STATE OF ARIZONA
Department of Insurance and Financial Institutions
FILED July 27, 2020 by AS

Arizona Department of Insurance
Market Regulation and Consumer Services Division

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

NATIONAL GENERAL INSURANCE COMPANY

NAIC #23728

As Of December 31, 2018

AZ Exam No. 30198

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Market Conduct Section
Market Regulation and Consumer Services Division
Arizona Department of Insurance
100 North 15th Ave., Suite 261, Phoenix, Arizona 85007-2630
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Honorable Christina Corieri
Interim Director of Insurance
State of Arizona
100 North 15th Ave., Suite 261
Phoenix, Arizona 85007-2630

Dear Interim Director Corieri:

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:

National General Insurance Company, NAIC #23728

The examination was conducted by Shelly Schuman, ACS, AIE, AMCM, CICSR, FLMI, HIA, Market Conduct Examination Supervisor and Market Conduct Examiner-in-Charge; June Coleman, AMCM, Market Conduct Insurance Examiner; and George Kalargyros, Market Conduct Insurance Examiner.

The examination covered the period of July 1, 2017 through December 31, 2018.

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

Sincerely yours,

Maria G. Ailor, AIE, AMCM
Assistant Director

AFFIDAVIT

STATE OF ~~ARIZONA~~) Missouri
) ss.
COUNTY OF ~~MARICOPA~~) JACKSON

Shelly Schuman, ACS, AIE, AMCM, CICSR, FLMI, HIA, being first duly sworn, states that I am a duly appointed Market Conduct Examination Supervisor and Examiner-in-Charge for the Arizona Department of Insurance. That under my direction and with my participation and the participation of June Coleman, AMCM, Market Conduct Insurance Examiner, and George Kalargyros, Market Conduct Insurance Examiner on the Examination of National General Insurance Company, hereinafter referred to as the "Company" was performed at the office of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss this Report. 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.

Shelly Schuman

Shelly Schuman, ACS, AIE, AMCM, CICSR, FLMI, HIA
Market Conduct Examination Supervisor
INS Regulatory Insurance Services, Inc.

Subscribed and sworn to before me this 18 day of May, 2020.

Maria D. Arellano-Hodges

Notary Public

My Commission Expires: Feb 13, 2021

MARIA D. ARELLANO-HODGES
Notary Public - Notary Seal
State of Missouri
Commissioned for Jackson County
My Commission Expires: February 13, 2021
Commission Number: 12013014

FOREWORD

This target market conduct examination report of National General 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 examining 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 Motorcycle (MC), Private Passenger Automobile (PPA) and Recreational Vehicle (RV) business operations:

1. Operations and Management
2. Complaint Handling
3. Underwriting and Rating
4. Claims Processing

Certain unacceptable or non-compliant practices may not have been discovered in the course of this examination. 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 July 1, 2017 through December 31, 2018. 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 were consistent with the public interest. This examination was completed by applying tests to each examination standard to determine compliance with said standard. Each standard applied during the examination is stated in this report along with the results of each standard.

In accordance with Department procedures, the examiners completed a Preliminary Finding ("Finding") form on those standards 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 Company procedures and operations. For each finding, the Company was offered an opportunity to agree, disagree or otherwise justify the Company's noted action.

The examiners utilized both examination by test and examination by sample, as appropriate. Examination by test involves review of all records within the population, while examination by sample involves the review from a systematically selected number of records from within the population. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data 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." For standards related to a procedure or form use, standards were considered to not be met if any exception was identified.

HISTORY OF THE COMPANY

(Provided by Company in Part)

National General Insurance Company ("NGIC" or "Company") is a wholly owned subsidiary of National General Holdings Corp., a Delaware corporation and insurance holding company. NGIC is a Missouri corporation and is licensed in 51 jurisdictions, including Arizona, and is a provider of a variety of insurance products, including personal and commercial automobile, homeowners, umbrella, recreational vehicle, and lender-placed insurance products. NGIC was licensed to do business in Arizona on November 12, 1971.

