

SERFF Tracking Number: NYAA-126753981 State: Arkansas
Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 46659
Company Tracking Number:
TOI: A02G Group Annuities - Deferred Non-variable Sub-TOI: A02G.003 Single Premium
Product Name: Surrender Charge Reduction Rider
Project Name/Number: /

Filing at a Glance

Company: New York Life Insurance and Annuity Corporation

Product Name: Surrender Charge Reduction Rider SERFF Tr Num: NYAA-126753981 State: Arkansas

TOI: A02G Group Annuities - Deferred Non-variable SERFF Status: Closed-Approved- Closed State Tr Num: 46659

Sub-TOI: A02G.003 Single Premium Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird

Author: Gina Babka Disposition Date: 09/02/2010

Date Submitted: 08/31/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
Project Number: Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Overall Rate Impact: Group Market Type: Association
Filing Status Changed: 09/02/2010 Explanation for Other Group Market Type:
State Status Changed: 09/02/2010

Deemer Date: Created By: Gina Babka
Submitted By: Gina Babka Corresponding Filing Tracking Number:

Filing Description:

Re: Group Home Health Care Surrender Charge Reduction Certificate Rider -

Form No. DA-HHCR

NAIC # 91596

FEIN # 13-3044743

The above referenced form is enclosed. The form is new and does not replace any existing forms.

Form DA-HHCR provides an increase in the annuity's surrender charge penalty free percentage previously approved

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annuities and any other future approved forms as applicable. The base contracts are group annuities delivered to the policyholder AARP sitused in the District of Columbia, under the AARP Fixed Annuity Program. The base certificates were approved by your department on under SERFF filing # .

We wish to certify that there is no discernible premium for this certificate rider.

Thank you for your attention to this form filing. Please review the enclosed item and provide us with your approval. We look forward to your early review and acceptance of this submission. If additional information is needed, please contact Gina Babka. Her contact information is shown at the bottom of this letter.

Sincerely yours,

Mike Horan
Corporate Vice President
New York Life Insurance and Annuity Corporation

Gina Babka
Senior Contract Consultant
Tel # (800) 595 3869, ext. 5717 (direct: 813-288-5717);
Fax # (813) 288 5773; or
E-mail address: Gina_Babka@NYLAARP.newyorklife.com

Company and Contact

Filing Contact Information

Gina Babka, Compliance Consultant Gina_Babka@NYLAARP.newyorklife.com
5505 West Cypress Street 813-288-5717 [Phone]
Tampa, FL 33607 813-288-5773 [FAX]

Filing Company Information

New York Life Insurance and Annuity Corporation CoCode: 91596 State of Domicile: Delaware
5505 West Cypress Group Code: 86 Company Type:
Tampa, FL 33607 Group Name: State ID Number:
(800) 595-3869 ext. 5717[Phone] FEIN Number: 13-3044743

SERFF Tracking Number: NYAA-126753981 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: 1 filing x 1 \$50.00 filing fee = \$50.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
New York Life Insurance and Annuity Corporation	\$50.00	08/31/2010	39132673

SERFF Tracking Number: NYAA-126753981 State: Arkansas
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Company Tracking Number:
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/02/2010	09/02/2010

SERFF Tracking Number: NYAA-126753981 *State:* Arkansas
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Corporation
Company Tracking Number:
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Product Name: Surrender Charge Reduction Rider
Project Name/Number: /

Disposition

Disposition Date: 09/02/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NYAA-126753981 State: Arkansas

Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 46659

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Out of State Group Master Policy Rider - Informational ONLY		Yes
Supporting Document	Transmittal		Yes
Form	Out of State Group Surrender Charge Reduction Reduction Rider		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	DA-HHCR	Certificate	Out of State Group Amendments, Insert Page, Rider Endorsement or Rider	Initial		50.800	DA - HHC Home Health Care Rider.pdf



New York Life Insurance and Annuity Corporation
Executive Office - 51 Madison Avenue, New York, NY 10010
Home Office – Newark, Delaware

CERTIFICATE RIDER

to be attached to and made a part of the BASE CERTIFICATE

AARP HOME HEALTH CARE SURRENDER CHARGE REDUCTION RIDER (GROUP DEFERRED ANNUITY RIDER)

DEFINED TERMS ARE ALL CAPITALIZED. PLEASE REFER TO THE DEFINITIONS OF THIS RIDER AND THE BASE CERTIFICATE.

[The Penalty Free Percentage increase described in this Certificate Rider is not available if any OWNER has attained age [86] on the ISSUE DATE.]

HOME HEALTH CARE

If YOU qualify, YOU may elect to increase the Penalty Free Percentage as shown on the Individual Schedule of Benefits by [10%].

At the time of each PARTIAL SURRENDER or Full Surrender (“Surrender”), to qualify to for an increased Penalty Free Percentage for the Surrender:

- a) the BASE CERTIFICATE must have completed its initial CERTIFICATE YEAR; and
- b) the ACCOUNT VALUE must be at least \$5,000; and
- c) an OWNER must have received Health Care Services for at least sixty (60) days during the last six (6) months.

WE reserve the right, at the time YOU request the Surrender, to require satisfactory proof that YOU have had a QUALIFYING EVENT or to have YOU examined by a licensed physician of OUR choice, at OUR expense.

During a CERTIFICATE YEAR, this Rider may not be combined with any other riders which increase the Penalty Free Percentage, as shown on the Individual Schedule of Benefits.

PROOF OF HOME HEALTH CARE

To qualify for this Penalty Free Percentage increase, an OWNER must submit:

- a) a bill or invoice from a HOME HEALTH CARE PROVIDER evidencing that the OWNER has received home health care services for at least sixty (60) days during the last six (6) months; and
- b) a licensed physician’s referral for home health care services.

