STATE OF ARIZONA
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DEPT. OF INSURANCE

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

CIVIL SERVICE EMPLOYEES INSURANCE COMPANY

NAIC #10693

AS OF

DECEMBER 31, 2008

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Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street
Suite 210, Second Floor
Phoenix, Arizona 85108-7256

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, an examination has been made of the market conduct affairs of the:

CIVIL SERVICE EMPLOYEES INSURANCE COMPANY
NAIC # 10693

The above examination was conducted by William Hobert, Examiner-in-Charge, and Market Conduct Examiners Laura Sloan-Cohen, AIE and Robert De Berge.

The examination covered the period of January 1, 2008 through December 31, 2008.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Helene I. Tomme

Helene I. Tomme, CPCU, CIE
Market Conduct Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

William P. Hobert being first duly sworn, states that I am a duly appointed Market Conduct Examinations Examiner-in-Charge for the Arizona Department of Insurance. That under my direction and with my participation and the participation of Market Conduct Examiners Laura Sloan-Cohen, AIE and Robert De Berge on the Examination of Civil Service Employees Insurance Company, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss this Report, but a copy was not provided to management as the Examination was incomplete and had not yet been finalized. The information contained in this Report, consists of the following pages, is true and correct to the best of my knowledge and belief and that any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

William P. Hobert, CPCU, CLU, CIE
Market Conduct Examiner-in-Charge
Market Oversight Division

Subscribed and sworn to before me this 25th day of November, 2009.

Notary Public

My Commission Expires 06/25/2013

VERONICA STAUDINGER HUGHES
NOTARY PUBLIC - ARIZONA
MARICOPA COUNTY
My Commission Expires
June 25, 2013

FOREWORD

This target market conduct examination report of Civil Service Employees Insurance Company (herein referred to as the "Company"), was prepared by employees of the Arizona Department of Insurance (Department) as well as independent examiners contracting with the Department. A target market conduct examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the state of Arizona. The examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158 and 20-159. The findings in this report, including all work product developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of the following Private Passenger Automobile (PPA) and Homeowners (HO) lines of business operations:

1. Complaint Handling
2. Marketing and Sales
3. Producer Compliance
4. Underwriting and Rating
5. Cancellations and Non-Renewals
6. Claims Processing

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The target market conduct examination of the Company covered the period of

January 1, 2008 through December 31, 2008 for business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws, and whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report and the results are reported beginning on page 7.

In accordance with Department procedures, the examiners completed a Preliminary Finding ("Finding") form on those policies, claims and complaints not in apparent compliance with Arizona law. The finding forms were submitted for review and comment to the Company representative designated by Company management to be knowledgeable about the files. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action.

The examiners utilized both examinations by test and examination by sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examination by test and by sample were completed without the need to utilize computer software.

File sampling was based on a review of underwriting and claim files that were systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company. Samples are tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data will result in an exception ratio, which determines whether or not a standard is met. If the exception ratio found in the sample is, generally less than 5%, the standard will be considered as "met." The standard in the areas of procedures and forms use will not be met if any exception is identified.

HISTORY OF THE COMPANY

The Company is part of the Civil Service Employees Insurance Group (CSE). The Company was founded in 1949 in San Francisco, California with the goal of furnishing insurance at competitive rates for civil servants. The Company initially used firefighters, police officers, postal workers, and other government workers as its sales force and wrote PPA insurance, and later all personal lines. In 1984, CSE Safeguard was incorporated to write qualified risks for non-civil servants, thereby expanding its offerings to the general public.

The Company's headquarters are at 50 California Street, 25th Floor, San Francisco, CA 94111-4624. Claims, operations, underwriting, and marketing are done at 2121 North California Blvd., Walnut Creek, California 94596. Regional claims offices are in Pasadena and Sacramento. The Company's products are marketed through more than 700 independent agents in Arizona, California, Nevada and Utah. The Company has an A- rating with AM Best.

