ANTI-FRAUD PLAN.
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FOR
The Legal & General America Companies:
Legal & General America, Inc.
Banner Life Insurance Company
William Penn Life Insurance Company of New York
First British American Reinsurance Company II
First British Vermont Reinsurance Company II
First British Bermuda Reinsurance Company II, Ltd

Hereinafter individually called the “Company” and collectively the “Companies”

STATEMENT OF POLICY

Legal & General America, Inc. and its subsidiaries Banner Life Insurance Company and William Penn Life Insurance Company of New York (hereafter referred to as the Company or collectively, the Companies) are licensed for life insurance and annuity lines of business. The Companies do not tolerate fraud, be it internal or external, and whether perpetrated by outsiders, customers, producers, executives, or staff.

All suspected fraud involving the Companies, in any way and in any form, will be fully investigated. Where appropriate, the fraud will be reported to law enforcement and/or regulatory authorities and those implicated will be pursued through the courts to seek conviction and the recovery of assets or restitution.

PURPOSE

The purpose of the Companies’ anti-fraud plan is to establish consistent and responsible actions to prevent and detect fraudulent activity which the Companies may encounter. This document outlines the responsibilities of the Companies and all individuals employed by or affiliated with the Companies to ensure the following:

• A climate of honesty that does not tolerate fraud.
• All suspected fraud is handled consistently by the appropriate staff.
• A program exists to minimize exposure to fraud and maintain a fraud awareness culture that ensures that staff reports all irregularities to the appropriate staff.
• All reported incidents are appropriately investigated and reported to appropriate levels.
• Appropriate disciplinary action is taken upon completion of the investigation.

EDUCATION & TRAINING

Employees
All employees are required to read and follow the Companies’ Anti-Fraud Plan, which is available on the Company intranet (Employee Handbook). The Companies’ operating and business units are expected to have established policies and procedures that shall be published in manuals and/or on-line and are available to appropriate staff. These policies and procedures will contain specific internal controls that have been designed to prevent and detect fraud. On the job training for new and existing employees shall include training to promote an understanding of the policies, procedures, and internal controls specific to the department and job position. Management will emphasize the importance of adhering to these policies, procedures, and internal controls to discourage fraud and to heighten your awareness of suspicious acts. As needed, procedure manuals and internal controls shall be revised to
ANTI-FRAUD PLAN

incorporate enhanced and/or new policies and procedures to prevent and detect suspected fraudulent acts.

Training will address specific aspects of fraud associated with the Companies’ product lines. Training will include recognition and referral of suspicious claims. Because the Companies’ product lines include life insurance, training courses to appropriate personnel will address application fraud as application fraud is a type of fraud commonly associated with life insurance. Courses of instruction will be at least two hours in duration. New employees will receive education and training regarding the detection of fraud within six months of their effective date of employment. Employees will be presented with updated educational materials at the entrance level and at least once every two years. In-house underwriting staff will undergo annual fraud training as explained in greater detail in the Appendix to this Anti-fraud Plan. Training programs may be developed and conducted by internal Company personnel or outside contractors.

Training and education is further accomplished through attendance at professional and industry trade association seminars relative to your job and area of expertise. Membership in such associations also provides literature relative to the specific area of expertise which may include fraud related issues. All staff are encouraged to share information obtained at seminars, conferences and newsletters.

The Companies encourage and provide financial assistance for educational programs to develop and improve your life insurance-related professional qualifications. The education and training programs include, but are not limited to, courses related to the following programs: International Claims Association, Life Office Management Association, Life Underwriting Education Committee, Chartered Life Underwriter, and Society of Actuaries. Upon successful completion of selected programs, continuing education credits may be required, thereby requiring courses to be continuously completed. Participation in these programs is strongly encouraged.

Brokers/Agents (Insurance producers)¹

All brokers/agents and general agents distributing the Companies’ products are independent contractors. In signing an Agreement with the Company these independent insurance producers agree to abide by the covenants in the Agreement. The Agreement sets forth the responsibilities and limitations of authority as a representative of the Company(s). Many state insurance departments require brokers/agents to complete continuing education to maintain their life insurance license which is intended to enhance their education in insurance related matters.

