs 1 through and including 219 as if fully set forth herein.

259. USFL has assumed a duty to disclose the reason for the 2015 COI increase once it uniformly informed Plaintiff and Class members the 2008 COI increase was based on future

mortality and claims.

260. USFL further assumed a duty to disclose the reason for the 2015 COI increase due to partially disclosing on a uniform basis the actual reason(s) for the second COI increase effective in 2015. USFL is in a superior position of knowledge and its notification of the 2015 COI increase omits the actual reasons for the increase. USFL's duty to fully disclosure to Plaintiff and Class members the reason(s) for the COI increase arose as it is necessary to cure misleading impressions created by a partial revelation underlying the reason for the COI increase.

261. USFL has uniformly concealed, suppressed, and failed to disclosure material facts as to the true nature and reason for the 2015 COI increase.

262. Namely, USFL has suppressed it is increasing the COI to (1) find new cash with which to fund the company, (2) rid itself of near-term liabilities because it is financially unstable – a fact they have cleverly hidden through a captive reinsurance scheme – and (3) to recoup past losses related to (a) record-low interest rates, (b) the miscalculation of the 2008 COI increase on Plaintiff's and Class members' policies, and (c) the tens of millions of dollars paid in 2014 and 2015 to 3,000 policyholders overcharged the maximum COI rate in their respective policies.

263. USFL intentionally concealed or suppressed the above-referenced facts for the 2015 COI increase.

264. Plaintiff and members of the putative Class were induced by USFL's statements as to the reason for the 2015 COI increase and acted or did not act due to this inducement. Specifically, Plaintiff and Class members continued to pay premiums long after they otherwise would have; Plaintiff and Class members did not attempt to obtain alternative life insurance policies at an earlier date when they either could have obtained an alternate policy and/or could have obtained one at a lesser charge than they can now.

265. If USFL had not suppressed the reason for the 2015 COI increase, Plaintiff and Class members would not have taken the above-described actions.

266. As a direct and proximate result of USFL's conduct, Plaintiff and members of the putative Class have been damaged in an amount to be determined at trial. The aforementioned damages include, but are not limited to, the diminished value in Plaintiff and the members of the Class' life insurance policies; the improper increased COI premiums; and any damages suffered by Plaintiff and members of the Class from not having the opportunity to pursue and secure alternatives to the diminished life insurance policies at issue. Plaintiff and the members of the putative Class are entitled to damages for all premiums paid or, in the alternative, the unlawful and artificially inflated COI charges that USFL has paid itself from the policies' cash value. Plaintiff and Class members are entitled to punitive damages and all other relief this Court orders in the interest of justice whether in law or equity.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for a judgment:

A. Certifying the Class as requested herein;

B. Awarding Plaintiff and Class members compensatory damages in an amount to be determined at trial;

C. Awarding Plaintiff and Class members restitution damages in an amount to be determined at trial;

D. Punitive Damages;

E. Awarding Plaintiff declaratory and injunctive relief;

F. Awarding Plaintiff and Class members attorneys' fees and costs; and

G. Affording Plaintiff and Class members with such further and other relief as deemed just and proper by the Court in law or equity.

JURY DEMAND

Plaintiff demands a jury trial of all issues triable by right by jury.

RESPECTFULLY SUBMITTED, this the 16th day of October, 2017.

/s/ Andrew E. Brashier
BEASLEY, ALLEN, CROW, METHVIN, PORTIS & MILES, P.C.
W. DANIEL "DEE" MILES, III (*pro hac vice*)
ANDREW E. BRASHIER (*pro hac vice*)
RACHEL N. BOYD (*pro hac vice*)
272 Commerce Street
Post Office Box 4160 (36103)
Montgomery, Alabama 36104
Telephone: 334-269-2343
Facsimile: 334-954-7555
dee.miles@beasleyallen.com
andrew.brashier@beasleyallen.com
rachel.boyd@beasleyallen.com

GEOFF McDONALD & ASSOCIATES, P.C.
GEOFFREY R. McDONALD (*pro hac vice anticipated*)
JUSTIN M. SHELDON (*pro hac vice anticipated*)
FRANK H. HUPFL, III (*pro hac vice anticipated*)
3315 West Broad Street
Richmond, Virginia 23230
Telephone: 804-888-8888
Facsimile: 804-359-5426
gmcdonald@mcdonaldinjurylaw.com
jsheldon@mcdonaldinjurylaw.com
fhupfl@mcdonaldinjurylaw.com