DEFINITIONS

BASE CERTIFICATE

BASE CERTIFICATE means the Certificate to which this Certificate Rider is attached. The BASE CERTIFICATE represents the coverage under the POLICY as described therein.

HOME HEALTH CARE PROVIDER

An organization or individual that is licensed to provide home health care to chronically ill individuals in their home or residence for an hourly or daily charge.

QUALIFYING EVENT

An OWNER, after the ISSUE DATE: a) begins receiving home health care services from a HOME HEALTH CARE PROVIDER as referred by a licensed physician; and b) receives home health care services for sixty (60) days during the last six (6) months.

Secretary

President

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Arkansas Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Out of State Group Master Policy Rider - Informational ONLY		
Comments:		
Attachment: DA - P-HHCR Home Health Care Rider.pdf		

	Item Status:	Status Date:
Satisfied - Item: Transmittal		
Comments:		
Attachment: AR - GMR-HHCR Transmittal.pdf		

Arkansas Certification

I, Michael Horan, hereby certify the submission of the Out of State Group Annuity product DA-HHCR GMR-DAN meets the provisions of Ark. Code Ann. 23-79-138, Bulletin 11-88 and Regulation 19s10 as well as all applicable requirements of the Arkansas Department of Insurance.

I also certify that each certificate holder is provided with a Guaranty Association Notice and contact information, including telephone number and address, for New York Life and the Arkansas Department Of Insurance.



Michael Horan, CVP



New York Life Insurance and Annuity Corporation
Executive Office - 51 Madison Avenue, New York, NY 10010
Home Office – Newark, Delaware

POLICY RIDER

to be attached to and made a part of the POLICY

**AARP HOME HEALTH CARE SURRENDER CHARGE REDUCTION RIDER
(GROUP DEFERRED ANNUITY RIDER)**

DEFINED TERMS ARE ALL CAPITALIZED. PLEASE REFER TO THE DEFINITIONS OF THIS RIDER AND THE POLICY.

[The Penalty Free Percentage increase described in this Certificate Rider is not available if any OWNER has attained age [86] on the ISSUE DATE.]

HOME HEALTH CARE

If the CERTIFICATE OWNER qualifies, the CERTIFICATE OWNER may elect to increase the Penalty Free Percentage of the annuity by [10%].

At the time of each PARTIAL SURRENDER or Full Surrender (“Surrender”), to qualify to for an increased Penalty Free Percentage for the Surrender:

- a) the annuity must have completed its initial CERTIFICATE YEAR; and
- b) the annuity’s ACCOUNT VALUE must be at least \$5,000; and
- c) a CERTIFICATE OWNER must have received Health Care Services for at least sixty (60) days during the last six (6) months.

WE reserve the right, at the time the CERTIFICATE OWNER requests the Surrender, to require satisfactory proof that the CERTIFICATE OWNER has had a QUALIFYING EVENT or to have the CERTIFICATE OWNER examined by a licensed physician of New York Life’s choice, at New York Life’s expense.

During a CERTIFICATE YEAR, this Rider may not be combined with any other riders which increase the Penalty Free Percentage of the annuity.

PROOF OF HOME HEALTH CARE

To qualify for this Penalty Free Percentage increase, the CERTIFICATE OWNER must submit:

- a) a bill or invoice from a HOME HEALTH CARE PROVIDER evidencing that the OWNER has received home health care services for at least sixty (60) days during the last six (6) months; and
- b) a licensed physician’s referral for home health care services.

DEFINITIONS

HOME HEALTH CARE PROVIDER

An organization or individual that is licensed to provide home health care to chronically ill individuals in their home or residence for an hourly or daily charge.

QUALIFYING EVENT

A CERTIFICATE OWNER, after the ISSUE DATE: a) begins receiving home health care services from a HOME HEALTH CARE PROVIDER as referred by a licensed physician; and b) receives home health care services for sixty (60) days during the last six (6) months.

Secretary

President

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address

5.	Requested Filing Mode	<input type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	
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7.	<input type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
		Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9.	Type of Insurance	
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10.	Product Coding Matrix Filing Code	
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11.	Submitted Documents	<p><input type="checkbox"/> FORMS</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Policy</td> <td><input type="checkbox"/> Outline of Coverage</td> <td><input type="checkbox"/> Certificate</td> </tr> <tr> <td><input type="checkbox"/> Application/Enrollment</td> <td><input type="checkbox"/> Rider/Endorsement</td> <td><input type="checkbox"/> Advertising</td> </tr> <tr> <td><input type="checkbox"/> Schedule of Benefits</td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p>Rates</p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate	<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate	<input type="checkbox"/> Application/Enrollment	<input type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising	<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other		
<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate										
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<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other											
		<input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____										
		<p>SUPPORTING DOCUMENTATION</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Articles of Incorporation</td> <td><input type="checkbox"/> Third Party Authorization</td> </tr> <tr> <td><input type="checkbox"/> Association Bylaws</td> <td><input type="checkbox"/> Trust Agreements</td> </tr> <tr> <td><input type="checkbox"/> Statement of Variability</td> <td><input type="checkbox"/> Certifications</td> </tr> <tr> <td><input type="checkbox"/> Actuarial Memorandum</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization	<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements	<input type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications	<input type="checkbox"/> Actuarial Memorandum		<input type="checkbox"/> Other _____	
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<input type="checkbox"/> Actuarial Memorandum												
<input type="checkbox"/> Other _____												

12.	Filing Submission Date		
13.	Filing Fee (If required)	Amount _____	Check Date _____
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval		
15.	Filing Description:		

16.	Certification (If required)
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of _____.</p>	
<p>Print Name _____ Title _____</p>	
<p>Signature _____ Date: _____</p>	

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

LH RFA-1