The Companies offer to independent insurance producers who have an appointment with the Companies the opportunity to participate in training in the recognition and referral of suspicious claims. The Companies also periodically distribute guidelines and bulletins to general agents regarding insurance, product, market conduct and compliance related matters which may include information pertaining to prevention, identification, and notification of suspected fraudulent acts.

¹ The terms “brokers/agents” and “insurance producers” will be used interchangeably in this Anti-Fraud Plan.
ANTI-FRAUD PLAN

DETECTION

The Companies’ established policies, procedures, and internal controls in each functional area create an environment to deter and promptly detect suspected fraudulent acts.

The Internal Audit department performs reviews of the Companies’ functional areas based upon a cycle determined by the overall risk assessment and available resources. The purpose of an audit is to identify weaknesses in control systems which have resulted in, or may result in errors and irregularities and to make recommendations for improvement. At the conclusion of an audit, a report is issued to management which includes a summary of the scope and purpose of the audit, the findings and agreed actions for improvement or corrective action. Should an irregularity be detected, or fraudulent activity suspected, during the course of an audit, Internal Audit will report it in accordance with the notification and investigation procedures. Internal Audit’s function of regularly and systematically monitoring internal controls is essential to the company’s anti-fraud efforts in that it identifies and reduces risks of errors and fraudulent activity.

The VP Internal Audit is a certified public accountant (CPA) and reports directly to the Board of Directors’ Audit Committee and the Chief Auditor of the parent company. The internal auditors on staff are encouraged to complete their auditing certifications, such as CPA, CIA, (certified internal auditor), CISA, (certified information systems auditor) or CFE, (Certified Fraud Examiner). All auditors on staff are required to obtain 40 continuing professional education credit hours every year, of which some of the courses are related to fraud issues.

The Legal Department works with the individual departments to ensure compliance with new and existing industry rules and regulations and provides advice to management on compliance issues. The Compliance & Regulatory Counsel is involved with the review of product and agent marketing material; monitors consumer complaints and broker/agent activities and provides recommendations for disciplinary action, when appropriate. In the course of these monitoring activities, if a fraudulent act is suspected, the Compliance and Regulatory Counsel will report it in accordance with the anti-fraud plan notification and investigation procedures. The Compliance & Regulatory Counsel reports to the General Counsel.

NOTIFICATION AND PROCEDURES FOR HANDLING FRAUD COMPLAINTS

The General Counsel for the Companies has been appointed to oversee the Companies’ anti-fraud efforts. You are to report suspected fraud to your manager or directly to the General Counsel. Any manager who has an employee report a suspected fraud is expected to immediately notify the General Counsel. If, for any reason, an employee is not comfortable reporting a suspected fraud to his or her manager or the General Counsel, the employee may report the information to the Company’s Whistleblower Hotline at 855-490-1548 on either an anonymous or attribution basis in accordance with the Companies’ Whistleblower Policy. Upon notification, the General Counsel or his designee will make an initial assessment as to whether the circumstance appears to be fraudulent. If the General Counsel determines that a report of suspected fraud warrants a full investigation, or an instance of suspected fraud has been detected, evaluated and found to warrant a full investigation, an internal investigation shall commence to determine the validity of the suspicions raised and the General Counsel will notify the following individuals of the situation: Chief Executive Officer, Chief Financial Officer, VP Internal Audit, Vice President of Human Resources, and Compliance & Regulatory Counsel.
ANTI-FRAUD PLAN

INVESTIGATION

The General Counsel and/or VP Internal Audit are responsible for conducting fraud investigations on behalf of the Companies. All investigations concerning reports of fraud shall be conducted on an internal basis under the direction of the General Counsel and/or VP Internal Audit. If upon initial review of the circumstances, it is determined that the cause of alarm is not the result of an error, a full investigation will be initiated. Each matter will be handled in a manner appropriate to its size and nature.

The General Counsel and/or VP Internal Audit will call upon the departments and specific individuals whose responsibilities are integral to the investigation. Investigations will include, as appropriate, interviews of individuals with knowledge or information potentially relevant to the suspected fraud and review of any relevant documents. No employee is to engage in any activities that impedes the investigation of suspected fraud. In extraordinary cases of suspected internal fraud, Internal Audit in consultation with the General Counsel may determine that an outside investigation or audit is warranted. If warranted, such investigation or audit will only be permitted by those with specific experience, training and proper licensing.