GOLDENBERG SCHNEIDER, L.P.A.
JEFFREY S. GOLDENBERG
TODD NAYLOR
One West Fourth Street, 18th Floor
Cincinnati, Ohio 45202-3604
Tel: 513.345.8297
Fax: 513.345.8294
JGoldenberg@gs-legal.com
TNaylor@gs-legal.com

CERTIFICATE OF SERVICE

I hereby certify that on October 16, 2017, a true and correct copy of the foregoing was served via CM/ECF to all counsel of record:

Matthew A. Rich (0077995)
KATZ, TELLER, BRANT & HILD
255 East Fifth Street, Suite 2400
Cincinnati, OH 45202
Telephone: (513) 721-4532
Facsimile: (513) 762-0075
mrich@katzteller.com

EDISON,MCDOWELL & HETHERINGTON LLP
David T. McDowell*
Diane Wizig *
William B. Thomas *
1001 Fannin, Suite 2700
Houston, Texas 77006
Telephone: (713) 337-5580
Telecopy: (713) 337-8850
* *pro hac vice*

EXHIBIT 1

U.S. FINANCIAL LIFE Insurance Co.
An AXA Financial Company

800-959-3894
Fax: 315-477-2828
USFLI-POS@AXA-Equitable.com

P.O. Box 4763
Syracuse, New York 13221-4763

03/17/2008

WIRT ADAMS YERGER JR LEGACY TRUST DATED 11-16-2005
129 WOODLAND CIRCLE
CIRCLE JACKSON MS 39216

RE: Policy Number:0000167447
Insured: WIRT A YERGER
Increase in the Cost of Insurance

Dear Policy Owner:

Your Universal Life policy from U.S. Financial Life Insurance Company (USFL) is a flexible premium product that allows for a change in the Cost of Insurance (COI) rates. A recent review of our mortality experience under this policy form has indicated that the trend in mortality and claims will be less favorable than anticipated when the product was priced. The COI rates for this product and your policy are being increased as of your policy anniversary.

Your policy is from our Nova series of products. This product includes a Target Premium Guarantee for a number of years specified on your policy's schedule page. As long as you continue to pay premiums at least equal to the Target Premium on the schedule page, your policy is guaranteed not to lapse even if the policy's cash value drops to zero. Therefore, premiums on your policy may not need to be increased to compensate for this increase in the COI rates to keep your policy in force during the Target Premium Guarantee period. However, loans, withdrawals and face amount changes impact the Target Premium Guarantee and may require an increase in premiums to prevent a policy lapse.

The increase in the COI rates will decrease the cash value accumulation of your policy and the overall performance of the policy. If you wish to keep your policy in force beyond the Target Premium Guarantee period, it may be necessary to increase the amount of your premium payment to improve the cash value growth in your policy; however, **we will not automatically increase the premium amount, even if you are on an automatic bank draft payment method. It is your responsibility to determine whether to increase your planned premiums. We will be happy to assist you in that evaluation. We can provide you with an illustration of the future anticipated and guaranteed performance of your policy. We can illustrate how your policy is expected to perform if you choose to increase your planned premium payments.**

We are also mailing to you the annual statement for your recent policy anniversary year. This statement will only reflect the policy information and activity for the past policy year. The increased level of the COI will be reflected on the statement on your next policy anniversary.

We encourage you to discuss your policy with your USFL agent. You may also feel free to contact our Policy Owner Services Department toll fee at 1-800-959-3894. We are here to service your insurance needs.

Sincerely,

Policy Owner Services Department

U. S. Financial Life Insurance Company

AXA FINANCIAL LLC/WILLIAM T BURNHAM

NOVALET

EXHIBIT 2

U.S. FINANCIAL LIFE Insurance Co.
An AXA Financial Company

800-959-3894
Fax: 315-477-2828
USFLI-POS@AXA-Equitable.com
P.O Box 4763
Syracuse, New York 13221-4763

08/11/2015

WIRT ADAMS YERGER JR LEGACY TRUST DATED 11-16-2005
129 WOODLAND CIRCLE
CIRCLE JACKSON MS 39216 US

Not Good

Re: 0000167447
Dear WIRT ADAMS YERGER JR LEGACY TRUST DATED 11-16-2005 ,

Your Nova series Universal Life policy from U.S. Financial Life was a valuable purchase. It provides both death benefit protection for your beneficiary and cash value accumulation for you on a tax-advantaged basis.