NGIC is a member of the National General Insurance personal lines insurance group ("Personal Lines"), a specialty provider of property and casualty products throughout the United States. Personal Lines is currently managed by National General Management Corp. ("Management"). Management is headquartered in Winston-Salem, North Carolina.

Personal Lines operates its business through three primary distribution channels: agency, affinity and direct. The agency channel focuses primarily on writing standard, preferred and nonstandard auto coverage and homeowners and umbrella coverage through a network of independent agents. In the affinity channel, it partners with a number of affinity groups and membership organizations to deliver insurance products tailored to the needs of the affinity partners' members or customers under the affinity partners' brand name or label, which is referred to as selling on a "white label" basis. A primary focus of a number of its affinity relationships is providing recreational vehicle coverage. The direct channel is operated through approximately 460 store fronts, web/mobile, phone sales centers and kiosks.

NGIC's auto insurance products have two primary coverages: liability and physical damage. The insurance coverages are underwritten and priced under Consent to Rate statutes by the states in which the Company is licensed to write.

NGIC cedes all of its business to an affiliate, Integon National Insurance Company, under a 100% quota share agreement and retains no premium. All of National General Holdings Corp.'s domestic subsidiary insurance companies cede 100% of premium to Integon National.

PROCEDURES REVIEWED WITHOUT EXCEPTION

The examiners' review of the Company operations of complaint handling indicated that the Company was in compliance with Arizona statutes and rules during the examination review period.

EXAMINATION REPORT SUMMARY

The examination revealed twenty-nine (29) compliance issues resulting in 639 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 four (4) sections of Company operations examined. The following is a summary of the examiners' findings:

Operations and Management

In the area of Operations and Management, one (1) compliance issue was found as follows:

- The Company failed to refer a claim that was denied for material misrepresentation to the Arizona Department of Insurance as a suspected fraud claim in one (1) file.

Complaint Handling

In the area of Complaint Handling, no compliance issues were found.

Underwriting and Rating

In the area of Underwriting and Rating, eighteen (18) compliance issues were found as follows:

- The Company failed to clearly represent the proper entity providing insurance coverages in 170 files.
- The Company failed to omit a notice to insureds of a fifty-dollar ($50) cancellation fee that was withdrawn from its rules on file with the Department on three (3) invoice forms.
- The Company failed to properly document and retain signed underinsured motorist and uninsured motorist coverage selection forms in fifteen (15) files.
- The Company did not make a monthly premium payment plan available to the policyholder in three (3) files.
- The Company stated on its premium billing notices that the premium payment is to be mailed seven (7) days before the due date and that the postmark is not sufficient proof of the payment date in ninety-four (94) files.
- The Company failed to provide sufficient evidence that an accident listed on the C.L.U.E. report was significantly contributed to by the actions of the insured. As a result, the Company increased the premium in thirty-one (31) files.
- The Company failed to fully document and accurately apply rating percentage premium increases (i.e. surcharges) used to determine premium in one (1) file.
- The Company applied a MC model year/vehicle age factor to comprehensive and collision coverages that was not filed with the Department in three (3) files.
- The Company applied an accident forgiveness factor that was not filed with the Department in thirty-four (34) files.
- The Company did not appropriately apply an accidental death and dismemberment base rate that included an increase limit factor for individual plans two (2) through seven (7) and all of its family plans in fifty-three (53) files.
- The Company applied a PPA model year/vehicle age factor to comprehensive and collision coverage that was not filed with the Department in fifty-five (55) files.
- The Company applied a new business discount factor that was not filed with the Department in ninety-five (95) files.
- The Company failed to apply a multiple RV owner surcharge in one (1) file.
- The Company applied an incorrect bodily injury model year factor in one (1) file.
- The Company applied a different driver class factor for medical payments coverage than the factor table filed with the Department in one (1) file.
- The Company failed to provide the specific reason for the adverse underwriting decision in writing or advise the person, in writing, that upon written request the person may receive the specific reason in writing in twenty-three (23) files.
- The Company permitted an unfair discrimination between insureds by applying a military surcharge when rating the policy in three (3) files.
- The Company failed to have in place processes or practices to ensure it makes all products available to all of its authorized insurance producers.