PROCEDURES REVIEWED WITHOUT EXCEPTION

The examiners review of the following Company departments[1] or functions indicates that they appear to be in compliance with Arizona statutes and rules:

Complaint Handling   Producer Compliance   Marketing and Sales

EXAMINATION REPORT SUMMARY

The examination revealed twelve (12) compliance issues that resulted in 119 exceptions due to the Company's failure to comply with statutes and rules that govern all insurers operating in Arizona. These issues were found in three (3) of the six (6) sections of Company operations examined. The following is a summary of the examiners' findings:

Underwriting and Rating

In the area of Underwriting and Rating, one (1) compliance issue is addressed in this report as follows:

- The Company failed to provide eleven (11) PPA insureds the reason for their premium increase was due to a chargeable accident; and

Cancellation and Non-Renewals

In the area of Cancellations and Non-Renewals, two (2) compliance issues are addressed in this report as follows:

- The Company failed to provide a complete Summary of Rights with two (2) HO underwriting cancellations, two (2) HO non-renewals and four (4) PPA non-renewals; and

[1] If a department name is listed there were no exceptions noted during the review.

- The Company failed to provide four (4) PPA insureds a non-renewal notice and fifty (50) PPA insureds a nonpayment notice that contained the right to complain to the Director of the Company's action within ten (10) days after the insured's receipt of the notice.

Claims Processing

In the area of Claims Processing, nine (9) compliance issues are addressed in this report as follows:

- The Company failed to complete the investigation of four (4) HO claims on a timely basis.
- The Company failed on one (1) claim authorization form to specify the types of persons authorized to disclose information about the individual.
- The Company failed on four (4) claim authorization forms to specify the length of time the authorization remains valid shall be no longer than the duration of the claim.
- The Company failed on four (4) claim authorization forms to advise a person authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form.
- The Company failed to accurately identify the state statutes and Insurance Department in its claim correspondence with nineteen (19) claimants.
- The Company failed on two (2) claim forms to include a fraud warning statement.
- The Company failed to correctly calculate and fully pay:
  (a) sales tax in the settlement of two (2) first and three (3) third party PPA total losses, and
  (b) fees in the settlement of one (1) first and four (4) third party PPA total losses.
- The Company failed to reimburse two (2) insureds their deductible on a timely basis after subrogation recovery.

FACTUAL FINDINGS

RESULTS OF PREVIOUS MARKET EXAMINATIONS

During the past three (3) years, the Company had one (1) market conduct examination conducted by the state of Washington. The Company indicated that California recently did an examination but it has not yet been resolved.

FACTUAL FINDINGS

UNDERWRITING AND RATING

Private Passenger Automobile (PPA):

The examiners reviewed:

(1) fifty (50) PPA new business and/or renewal policies from a population of 4,042; and
(2) fifty (50) PPA surcharged policies from a population of 205.

Homeowners (HO):

The examiners reviewed:

(1) fifty (50) new business and/or renewal policies from a population of 2,103.

The following Underwriting and Rating Standards were met:

#	STANDARD	Regulatory Authority
1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company Rating Plan.	A.R.S. §§ 20-341 through 20-385
3	All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations, including, but not limited to, the Notice of Insurance Information Practices and the Authorization for Release of Information.	A.R.S. § 20-2104, 20-2106, 20-2110, 20-2113
4	All forms and endorsements forming a part of the contract should be filed with the director (if applicable).	A.R.S. § 20-398
5	Policies and endorsements are issued or renewed accurately, timely and completely.	A.R.S. §§ 20-1120, 20-1121, 20-1654
6	Rescissions are not made for non-material misrepresentations.	A.R.S. §§ 20-463, 20-1109

The following Underwriting and Rating Standard failed:

#	STANDARD	Regulatory Authority
2	Disclosures to insureds concerning rates and coverage are accurate and timely.	A.R.S. §§ 20-259.01, 20-262, 20-263, 20-264, 20-266, 20-267, 20-2110

Preliminary Findings #11 – Chargeable Accident Notification - The Company failed to inform eleven (11) insureds the reason for a premium increase was an at-fault chargeable accident. These represent eleven (11) violations of A.R.S. § 20-263.