Your policy allows for changes in the cost of insurance rates based on anticipated experience. We anticipate the future mortality experience for this product to be worse than was anticipated when the current schedule of cost of insurance rates was established.

We are writing to inform you that beginning on your next policy anniversary after August 31, 2015, the cost of insurance rates will be based on a new schedule that is higher than the current schedule. These rates will never be greater than the guaranteed rates as specified in your policy.

If you have any questions, contact our Customer Service Department at 800-959-3894 or your U.S. Financial Life representative. We appreciate the opportunity to service your life insurance needs.

Sincerely,

Policy Owner Services Department

cc: MONY BROKERAGE INC /SCOTT BINGHAM

EXHIBIT 3

U.S. FINANCIAL
LIFE INSURANCE COMPANY
A Stock Insurance Company
10290 Alliance Road
Cincinnati, Ohio 45242 www.usfli.com

U.S. FINANCIAL LIFE INSURANCE COMPANY (known as we, us and our) will pay the proceeds of the policy if the Insured dies while the policy is in force. We will pay the benefit upon receipt at our Home Office of due proof of the Insured's death. We issue this policy in consideration of the application and the payment of premiums. All benefits are subject to the terms and conditions of this policy.

Right to Examine: We want you to be satisfied with this policy. If you are not satisfied, you may return the policy to our Home Office or to our agent. You must return it within 20 days after its delivery. Once returned, the policy will be void from its beginning. We will refund any premium paid.

Executed by the U.S. FINANCIAL LIFE INSURANCE COMPANY at its Home Office in Cincinnati, Ohio as of the policy date.

Gail Lee
Secretary

President

FLEXIBLE PREMIUM ADJUSTABLE LIFE. Death Benefit payable on Insured's death prior to the maturity date. Cash value payable at maturity date if the Insured is living. Death benefits and premiums are flexible prior to termination of this policy. Nonparticipating - no dividends will be payable.

TABLE OF CONTENTS

Any riders and a copy of the application follow page 15.

U. S. FINANCIAL LIFE INSURANCE CO.
SCHEDULE

BILLED PREMIUM	$100,025.00 — Maximum Annual Premium per Bill Bracken since Universal Life
PREMIUM FREQUENCY	ANNUALLY
ANNUAL PLANNED PREMIUM	$100,025.00
ANNUAL TARGET PREMIUM	$100,025.00
DEATH BENEFIT	EQUALS SPECIFIED AMOUNT (OPT A)
MONTHLY DEDUCTION DATE	15TH DAY OF EACH MONTH
MATURITY DATE	March 15, 2031
MINIMUM SPECIFIED AMOUNT	$10,000
SERVICE FEE	$25.00 PER PARTIAL SURRENDER
TARGET PREMIUM GUARANTEE PERIOD	5 YEARS
PREMIUM LOAD	5.5% OF PREMIUM RECEIVED

IT IS POSSIBLE THAT COVERAGE WILL EXPIRE BEFORE THE MATURITY DATE IF EITHER NO PREMIUMS ARE PAID FOLLOWING PAYMENT OF THE INITIAL PREMIUM OR PREMIUMS ARE INSUFFICIENT TO CONTINUE COVERAGE TO THAT DATE.

BENEFICIARY - UNLESS CHANGED AS PROVIDED IN THIS POLICY, THE BENEFICIARY SHALL BE AS DESCRIBED IN THE APPLICATION.

INSURED: WIRT A YERGER JR

OWNER: SEE APPLICATION

INITIAL SPECIFIED AMOUNT: 1,750,000

PREMIUM CLASS: SUPER STANDARD NONSMOKER

POLICY NUMBER: 0000167447

ISSUE AGE: 70

POLICY DATE: March 15, 2001

U. S. FINANCIAL LIFE INSURANCE CO.

TABLE OF SURRENDER CHARGES

POLICY YEAR	SURRENDER CHARGE DURING POLICY YEAR
1	$84,350.00
2	$84,350.00
3	$84,350.00
4	$84,350.00
5	$84,350.00
6	$75,915.00
7	$67,480.00
8	$59,045.00
9	$50,610.00
10	$42,175.00
11	$33,740.00
12	$25,305.00
13	$16,870.00
14	$8,435.00
15	$.00

THIS TABLE APPLIES TO THE SPECIFIED AMOUNT AT ISSUE. A TABLE OF ADDITIONAL SURRENDER CHARGES WILL BE PROVIDED FOR EACH INCREASE IN THE SPECIFIED AMOUNT.