Claims Processing

In the area of Claims Processing, ten (10) compliance issues were found as follows:

- The Company failed to include the required fraud wording on the estimates of physical damage in four (4) files.
- The Company failed to make an appropriate total loss offer and compelled its insured to institute litigation to recover amounts due under an insurance policy in one (1) file.
- The Company failed to respond within ten (10) working days to communications received from claimants in nine (9) files.
- The Company failed to investigate claims within thirty (30) days in eleven (11) files.
- The Company failed to pay the proper tax rate on the total loss claim in one (1) file.
- The Company failed to pay the interest pursuant to ARS §20-462(A) of ten percent (10%) on a first party claim not paid within thirty (30) days after the receipt of an acceptable proof of loss in five (5) files.
- The Company failed to affirm or deny the claims within fifteen (15) working days after receiving a properly executed proof of loss in two (2) files.
- The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear in one (1) file.
- The Company failed to acknowledge the subrogation claim within ten (10) working days in eleven (11) files.
- The Company failed to provide complete subrogation files in order for the examiners to reconstruct the claim events in six (6) files.

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NATIONAL GENERAL INSURANCE COMPANY

FINDINGS

OPERATIONS AND MANAGEMENT

The following Operations and Management Standard failed:

#	Standard	Regulatory Authority
CH16 3	Reporting of a fraudulent claim by the Company to the Department of Insurance.	A.R.S. § 20-466

FINDING #15 –DENIED/CLOSED WITHOUT PAYMENT CLAIMS

The Company failed to refer a claim that was denied for material misrepresentation to the Arizona Department of Insurance as a suspected fraud claim. This represents one (1) violation of A.R.S. § 20-466(G).

DENIED/CLOSED WITHOUT PAYMENT CLAIMS

Failure to refer a suspected fraud claim to the Arizona Department of Insurance.

Violation of A.R.S. § 20-466(G)

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

Any error or exception identified in the areas of a procedure or form use does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #1

Within ninety (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 refers suspected fraud claims to the Arizona Department of Insurance, in accordance with the applicable state statutes and rules.

Subsequent Event: The Company provided a copy of Claims Handling Procedures detailing the Company's procedures for referring suspected fraud claims to the Arizona Department of Insurance.

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COMPLAINT HANDLING

The examiners reviewed:

1. Fifteen (15) Department of Insurance complaints; and
2. Ten (10) direct consumer complaints.

The following Complaint Standards were met:

#	Standard	Regulatory Authority
CH163	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
CH164	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

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UNDERWRITING AND RATING

Motorcycle (MC), Private Passenger Automobile (PPA) and Recreational Vehicle (RV)

The examiners reviewed:

1. Fifty (50) MC new business files were selected from a population of 282 files;
2. Fifty (50) MC renewal files were selected from a population of 545 files;
3. Fifty (50) PPA new business files were selected from a population of 1,836 files;
4. Fifty (50) PPA renewal files were selected from a population of 7,735 files;
5. Fifty (50) RV new business files were selected from a population of 3,573 files; and
6. Fifty (50) RV renewal files were selected from a population of 7,259 files.