All claims submitted within the policy’s contestable period (within two years of policy issue) are fully investigated under the guidance and direction of Claims Management. They will call upon the departments and specific individuals whose responsibilities are integral to the investigation and may also enlist the help of an outside investigator(s), if necessary for external investigations. Outside investigations will only be permitted by those with specific experience, training and proper licensing. If fraud or misrepresentation is suspected it is brought to the attention of appropriate management and will be reported in accordance with the notification procedures. Appropriate rescission action is taken based on applicable state law.

The Companies’ Claims Management team has extensive training in all facets of insurance claims handling and continuously keeps abreast of insurance claims and fraud related matters by regularly attending conferences and seminars relative to the claims area of expertise.

REPORTING

The General Counsel and/or VP Internal Audit will issue an initial briefing report to be distributed to officers listed in the notification section. This report will provide a summary of the problem, an outline of procedures for the investigation, liaison with or notification to the police and/or regulatory authorities, insurance coverage implications, press implications, regulatory issues, other areas of the business for which the fraud might be relevant, the reporting timetable of the investigation and any other relevant information.

Upon completion of the investigation, a final report covering all aspects of the case will be produced to provide a formal record of the events and resultant action. Content of this report will include the circumstances of the fraud and its discovery, the amounts involved, insurance position, regulatory position, whether action has been taken to seek restitution, any legal actions initiated or pending, necessary controls to stop future abuse and implementation schedule for improvements.

If the General Counsel in good faith has cause to believe that insurance fraud has been or is being committed, the General Counsel shall report the suspected fraud in writing to the appropriate insurance fraud department and/or to the appropriate federal, state and local law enforcement authorities on an incidental basis, including the Insurance Fraud Division of the...
ANTI-FRAUD PLAN

Maryland Insurance Administration for cases of suspected insurance fraud occurring in Maryland or with respect to Maryland insureds.

The Companies shall cooperate with the appropriate law enforcement agency, or the Insurance Fraud Division of the Maryland Insurance Administration, in any criminal investigation, including, to the extent appropriate, making employees available to provide courtroom testimony and providing work product of its investigation. Although the Companies seek to cooperate fully with the Insurance Fraud Division and law enforcement agencies in the prosecution of perpetrators of fraud, the Companies reserve the right to protect any trade secrets, proprietary information, privileged information and/or attorney work product from disclosure to the full extent permitted by law.

This Anti-Fraud plan, including the reporting policies contained herein, shall be maintained in the General Counsel’s office and shall be open for inspection by the Maryland Insurance Administration. The Companies shall also maintain appropriate records for the Maryland Insurance Administration to determine the effectiveness of this Anti-Fraud Plan.

REFERRAL FOR PROSECUTION

The Chief Executive Officer will make the final decision regarding the practicality or economic feasibility of seeking restitution from the perpetrators of a fraudulent act. Once the decision to seek recovery has been made, the General Counsel or his nominee is responsible for informing the appropriate law enforcement agency and the insurance fraud departments.

Prosecution will be sought based not only on the financial position, but also in circumstances in which public interest or corporate benefit will be achieved even when smaller amounts are involved. Offenders will be prosecuted where appropriate. General Counsel shall act as liaison with the appropriate authorities and attorneys or consultants hired by the Companies to attempt recovery.

Requests from law enforcement officers to assist with their investigation of a suspected fraud involving an employee or agent of the Companies must be approved by the General Counsel or his nominee. If you receive a direct request in respect of a matter that affects or is likely to concern the Companies, it must be given to the General Counsel or any specific person he nominates. To safeguard Legal & General America’s statutory duty to protect certain information against disclosure, it may be necessary to require a legal mandate before releasing information as evidence.

ANNUAL REPORTING TO STATE DEPARTMENT OF INSURANCE

Internal Audit and/or the Legal Department will maintain all documentation pertaining to fraud investigations, with the exception of investigations pertaining to claims which will be retained by the Claims Department. If required by a state, the General Counsel or his designee will file an annual report of fraud related data to the appropriate Department of Insurance reporting the previous year’s fraud investigations.
ANTI-FRAUD PLAN

APPENDIX

FRAUD DETECTION PROCEDURES

The policies, procedures and internal controls noted below create an environment to enable the Companies to deter or promptly detect suspected fraudulent acts.