POLICY NUMBER: 0000167447

U. S. FINANCIAL LIFE INSURANCE CO.

TABLE OF MAXIMUM INSURANCE COSTS

MAXIMUM MONTHLY COSTS PER $1,000 OF INSURANCE

ATTAINED AGE	RATE	ATTAINED AGE	RATE	ATTAINED AGE	RATE
20	0.14000	50	0.42750	80	8.15667
21	0.13833	51	0.46667	81	8.93750
22	0.13583	52	0.51167	82	9.81833
23	0.13250	53	0.56333	83	10.79500
24	0.12917	54	0.62083	84	11.84833
25	0.12500	55	0.68500	85	12.95417
26	0.12250	56	0.75500	86	14.09833
27	0.12083	57	0.82917	87	15.26333
28	0.12000	58	0.91167	88	16.44417
29	0.12000	59	1.00417	89	17.65750
30	0.12083	60	1.10750	90	18.92083
31	0.12333	61	1.22250	91	20.26333
32	0.12667	62	1.35500	92	21.73500
33	0.13167	63	1.50500	93	23.47917
34	0.13750	64	1.67167	94	25.81917
35	0.14417	65	1.85417	95	29.32167
36	0.15167	66	2.05167	96	35.08250
37	0.16167	67	2.26333	97	45.08333
38	0.17250	68	2.49333	98	62.09583
39	0.18417	69	2.74833	99	83.33333
40	0.19833	70	3.03667		
41	0.21333	71	3.36583		
42	0.22917	72	3.74583		
43	0.24667	73	4.17583		
44	0.26583	74	4.64833		
45	0.28750	75	5.15333		
46	0.31083	76	5.68667		
47	0.33583	77	6.24417		
48	0.36333	78	6.82917		
49	0.39333	79	7.46000		

WE HAVE BASED THE ABOVE RATES AND THE MINIMUM CASH VALUES FOR THIS POLICY ON THE 1980 CSO MALE NONSMOKER TABLE.

POLICY NUMBER: 0000167447

DEFINITIONS

Assignment - The Owner's transfer of a right or interest in this policy.

Attained Age - The issue age of the Insured as shown on the Schedule plus the number of full years which have elapsed since the policy date.

Beneficiary - The person chosen to receive the death benefit of this policy.

Evidence of Insurability - Information about the Insured used to approve, change or reinstate this policy.

Insured - The person whose life is insured as shown on the Schedule.

Irrevocable Beneficiary - Capable of being changed by the Owner only with the consent of the beneficiary.

Issue Age - Age of the Insured on the Insured's last birthday before the policy date.

Monthly Deduction Date - The date each month that the monthly deduction is calculated as shown on the Schedule.

Policy - All of this written document including any riders or endorsements.

Policy Date - The date that coverage was effective as shown on the Schedule. Policy years, months and anniversaries are determined from the policy date.

Reinstatement - To restore coverage after the policy terminates for nonpayment of premiums.

Revocable Beneficiary - Capable of being changed by the Owner without the consent of the beneficiary.

Target Premium - The premium that must be paid so that the policy will remain in force during the target premium guarantee period.

We, us, our - U.S. Financial Life Insurance Company, the insurer.

You - The Owner of the policy.

GENERAL PROVISIONS

Basic Benefit

Death Benefit
We will pay the death benefit if the Insured dies while this policy is in force.

The amount of the death benefit will be:
(a) the Insured Amount on the date of death; plus
(b) the amount provided by any additional benefits; minus
(c) the amount of any outstanding policy loans less unearned interest from the date of death to the end of the policy year.

If the Insured dies during the grace period, we will deduct the monthly deduction for the grace period from the death benefit.

Benefit Payments
We will pay benefits in a lump sum unless another payment option is requested. At your request, we may pay benefits in any other manner acceptable to us.

Notice of Claim
We will pay a death benefit when we receive proof that the Insured died while this policy was in force. Due proof must be sent to us at our Home Office. Due proof will include a copy of the death certificate. We may request the return of the policy. All death benefits are paid from our Home Office.

Insurance Coverage

Insured Amount

The insured amount depends on the death benefit option elected by you. The death benefit option in effect on the policy date is listed on Page 3.

If the death benefit option is Option A, the insured amount is the greater of the following:
(a) the specified amount onthe date of death; or
(b) the policy value on the date of death multiplied by the percentage from the table below.