PPA NEW, RENEWAL SURCHARGED POLICIES

Failed to inform insureds of premium increase due to an at-fault chargeable accident
Violation of A.R.S. § 20-263

Population	Sample	# of Exceptions	% to Sample
205	54	11	20.4%

A 20.4% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #1

Within 90 days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place so that insureds whose policies are subject to premium increase due to an at-fault chargeable accident, are notified of the specific reason for that increase, in accordance with the applicable state statutes.

Subsequent Event

During the course of the examination, the Company provided the examiners a copy of their revised declaration page showing the reason for the increase. The Company provided examiners evidence these revisions were put into production 12/17/09.

FACTUAL FINDINGS

CANCELLATIONS AND NON-RENEWALS

Private Passenger Automobile (PPA):

The examiners reviewed:

(1) fifty (50) PPA non-payment cancellations from a population of sixty two (62); and
(2) all four (4) PPA non-renewals.

The Company did not cancel any policies for underwriting reasons during the exam period.

Homeowners (HO):

The examiners reviewed:

(1) both HO cancellations for underwriting reasons;
(2) all thirty seven (37) HO non-payment cancellations; and
(3) both HO non-renewals.

The following Cancellation and Non-Renewal Standard failed:

#	STANDARD	Regulatory Authority
1	Declinations, Cancellations and Nonrenewal shall comply with state laws and Company including the Summary of Rights to be given to the applicant and shall not be unfairly discriminatory.	A.R.S. §§ 20-448, 20-2108, 20-2109, 20-2110

Preliminary Finding #1 – Summary of Rights - The Company failed to provide eight (8) policyholders a complete Summary of Rights, when terminating coverage for an adverse underwriting decision. These represent eight (8) violations of A.R.S. §§ 20-2108, 20-2109 and 20-2110.

PPA NON-RENEWALS & HO CANCELLATIONS & HO NON-RENEWALS

Failed to provide an adequate Summary of Rights with adverse underwriting decision cancellation and non-renewal notices

Violation of A.R.S. §§ 20-2108, 20-2109 and 20-2110

Population	Sample	# of Exceptions	% to Sample
8	8	8	100%

A 100% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #2

Within 90 days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place so that the required Summary of Rights is sent with all adverse underwriting decision cancellation and non-renewal notices, in accordance with the applicable state statutes.

Subsequent Event

During the course of the examination, the Company provided the examiners a copy of the Company's revised Summary of Rights. The examiners confirmed the Company began 10/27/09 providing the corrected Summary with all adverse underwriting decision notices.

The following Cancellation and Non-Renewal Standard failed:

#	STANDARD	Regulatory Authority
2	Cancellation and Nonrenewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, nonrenewal based on condition of premises, and shall not be unfairly discriminatory.	A.R.S. §§ 20-191, 20-443, 20-448, 20-1631, 20-1632, 20-1632.01 20-1651-20-1656

Preliminary Findings #2 and #8 –Notice Failed to Include Right to Complain to Director - The Company failed to include with four (4) non-renewal notices and fifty (50) non-payment notices sent PPA insureds notice of their right to complain to the Director of the insurer's action within ten (10) days after receipt of the notice. These represent fifty four (54) violations of A.R.S. §§ 20-1632(A)(1), 20-1632.01(B) and the prior Consent Order.

PRIVATE PASSENGER AUTOMOBILE CANCELLATIONS

Failed to provide a notice that contained the right to complain to the Director of the insurer's action within ten (10) days after receipt of the notice by the insured.
Violation of A.R.S. §§ 20-1632(A)(1), 20-1632.01(B) and prior Consent Order

Population	Sample	# of Exceptions	% to Sample
54	54	54	100%

A 100% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #3

Within 90 days of the filed date of this report, provide documentation to the Department that Company procedures and controls are in place to ensure the cancellation notices contain the right to complain to the Director of the insurer's action within ten (10) days after receipt of the notice by the insured, in accordance with the applicable state statute.