The following Underwriting and Rating Standards were met:

#	Standard	Regulatory Authority
CH165	All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the insurance department (if applicable).	A.R.S. § 20-398
CH169	Rescissions are not made for non-material misrepresentations.	A.R.S. §§ 20-463, 20-1109

The following Underwriting and Rating Standard passed with comment:

#	Standard	Regulatory Authority
CH164	The Company's underwriting practices are not unfairly discriminatory. The Company adheres to applicable statutes, rules and regulations in its application of mass marketing plans.	A.R.S. § 20-448

NEW BUSINESS AND RENEWAL POLICIES

The following Underwriting and Rating Standard failed:

#	Standard	Regulatory Authority
AZ 5	All advertising, sales, and policyholder materials are in compliance with applicable statutes, rules and regulations.	A.R.S. §§ 20-442, 20-443 and 20-444(B)

FINDING #11 – NEW BUSINESS/RENEWAL POLICIES

The Company failed to clearly represent the proper entity providing insurance coverages. The Company issued MC, PPA and RV new business and renewal policies with the name and logo of "Good Sam Vehicle Insurance Plan" or "NRLCA Vehicle Insurance Plan" rather than the registered "Doing Business As" name. In some files, the logo is also on the Identification Card and Declaration page. The use of the words "Vehicle Insurance Plan" leads the reader to believe Good Sam or NRLCA is the insurer and not National General Insurance Company. These represent 170 violations of A.R.S. §§ 20-442, 20-443 and 20-444(B).

NEW BUSINESS/RENEWAL POLICIES

Failure to clearly represent the proper entity providing insurance coverages.

Violation of A.R.S. §§ 20-442, 20-443 and 20-444(B)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
MC New Business	282	50	29	58%
MC Renewal	545	50	12	24%
PPA New Business	1,836	50	27	54%
PPA Renewal	7,735	50	17	34%
RV New Business	3,573	50	41	82%
RV Renewal	7,259	50	44	88%
Totals	**21,230**	**300**	**170**	

Each of the new business and renewal error ratios noted in the above table do not meet the Standard; therefore, a recommendation is warranted.

Recommendation #2

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure it clearly represents the proper entity providing insurance coverages, in accordance with applicable statutes.

Subsequent Event: The Company provided documentation of its modifications to all of its advertising, sales and policyholder materials to clearly represent the proper entity providing insurance coverages.

FINDING #24 – NEW BUSINESS/RENEWAL POLICIES

During the review of new business and renewal files, it was noted that three (3) invoice forms stated that a fifty-dollar ($50) cancellation fee will be applied. However, the Company filed with the Department a withdrawal of the cancellation fee rule (SERFF filing # GMMX-130663433-July 22, 2016) with the new business effective date of July 29, 2016 and the renewal effective date of September 3, 2016. It was noted that no policyholders were charged the withdrawn $50 cancellation fee. These represent three (3) violations of A.R.S. § 20-443.

NEW BUSINESS/RENEWAL POLICIES

Failure to omit a notice to insureds of a fifty dollar ($50) cancellation fee on forms.

Violation of A.R.S. § 20-443

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
N/A	N/A	N/A	3	N/A

Any error or exception identified in the areas of a procedure or form use does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #3

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure all forms omit notifying insureds of a withdrawn rule of a fifty dollar ($50) cancellation fee, in accordance with applicable statutes.

Subsequent Event: The Company provided the Department with evidence that it has revised all pertinent forms to omit language pertaining to the fifty dollar ($50) cancellation fee.

The following Underwriting and Rating Standard failed:

#	Standard	Regulatory Authority
CH16 2	Disclosures to insureds concerning rates and coverage are accurate and timely.	A.R.S. § 20-259.01 20-267

FINDING #12 – NEW BUSINESS/RENEWAL POLICIES

The Company failed to properly document and retain signed underinsured motorist and uninsured motorist coverage selection forms. These represent fifteen (15) violations of A.R.S. § 20-259.01(A) and A.R.S. § 20-259.01(B).

NEW BUSINESS/RENEWAL POLICIES

Failure to document and retain signed underinsured and uninsured motorist coverage selection forms.
Violation of A.R.S. § 20-259.01(A) and A.R.S. § 20-259.01(B)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
MC New Business	282	50	15	30%

A thirty percent (30%) error ratio does not meet the Standard; therefore, a recommendation is warranted.