If the death benefit option is Option B, the insured amount is the greater of the following:
(a) the specified amount on the date of death plus the policy value; or
(b) the policy value on the date of death multiplied by the percentage from the table below.

The specified amount on the date of death is the amount shown on Page 3, or as changed after the policy date as allowed by the Changes in Coverage provision.

TABLE OF MINIMUM INSURED AMOUNTS

For Attained Age	Insured Amount as a Percentage of Policy Value	For Attained Age	Insured Amount as a Percentage of Policy Value
0-40	250%	60	130%
41	243%	61	128%
42	236%	62	126%
43	229%	63	124%
44	222%	64	122%
45	215%	65	120%
46	209%	66	119%
47	203%	67	118%
48	197%	68	117%
49	191%	69	116%
50	185%	70	115%
51	178%	71	113%
52	171%	72	111%
53	164%	73	109%
54	157%	74	107%
55	150%	75 - 90	105%
56	146%	91	104%
57	142%	92	103%
58	138%	93	102%
59	134%	94 - 99	101%

Changes in Coverage

At any time after the first policy year but before the policy anniversary on which the Insured's attained age is 86, you may elect to increase the insured amount under this policy. At any time after the first policy year, you may elect to decrease the insured amount. These changes may be accomplished by:

(a) changing the death benefit option, or
(b) changing the specified amount.

In either case, the election must be in writing signed by you and filed with us at our Home Office. Any such change is subject to the following conditions:

(a) If Death Benefit Option A is in effect, you may change the policy so that Death Benefit Option B is in effect. In this case, the specified amount will be reduced to equal the insured amount, less the policy value, as of the monthly deduction date next following the day we receive the request at our Home Office.

(b) If Death Benefit Option B is in effect, you may change the policy so that Death Benefit Option A is in effect. The specified amount will be increased by the policy value so that the insured amount following the change will be equal to the insured amount in effect under Option A on the date that the change becomes effective.

(c) An election to increase the specified amount must be for an amount of at least $10,000 and be accompanied by a supplementary application and evidence of insurability acceptable to us. Any increase in the specified amount will take effect on the monthly deduction date on or next following the date on which the increase in the specified amount is approved by us. If an increase is approved, additional surrender charges will be applied to that increase. We will send you written notice of the amount and duration of these additional surrender charges. The target premium shown on Page 3 will be increased when the specified amount is increased. Additionally, the Target Premium Guarantee Period will start over from the effective date of the increase. If the request for increase is not approved, you will be notified in writing.

(d) An election to decrease the specified amount must be for an amount of at least $10,000 and will take place on the monthly deduction date next following the day we receive the written request at our Home Office.

(e) Decreases in the specified amount will first be applied against the most recent increase in the specified amount. Any excess amount of decrease will then be applied against the next most recent increases, in order, and finally against the specified amount on the policy date.

(f) The specified amount following a decrease may not be less than the minimum specified amount shown on Page 3.

(g) Any decrease in specified amount will not reduce the original or any additional surrender charges. The target premium shown on Page 3 will not be reduced. The Target Premium Guarantee as described on Page 10 will not be affected by a decrease in specified amount.

We will not make any changes which would disqualify this policy from being considered life insurance under the Internal Revenue Code.

Premiums and Reinstatement

Payment Of Premiums

The first premium is payable on the policy date and there is no insurance until the first premium is paid. Premium payments after the first payment are flexible and may be made at any time while the Insured is living. Such payments may be for any amount of $25.00 or more.

If you make a payment that would disqualify this policy as life insurance under the Internal Revenue Code, we may refund that premium to you.

We will send you premium notices unless you request otherwise. Such notices will be based on the billed premium and premium frequency shown on Page 3. Premium payments must be paid directly to us at our Home Office. We will give you a receipt for a payment if you request it. Premiums will be considered received on the date that we receive them in our Home Office.

Continuation of Coverage

If you do not pay a premium, we will keep your policy in force so long as the cash value is enough to pay the amount of the monthly deductions as they fall due.

Target Premium Guarantee

During the Target Premium Guarantee Period following the policy date, this policy will not lapse even if the cash value is negative provided that (a) exceeds (b), where:

(a) is the total premiums paid since the policy date less the sum of any outstanding policy loan and any partial surrenders taken; and

(b) is one twelfth of the annual target premium shown on Page 3 multiplied by the number of policy months since the policy date.