Subsequent Event

During the course of the examination, the Company advised the examiners that the notice had been revised and was put into full production 10/27/09. A copy of the revision was provided.

FACTUAL FINDINGS

CLAIMS PROCESSING

Private Passenger Automobile (PPA):

The examiners reviewed:

(1) fifty two (52) paid claims from a population of 160;
(2) all nineteen (19) total loss claims;
(3) fifty two (52) claims closed without payment from a population of seventy (70); and
(4) all thirty nine (39) subrogation claims.

Homeowners (HO):

The examiners reviewed:

(1) all fifty (50) HO paid claims;
(2) all fourteen (14) claims closed without payment; and
(3) all ten (10) HO subrogations.

All claim files were reviewed to ensure compliance with Arizona Statutes and Rules.

The following Claim Processing Standards were met:

#	STANDARD	Regulatory Authority
1	The initial contact by the Company with the claimant is within the required time frame.	A.R.S. § 20-461, A.A.C. R20-6-801
4	Claim files are adequately documented in order to be able to reconstruct the claim.	A.R.S. §§ 20-461, 20-463, 20-466.03, A.A.C. R20-6-801
6	The Company uses reservation of rights and excess of loss letters, when appropriate.	A.R.S. § 20-461, A.A.C. R20-6-801
8	The Company responds to claim correspondence in a timely manner.	A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801
9	Denied and closed without payment claims are handled in accordance with policy provisions and state law.	A.R.S. §§ 20-461, 20-462, 20-463, 20-466, 20-2110, A.A.C. R20-6-801
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented.	A.A.C. R20-6-801
11	Adjusters used in the settlement of claims are properly licensed.	A.R.S. §§ 20-321 through 20-321.02

The following Claim Processing Standard failed:

2	Timely investigations are conducted.	A.R.S. § 20-461, A.A.C. R20-6-801

Preliminary Finding #4 - Timely Investigations - The Company failed to conduct a timely investigation on four (4) homeowner claims. These represent four (4) violations of A.R.S. § 20-461(A)(3) and A.A.C. R20-6-801(F).

HOMEOWNER CLAIMS PAID.
Failed to conduct timely investigations
Violation of A.R.S. § 20-461(A)(3) and A.A.C. R20-6-801(F)

Population	Sample	# of Exceptions	% to Sample
50	50	4	8.0%

An 8.0% error ratio does not meet the Standard; therefore a recommendation is warranted

Recommendation #4
Within 90 days of the filed date of this report, provide documentation to the Department that Company procedures and controls are in place to ensure that the Company completes any claim investigation on a timely basis, in accordance with the applicable state statute.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
3	The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations.	A.R.S. §§ 20-461, 20-466.03, 20-2106, A.A.C. R20-6-801

Preliminary Finding #7 – Authorization Disclosures – On the following claim authorization forms:

- Authorization to Obtain Information (Authorization to Obtain AZ 9-2005)
- Medical Authorization Form (Medauth ico AZ (9-2005))
- Wage Authorization Form (Wage Auth ICO AZ (9-2005))
- Authorization for the Release of Medical, Employment, Social Security, Scholastic and Insurance Records (Authorization 2003 HIPPA)

the Company failed to:

(a) specify the authorization remains valid for no longer than the duration of the claim;
(b) advise that a person authorized to act on behalf of the individual is entitled to receive a copy of the authorization form; and
(c) the Wage Authorization Form (Wage Auth ICO AZ (9-2005)) also failed to specify the types of persons authorized to disclose information about the individual.

These forms fail to comply with A.R.S. § 20-2106(3), (8)(b) and (9).

The following table summarizes these authorization form violations.