Claims
Each claim is individually reviewed, information is verified, and payment approved (per delegation of authority) before any claim funds are distributed. Required documentation is obtained and includes, but is not limited to, the completed Claimant Statement, the life insurance contract or Lost Policy Affidavit, and the certified death certificate. In so far as our exposure to possible fraud relates to life insurance claims, particular attention is paid to evidence of, and due proof of the death of the insured. Insurable interest issues are also examined. All foreign death claims are scrutinized and an independent investigation and verification of the death of the insured may be made. Check disbursements are processed in accordance with the company’s accounts payable procedures.

For contestable claims (within two years of policy issue), a comprehensive investigation using outside investigative services is initiated to gather documentation and to interview relevant witnesses. Included in the investigation, but not limited to, are issues relating to the cause of death, place of death, financial history of the insured, medical history, relationship of the beneficiary and the sales transaction. If any irregularities are discovered, the claim is immediately brought to the attention of the claims AVP. If there are sufficient indicators of the commission of a fraud, the suspected fraudulent activity is immediately referred to the company’s fraud officer as well as the proper legal authorities. Rescission action may be taken based on applicable state law.

As a tool for the early detection of claims fraud, all claims personnel also have a list of red flag indicators that they refer to at the time of claim notification. These procedures are included in a claims procedures manual. The following are examples of red flag indicators that may trigger further investigation: (i) death has taken place outside of the country; (ii) cause of death “undetermined” or (iii) dates on documents are inconsistent with normal business days. The existence of red flags may warrant further investigation as to whether insurance fraud is suspected.

Broker/Agent Activities
Regional vice presidents, senior account managers and marketing coordinators act as liaisons between the Companies and the brokerage general agencies. The staff is knowledgeable of relevant company policies and procedures and can identify activities that are not in compliance with the Companies procedures or established rules. In accordance with this policy, marketing staff will report any identified concerns as appropriate.

All broker/agent licensing, contracting, appointments and terminations are processed in the Administrative Services Department. The selection process requires a broker/agent to complete a background information questionnaire which the general agent is required to review and sign thereby recommending the broker/agent for contracting. If the information provided by the broker/agent indicates any adverse history a further background investigation will be conducted and contracting will be decided by Sales and Compliance management.
ANTI-FRAUD PLAN

Advertising and sales literature created by a broker/agent or general agent is required to be submitted for review and approval before use. All material is reviewed by the Compliance & Regulatory Counsel and comments are returned to the originator. A reminder of the advertising review procedure is sent quarterly.

Agent/agency checks are not acceptable as payment of premium and if received, the check is returned.

Disbursements (e.g. loans, surrenders, premium refunds) are analyzed by staff in the Premium Administrative Center. Payees on checks are restricted to the policy owner named in the policy record within the policy administration system. Changes of address generate confirmation letters that are sent to the policy owner’s old and new address.

All written policyholder complaints are recorded in a complaint log. This log is monitored by the Compliance & Regulatory Counsel to detect any patterns by a broker/agent or agency. If so detected, the activities will be investigated and the broker/agent referred to management for review and disciplinary action, if warranted.

Auditing of Brokers/Agents
All brokers/agents and general agents representing the Companies are independent contractors. The Companies shall perform routine and random audits of insurance producers appointed by the Companies.

Broker/agent activity in the areas of sales, service, and policy transactions are reviewed to detect patterns which may be an indication of potential market conduct and/or fraudulent activity. This review includes customer complaints, advertising and sales presentations/practices, replacements, premium collection, temporary insurance agreement and application, client confidentiality, policy delivery, suitability and claims.

Fraudulent insurance acts include misappropriation or withholding unreasonably funds received or held by insurance producers if the funds represent premiums or return premiums. In an effort to detect such fraud, the Companies’ insurance producer audits may include reconciling premium records.

If an irregularity is detected, the circumstances of the case will be reviewed to determine if fraud is suspected. The General Counsel shall be notified immediately of all irregularities discovered during an insurance producer audit.