During the Target Premium Guarantee Period following the effective date of an increase in the specified amount, this policy will not lapse even if the cash value is negative provided that (a) exceeds (b), where:

(a) is the total premiums paid since the effective date of the increase less the sum of any outstanding policy loan and any partial surrenders taken since the effective date of the increase; and

(b) is one twelfth of the annual target premium established on the effective date of the increase multiplied by the number of policy months since the effective date of the increase.

The Target Premium Guarantee and the target premium will not be changed by a decrease in the specified amount. If the target premium is paid, the policy value at the end of the Target Premium Guarantee Period may not be sufficient to keep the policy inforce unless additional payment is made at that time.

Grace Period

If the cash value at the end of any policy month is not larger than the monthly deduction then due, this policy will be in default. You have a grace period of 60 days after the end of the policy month to pay a premium large enough to cover the monthly deductions due during the grace period. The policy will continue during the grace period. If the Insured dies during the grace period, we will deduct the unpaid monthly deduction from the death benefit of this policy.

If sufficient premium is not paid by the end of the grace period, the policy will terminate without value. We will send you a notice of the default at least 31 days prior to the end of the grace period.

The policy will not be considered to be in default if the Target Premium Guarantee described above is in effect.

Reinstatement
This policy may be reinstated, while the Insured is alive, at any time within five years from the date the policy terminated. To reinstate the policy, we must receive:
(a) satisfactory evidence of insurability;
(b) the payment of all amounts owed on the policy on the date of termination; and
(c) a premium large enough to keep the policy including any riders in force for three months.

Reinstatement is not available if the policy has been surrendered for cash.

Upon reinstatement, any outstanding policy loan on the date of lapse will be offset against the policy value. As a consequence, the policy loan will be reduced to zero and the policy value on the date of reinstatement will be reduced by the amount of the policy loan on the date of lapse. Any surrender charges will be reinstated. Future surrender charges will be adjusted for the period that the policy has been lapsed.

Policy Values

Cash Value
At any time, you may surrender this policy for its cash value. The cash value is the policy value on the date of surrender, less any amounts owed on the policy, and less any surrender charges.

Normally, we will make the payment of the cash value within a few days of your request. However, we have the right to defer payments for a period of up six months after the date of surrender. If we defer payment for thirty days or more, interest, at a rate which will not be less than 4.0% per year, will be added from the date of surrender.

Policy Value
The policy value on the policy date is the initial net premium reduced by the Monthly Deduction for the month following the monthly deduction date.

On each monthly deduction date, the policy value is:
(a) the policy value on the preceding monthly deduction date; plus
(b) one month's interest on the amount described in item (a); plus
(c) all net premiums received since the preceding monthly deduction date; minus
(d) the monthly deduction for the month following the monthly deduction date.

On any date other than a monthly deduction date, is the policy value as of the preceding monthly deduction date, plus all net premiums received since the preceding monthly deduction date. The cash value, during the thirty days after the end of a policy year, will not be less than the cash value at the end of the policy year, less any subsequent partial surrenders or policy loans.

Net Premium
The net premium is the premium received less the premium load listed on Page 3.

Interest Rate
The guaranteed interest rate used in calculating policy values is .32737% per month, compounded monthly. This is equivalent to 4.0% per year. We may use interest rates greater than the guaranteed rate to calculate policy values. We have the right to apply a different rate of interest to that portion of the policy value which equals the amount of an outstanding loan, but it will not be less than 4.0% per year.

Monthly Deduction
Each monthly deduction consists of the sum of the following:
(a) the cost of insurance plus the cost of any additional benefits provided by rider; plus
(b) the monthly policy fee of $8.33.

Cost Of Insurance
The cost of insurance for the Insured is determined on a monthly basis. The cost is calculated as follows:
(a) The insured amount at the beginning of the policy month is divided by 1.0032737. The result is then reduced by the policy value at the beginning of the month.
(b) The final result in (a) above is multiplied by the applicable cost of insurance rate or rates.

If there has been no increase in the specified amount, the cost of insurance will be calculated by multiplying the amount described in (a) by the cost of insurance rate which is applicable.

If there has been one or more increases in the specified amount, there will be a cost of insurance rate applicable to each increase. The cost of insurance will then be the sum of the amounts determined by multiplying each portion by the cost of insurance rate which applies to it. If Death Benefit Option A is in effect and the specified amount has been increased, the policy value will first be considered part of the initial specified amount. If the policy value is greater than the initial specified amount, it will be part of any additional specified amounts in order of increase.