Form Description / Title	Form #	Statute Provision
Authorization to Obtain Information	Authorization to Obtain AZ 9-2005	8(b) and 9
Medical Authorization Form	Medauth ico AZ (9-2005)	8(b) and 9
Wage Authorization Form	Wage Auth ICO AZ (9-2005)	3, 8(b) and 9
Authorization for the Release of Medical, Employment, Social Security, Scholastic and Insurance Records	Authorization 2003 HIPPA	8(b) and 9

CLAIM FORMS

Failed to specify the types of persons authorized to disclose information about the individual
Violation of A.R.S. § 20-2106(3)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	1	N/A

Any error does not meet the Standard; therefore a recommendation is warranted.

Failed to specify the authorization remains valid for no longer than the duration of the claim
Violation of A.R.S. § 20-2106(8)(b)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	4	N/A

Any error does not meet the Standard; therefore a recommendation is warranted.

Failed to advise a person authorized to act on behalf of the individual is entitled to receive a copy of the authorization form
Violation of A.R.S. § 20-2106(9)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	4	N/A

Any error does not meet the Standard; therefore a recommendation is warranted.

Recommendation #5

Within 90 days of the filed date of this report, provide documentation to the Department that these forms specify, as needed, (a) the types of persons authorized to disclose information about the individual, (b) the authorization is valid for no longer than the duration of the claim, and (c) inform that a person authorized to act on behalf of the individual is entitled to receive a copy of the authorization form, in accordance with applicable state statute.

Subsequent Event

During the course of the examination, the Company provided examiners with corrected, compliant, Department approved copies of the forms. The Company stated the revised forms would be implemented on 12/1/09.

Preliminary Finding #9 – Wrong State Identified on Claim Correspondence - The Company failed to accurately identify the state statutes and Insurance Department in claim correspondence with nineteen (19) claimants. These represent nineteen (19) violations of A.R.S. § 20-461(A)(1).

The following table summarizes these claim correspondence findings.

ADOI I.D.	DOL	Correspondence		Incorrect Reference Made
		Date	Type	
PD Sample-01	2/13/08	N/A	Auto Body Repair Consumer Bill of Rights	CA Dept. of Consumer Affairs and CA Dept. of Insurance
PD-17	10/1/08	11/4/08	Repair Estimate Letter	CA Dept of Insurance
PD-19	10/7/08	10/22/08	Repair Estimate Letter	CA Dept of Insurance
PD-21	11/4/08	4/2/09	Betterment Letter	CA Dept of Insurance
PD-27	11/30/07	1/24/07	At-Fault Letter	California Law
PD-35	4/3/08	6/17/08	Comparative Negligence Letter	CA Dept of Insurance
PD-34	3/31/08	4/9/08	Claim Investigation Letter	California Law
PD-39	5/1/08	5/5/08	At-Fault Letter	California Law
PD-40	5/7/08	N/A	Auto Body Repair Consumer Bill of Rights	CA. Dept. of Consumer Affairs and CA Dept. of Insurance
PD-42	5/21/08	6/20/08	At-Fault Letter	California Law
PD-50	7/21/08	7/22/08	At-Fault Letter	California Law
CWP-06	1/2/08	N/A	Auto Body Repair Consumer Bill of Rights	CA. Dept. of Consumer Affairs and CA Dept. of Insurance
CWP-10	2/21/08	2/26/08	At-Fault Letter	California Law
CWP-17	5/21/08	6/20/08	At-Fault Letter	California Law
CWP-22	6/23/08	6/25/08	At-Fault Letter	California Law
CWP-25	7/6/08	7/22/08	At-Fault Letter	California Law
CWP-48	12/27/07	1/10/08	At-Fault Letter	California Law
CWP-52	4/23/08	N/A	Auto Body Repair Consumer Bill of Rights	CA. Dept. of Consumer Affairs and CA Dept. of Insurance
HOPD-35	8/6/08	9/30/08	ACV Settlement Breakdown	California Law

CLAIM CORRESPONDENCE

Failed to accurately identify Arizona statutes and Insurance Department in claim correspondence
Violation of A.R.S. § 20-461(A)(1)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	19	N/A

Any error does not meet the Standard; therefore a recommendation is warranted.