Underwriting
Annually, fraud related training is provided in-house to all underwriting staff. Training covers well known fraud “red flags” as well as high profile current events and topics. All personnel integral to fraud identification have been provided with a list of potential red flags that are referred to during the review of the application data and title, beneficiary and other policy changes.

For each proposed insured, an MIB report is obtained. Through MIB reports the underwriter is alerted to whether the proposed insured has any prior medical or non-medical history that may not have been disclosed on the application. An underwriter will then attempt to secure additional medical information through various sources and methods including requesting details of any MIB code reports made by other companies. This process may indicate potential
ANTI-FRAUD PLAN

fraud by non-disclosure of health and other non-medical problems. In addition, the Company subscribes to additional MIB services that provide alerts when reports on an insured are received subsequent to original policy issuance and through the two-year contestability period. This allows Underwriting to evaluate the subsequent information to determine the potential for fraud or misrepresentation at the time of application.

The Companies have a Special Investigative Unit (SIU) that is under the management of the AVP of Claims. Suspected external fraud is referred to the SIU for handling. The Companies have developed a system which is designed to detect potential fraud at the time an application is submitted to the Companies. This system reviews all new applications on a weekly basis utilizing a list of red flags. All applications that meet certain red flag criteria are further reviewed by the Companies’ SIU personnel, who then refer the information to the underwriting director for further consideration. Those selected policies are subject to final review and approval by underwriting management and the company’s SIU. A similar system has been designed to detect potential fraud utilizing red flag criteria with policy change requests which occur within eighteen months from the policy issue date. After further review by SIU personnel, any suspected fraud is referred to a group consisting of underwriting management, SIU personnel and legal for additional evaluation.

The Companies have also instituted a program called “Instant ID”, whereby application data including the name, DOB, SSN and address for all new proposed insured’s are automatically compared with information retained by an outside public records vendor. All discrepancies are first reviewed by the Companies’ New Business Department. If the discrepancies are not resolved, it is referred to the SIU for further investigation and research.

A review system similar to the one referred to for new business has been designed to detect potential fraud utilizing red flag criteria associated with policy change and verification of coverage requests that occur within eighteen months from the policy issue date. After further review by dedicated investigative personnel, any suspected fraud is referred for additional evaluation to a group consisting of underwriting, investigative and legal staff.

Internal Fraud

Embezzlement and internal theft are types of fraud that can occur within an insurer. The Companies aim to or detect at the earliest possible time any instances of embezzlement and internal theft.

The standard internal controls in place in the financial operations area are effective measures to either prevent or detect fraud including embezzlement and internal theft. The internal controls include, but are not limited to the following:

- Individuals are given disbursement approval authority based on their job function.
- Individuals may not approve checks payable to themselves.
- Checks > $4,999 must be manually signed by an authorized signer.
- Checks > $49,999 must be manually signed by two authorized signers.
- Check requisitions must include appropriate supporting documents (invoice).
- All checks are matched to supporting documentation prior to release.
- All check numbers are accounted for daily.

9
ANTI-FRAUD PLAN

• Cash is deposited and applied to customer accounts by individuals in different departments.
• Travel & Expense reports are reviewed for compliance with corporate guidelines prior to reimbursement.
• Bank reconciliations are prepared on a monthly basis. Any checks cleared but not on written lists are investigated.
• Monthly account detail is distributed to each cost center manager. Variances from budget of >$5,000 must be explained.
• In conjunction with the quarterly financial statement process, detailed analysis is prepared on financial statement line items.
• The Company sends a daily file to the bank that lists all checks issued. Each day, the Company receives an exception report from the bank, identifying any checks presented that were not included on the lists. Finance reviews each of the items reported and provides instructions to the bank about whether to approve or deny the check. A formal process has been established to validate the legitimacy of new vendors.
• Individuals who prepare a check requisition must be someone other than the approver to ensure two persons from the business area are involved with the payment request.
• Logical security controls exist to ensure that access to banking and check printing applications is appropriately restricted as well as physical security controls to the check printing environment.

Any suspicious activity noted by Finance staff would first be reported to the Chief Financial Officer who would then report this information to the General Counsel. The internal control procedures are designed to prevent or detect material fraud. Each individual is trained in their job responsibilities which include these various internal control procedures.