Cost Of Insurance Rate
The cost of insurance rate is based on the Insured's sex, attained age and premium class. For the initial specified amount, we will use the premium class on the policy date. For each increase in the specified amount, we will use the premium class applicable to the increase. As a result, there may be a different cost of insurance rate for each increase.

The guaranteed maximum cost of insurance rates are shown in the Table of Maximum Monthly Insurance Costs on page 5. We have the right to use cost of insurance rates that are lower than the guaranteed rates and may change the rates from time to time. Any change in the cost of insurance rates will apply uniformly to all members of the same class.

Surrender Charge
If this policy is surrendered before its fourteenth anniversary, a surrender charge will be imposed. The amount of the surrender charges are show in the Table of Surrender Charges on Page 4. The surrender charge will be reduced on a pro rata basis if a partial surrender is taken as described on Page 13.

Additional surrender charges will apply to any increase in the specified amount. We will send you written notice of the amount and duration of these additional surrender charges.

Any decrease in specified amount will not reduce the original or any additional surrender charges.

Basis of Values
All values are calculated based on the Commissioners 1980 Standard Ordinary Smoker or Nonsmoker Mortality Tables with interest at the rate of 4.0% per year. All values are at least as great as those required by law in the state where this policy is delivered. Details of how values are calculated have been filed with the insurance regulator of that state.

Partial Surrender
A partial surrender may be made at any time after the first policy year. The minimum partial surrender is $125. The maximum partial surrender is that amount which will leave a cash value of $500.

The insured amount and the policy value will be reduced by the amount of the partial surrender. If Death Benefit Option A is in effect, the specified amount will be reduced by the amount of the partial surrender. The specified amount remaining in force after the partial surrender will be subject to the limits and minimum amount described in the Changes in Coverage provision. We will not allow a partial surrender which would disqualify this policy from being considered life insurance under the Internal Revenue Code.

If you make a partial surrender, a pro rata surrender charge will be deducted. The pro rata surrender charge will be equal to the surrender charge multiplied by the portion of the cash value being withdrawn. Future surrender charges will be reduced proportionally.

Each time you make a partial surrender, we will deduct a service fee from the amount you request. The service fee for a partial surrender is shown on Page 3. We reserve the right to limit the number of partial surrenders in a policy year.

Normally, we will make the payment of the partial surrender value within a few days of your request. However, we have the right to defer making payments for a period up to six months after the date of the partial surrender. If we defer payment for thirty days or more, interest, at a rate which will not be less than 4.0% per year, will be added from the date of partial surrender.

Loans

Policy Loans
You may obtain a loan from us on the sole security of this policy whenever it has a loan value.

You may borrow all or a part of the loan value. The loan value is the amount which, with interest, will equal the cash value on the next anniversary.

We will charge interest on all loans at a rate of 5.66% per year in advance. If the interest at the beginning of a policy year is not paid at that time, we will add it to the amount of the loan. The amount of the loan is the amount owed on the policy.

Failure to repay the loan or to pay interest will not lapse this policy unless amounts owed on the policy equal or exceed the policy value less any surrender charges.

Normally, we will make the loan within a few days of your request. However, we may defer making the loan for up to six months unless it is to be used to pay premiums or amounts owed to us.

At any time before the maturity date, you may repay all or a part of the amounts owed on the policy. Any loan repayment made to us must be identified by you as a loan repayment or else it will be treated as an additional premium payment.

THE CONTRACT

Entire Contract
This policy, any riders, endorsements or amendments, the application attached at issue, and any supplemental applications are the entire contract. All statements made by the Insured or on behalf of the Insured will be representations and not warranties. No statement will be used in defense of any claim unless that statement is contained in the attached written application or in a supplemental application that is made part of the policy when a change becomes effective. No agent or other person, except our President, elected Vice President or Secretary has the authority to:
(a) make or modify this contract;
(b) extend the time for payment of a premium or interest.
(c) waive any of our rights or requirements.

Incontestability
We cannot contest this policy after it has been in force during the Insured's lifetime for two years. The two-year period starts on the policy date. In the event this policy is reinstated, information provided in the application for reinstatement is contestable for a two-year period following the date of reinstatement. In the event this policy has had an increase in the specified amount, information provided in the supplementary application for the increase is contestable for a two-year period following the effective date of the increase. We may contest the policy for nonpayment of premium at any time.

Suicide
If the Insured commits suicide within two years after the policy date, the total benefits paid will be equal to the premiums paid less any amounts owed under the policy. If the Insured commits suicide within 2 years following the effective date of an increase in the specified amount, the total benefit paid with respect to the increase will be equal to the cost of insurance for the increase.