Recommendation #6

Within 90 days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure all correspondence between the Company and parties to a claim are not misleading and accurately identify the state statutes and the Department, in accordance with the applicable state statute.

Preliminary Finding #10 – Fraud Warning Statement – The Company failed to include the required fraud warning statement on two (2) claim forms. These represent two (2) violations of A.R.S. § 20-466.03

The following table summarizes the fraud warning statement findings:

	Specimen Form / Letter Description	Date	Form / Letter #	ADOI #
1	Affidavit of Vehicle Theft	None	AZ 9-2005	None
2	Authorization for the Release of Medical, Employment, Social Security, Scholastic & Insurance Records (HO)	None	Authorization 2003 HIPPA	None

CLAIM FORMS

Failed to include the fraud warning statement

Violation of A.R.S. § 20-466.03

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	2	N/A

Any error does not meet the Standard; therefore a recommendation is warranted.

Recommendation #7

Within 90 days of the filed date of this report, provide documentation to the Department that the required fraud warning statement, in 12-point type, is included on each of the claim forms cited, in accordance with the applicable state statute.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	A.R.S. §§ 20-268 20-461, 20-462, A.A.C. R20-6-801

Preliminary Finding #5 and #6 – Total Loss Sales Tax and Fees – The Company failed to accurately calculate and fully pay the correct:

(a) sales tax with two (2) first and three (3) third party total loss settlements; and
(b) fees with one (1) first and four (4) third party total loss settlements.

These represent ten (10) violations of A.R.S. § 20-461(A)(6), A.A.C. R20-6-801(H)(1)(b) and the prior Consent Order.

PRIVATE PASSENDER AUTOMOBILE TOTAL LOSSES

Failed to correctly calculate and pay sales taxes and fees associated with total loss settlements.
Violation of A.R.S. § 20-461(A)(6), A.A.C. R20-6-801(H)(1)(b) and prior Consent Order

Population	Sample	# of Exceptions	% to Sample
19	19	10	52.6%

A 52.6% error ratio does not meet the Standard; therefore a recommendation is warranted

Recommendation #8

Within 90 days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company correctly calculates and fully pays any sales tax and title, registration or other fees owed any claimant in the settlement of a total loss, in accordance with applicable state statutes and regulations.

Subsequent Event

During the course of the examination, the Company made sales tax restitutions of $350.78, which included $38.88 interest, and fee restitutions of $44.30, which included $5.55 interest. A copy of the letters of explanation and payments were sent to the Department prior to completion of the Examination.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner.	A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801

Preliminary Finding #3 – Deductible Recovery – The Company failed to reimburse two (2) insureds their deductibles on a timely basis after subrogation recovery. These represent two (2) violations of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(H)(4)

SUBROGATION RECOVERY

Failed to reimburse the deductible on a timely basis after subrogation recovery
Violation of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(H)(4)

Population	Sample	# of Exceptions	% to Sample
39	39	2	5.1%

A 5.1% error ratio does not meet the Standard; therefore a recommendation is warranted

Recommendation #9

Within 90 days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company promptly and proportionally returns insureds' deductibles after successful subrogation recovery, in accordance with applicable state statutes and regulations.