Age and Sex
If the age or sex of the Insured has been misstated on the application, the amount payable will be the policy value plus the amount that would have been purchased by the most recent cost of insurance charge at the correct age or sex.

Termination
This policy will terminate on the earliest of the following:
(a) The date the grace period ends;
(b) The date the policy is surrendered for cash;
(c) The policy maturity date; or
(d) The date the Insured dies.

Annual Report
We will send you, at least once a year, a report which shows the current policy value, cash value, premiums paid and charges made since the last report, and any outstanding policy loans.

Projection Report
At your request, we will send you a report showing a projection of expected future values of your policy. A service fee may be charged for this projection. The fee payable will be the one then in effect for this service.

Nonparticipating
This policy is not eligible for dividends and will not participate in our divisible surplus.

Conformity with State Laws
This policy is subject to the laws of the state where the application was signed. If part of it does not follow that law, it will be treated as if it does.

Ownership

Ownership
The Insured is the Owner of the policy unless an Owner other than the Insured is either:
(a) named in the application; or
(b) later chosen, in writing, in a form acceptable to us and which is shown by our endorsement.

Unless otherwise provided in this policy, as Owner, you are entitled without the consent of any other person to:
(a) assign this policy;
(b) agree with us to any change to this policy; or
(c) exercise any rights or privileges under the policy.

Assignment
You may assign this policy. The interest of any revocable beneficiary is subject to any assignment. We are not responsible for the validity or effect of any assignment. The assignment must be in writing and filed with us at our Home Office. We are not liable for any payment made by us before we record the assignment.

Beneficiary
The beneficiary is shown on the application. A change in beneficiary must be made in a form acceptable to us. No change will become effective until we record it. Once recorded, the change will be effective as of the date you signed the request for the change. The change will be subject to any action we may have taken before we receive the request. You may change the beneficiary, unless the beneficiary is irrevocable. If the beneficiary is irrevocable, you must obtain the beneficiary's written consent to change the beneficiary.

The interest of any revocable beneficiary is subject to the rights of an assignee. The interest of any beneficiary who does not survive the Insured will pass to the Insured's estate, unless indicated otherwise in the beneficiary designation.

If any beneficiary dies:
(a) within 15 days after the Insured's death; and
(b) before we receive proof of the Insured's death;
the proceeds of the policy will be paid as if that beneficiary had not survived the Insured.

U.S. FINANCIAL LIFE INSURANCE COMPANY
10290 Alliance Road, P.O. Box 429560
Cincinnati, Oh 45242

DEATH BENEFIT MATURITY EXTENSION ENDORSEMENT

This Endorsement is added to and made a part of the policy to which it is attached.

The maturity date of this policy will be your attained age 120 if the policy is in force and you are still living on that date. The Table of Minimum Insured Amounts is hereby changed to 100% for attained ages 100 and higher.

Starting at attained age 100, the following changes will be made to this policy:

1. No new premiums will be accepted.
2. The Table of Maximum Monthly Insurance Costs for ages 100 and over will be zero.
3. The Monthly Deduction will stop.
4. The Policy Value will earn interest at the guaranteed rates specified for loaned and non-loaned funds.
5. The Death Benefit will be equal to the Insured Amount in effect at attained age 100 less any outstanding policy loans, but not less than 100% of the Policy Value less any outstanding loans.
6. The policy will mature at your attained age 120 for the Policy Value less any outstanding policy loans.
7. Interest on policy loans will continue to accrue as stated in the Policy Loan Provision.
8. No face amount increases or decreases may be made.
9. No changes in the death benefit option may be made.

Following attained age 100, this policy may or may not qualify as life insurance under the Internal Revenue Code. The owner should consult his or her tax advisor as to the possible tax consequences of this endorsement.

This Endorsement is effective on the Policy Date unless a later date is shown below.

Gail Lee

Secretary

MAT END

U.S. FINANCIAL
LIFE INSURANCE COMPANY
A Stock Insurance Company
10290 Alliance Road
Cincinnati, Ohio 45242 www.usfli.com

LIFE INSURANCE POLICY

FLEXIBLE PREMIUM ADJUSTABLE LIFE. Death Benefit payable on Insured's death prior to the maturity date. Cash value payable at maturity date if the Insured is living. Death benefits and premiums are flexible prior to termination of this policy. Nonparticipating - no dividends will be payable.