SUMMARY OF FAILED STANDARDS

EXCEPTION	Rec. No.	Page No.
UNDERWRITING AND RATING		
Standard #2 Disclosures to insureds concerning rates and coverage are accurate and timely.	1	12
CANCELLATIONS AND NON RENEWALS		
Standard #1 Declinations, Cancellations and Non-Renewals shall comply with state laws and Company guidelines including the Summary of Rights to be given to the applicant and shall not be discriminatory.	2	14
Standard #2 Cancellation and Non-Renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, nonrenewal based on condition of premises, and shall not be unfairly discriminatory	3	15

CLAIMS PROCESSING		
Standard #2 Timely investigations are conducted	4	18
Standard #3 The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations.	5,6&7	19, 20 & 21
Standard #5 Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	8	22
Standard #7 Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner.	9	22

SUMMARY OF PROPERTY AND CASUALTY STANDARDS

A. Complaint Handling

#	STANDARD	PASS	FAIL
1	The company takes adequate steps to finalize and dispose of the complaints in accordance with applicable statutes, rules, regulations and contract language. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

B. Marketing and Sales

#	STANDARD	PASS	FAIL
1	All advertising and sales materials are in compliance with applicable statutes, rules and regulations. (A.R.S. § 20-442 through 20-445)	X	

C. Producer Compliance

#	STANDARD	PASS	FAIL
1	The producers are properly licensed in the jurisdiction where the application was taken. (A.R.S. §§ 20-282, 20-286, 20-287, 20-311 through 311.03)	X	
2	An insurer shall not pay any commission, fee, or other valuable consideration to unlicensed producers. (A.R.S. § 20-298)	X	

D. Underwriting and Rating

#	STANDARD	PASS	FAIL
1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company Rating Plan. (A.R.S. §§ 20-341 through 20-385)	X	
2	Disclosures to insureds concerning rates and coverage are accurate and timely. (A.R.S. §§ 20-259.01, 20-262, 20-263, 20-264, 20-266, 20-267, 20-2110)		X

3	All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations, including, but not limited to, the Notice of Insurance Information Practices and the Authorization for Release of Information. (A.R.S. §§ 20-2104, 20-2106, 20-2110 and 20-2113)	X	
4	All forms and endorsements forming a part of the contract should be filed with the director (if applicable). (A.R.S. § 20-398)	X	
5	Policies and endorsements are issued or renewed accurately, timely and completely. (A.R.S. §§ 20-1120, 20-1121, 20-1654)	X	
6	Rescissions are not made for non-material misrepresentations. (A.R.S. §§ 20-463, 20-1109)	X	

E. Declinations, Cancellations and Non-Renewals

#	STANDARD	PASS	FAIL
1	Declinations, Cancellations and Non-Renewals shall comply with state laws and Company guidelines including the Summary of Rights to be given to the applicant and shall not be unfairly discriminatory. (A.R.S. §§ 20-448, 20-2108, 20-2109, 20-2110)		X
2	Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, and shall not be unfairly discriminatory. (A.R.S. §§ 20-191, 20-443, 20-448, 20-1631, 20-1632, 20-1632.01, 20-1651 through 20-1656)		X

F. Claims Processing

#	STANDARD	PASS	FAIL
1	The initial contact by the Company with the claimant is within the required time frame. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	Timely investigations are conducted. (A.R.S. § 20-461, A.A.C. R20-6-801)		X
3	The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations. (A.R.S. §§ 20-461, 20-466.03, 20-2106, A.A.C. R20-6-801)		X

#	STANDARD	PASS	FAIL
4	Claim files are adequately documented in order to be able to reconstruct the claim. (A.R.S. §§ 20-461, 20-463, 20-466.03, A.A.C. R20-6-801)	X	
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. (A.R.S. §§ 20-268, 20-461, 20-462, A.A.C. R20-6-801)		X
6	The Company uses reservation of rights and excess of loss letters, when appropriate. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)		X
8	The Company responds to claim correspondence in a timely manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	
9	Denied and closed without payment claims are handled in accordance with policy provisions and state law. (A.R.S. §§ 20-461, 20-462, 20-463, 20-466, 20-2110, A.A.C. R20-6-801)	X	
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented. (A.A.C. R20-6-801)	X	
11	Adjusters used in the settlement of claims are properly licensed (A.R.S. §§ 20-321 through 20-321.02)	X	