Subsequent Event: Arizona Senate Bill 1087 amended Title 20 Section 259.01 effective July 1, 2020, by removing the requirement that insurers use the UM/UIM form to reflect the insured's "selection" of UM/UIM coverages. Instead, the form must be used to reflect the insurer's "offer" of UM/UIM coverage. The law was further amended so that the policy declarations page now constitutes the final expression of the named insured's decision to purchase or reject the uninsured and underinsured motorist coverage.

FINDING #17 – NEW BUSINESS/RENEWAL POLICIES

The Company did not make a monthly premium payment plan available to the policyholder for MC and PPA renewal policies. These represent three (3) violations of A.R.S. § 20-267.

NEW BUSINESS/RENEWAL POLICIES

Failure to make a monthly premium payment plan available to the policyholder.
Violation of A.R.S. § 20-267

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
MC Renewal	545	50	1	2%
PPA Renewal	7,735	50	2	4%
Totals	**8,280**	**100**	**3**	

Each of the renewal error ratios noted in the above table meet the Standard; therefore, a recommendation is not warranted.

The following Underwriting and Rating Standard failed:

#	Standard	Regulatory Authority
AZ 6	Policyholder 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

FINDING #16 – NEW BUSINESS/RENEWAL POLICIES

The Company issued billing notices to its policyholders stating that the premium payment was to be mailed seven (7) days before the due date and that the postmark is not sufficient proof of date of payment. These represent ninety-four (94) violations of A.R.S. § 20-191(A) and A.R.S. § 20-191(B).

NEW BUSINESS/RENEWAL POLICIES

Including on its premium billing notices a statement that the premium payment was to be mailed seven (7) days before the due date and that the postmark is not sufficient proof of date of payment. Violation of A.R.S. § 20-191(A) and A.R.S. § 20-191(B)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
MC New Business	282	50	4	8%
MC Renewal	545	50	41	82%
PPA New Business	1,836	50	6	12%
PPA Renewal	7,735	50	19	38%
RV New Business	3,573	50	3	6%
RV Renewal	7,259	50	21	42%
Totals	**21,230**	**300**	**94**	

The MC renewal, PPA new business, PPA renewal and RV renewal error ratios as noted in the above table do not meet the Standard; therefore, a recommendation is warranted.

Recommendation #4

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure it properly processes premium payments that are mailed on or before the date the premium is due, as shown by the postmark, as timely payments in accordance with applicable statutes.

Subsequent Event: The Company provided the Department with documentation that it has removed all language from its billing notices stating that the premium payment must be mailed seven (7) days before the due date and that the postmark is not sufficient proof of date of payment.

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The following Underwriting and Rating Standard failed:

#	Standard	Regulatory Authority
AZ 2	No insurer shall increase the motor vehicle insurance premium of an insured as a result of an accident not caused or significantly contributed to by the actions of the insured. Any insurer which increases the premium as a result of accident involvement shall notify the insured of the reason for such increase.	A.R.S. § 20-263(A)

FINDING #19 – NEW BUSINESS/RENEWAL POLICIES

The Company failed to provide sufficient evidence that an accident listed on the C.L.U.E. report was caused by or significantly contributed to by the actions of the insured. As a result, the Company increased the premium of the insured. These represent thirty-one (31) violations of A.R.S. § 20-263.

NEW BUSINESS/RENEWAL POLICIES

Failure to provide sufficient evidence that an accident listed on the C.L.U.E. report was significantly contributed to by the actions of the insured.

Violation of A.R.S. § 20-263

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
MC New Business	282	50	8	16%
MC Renewal	545	50	3	6%
PPA New Business	1,836	50	6	12%
PPA Renewal	7,735	50	3	6%
RV New Business	3,573	50	7	14%
RV Renewal	7,259	50	4	8%
Totals	**21,230**	**300**	**31**	

The MC new business, PPA new business and RV new business error ratios as noted in the above table do not meet the Standard; therefore, a recommendation is warranted.

Recommendation #5

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure it provides sufficient evidence that an accident listed on the C.L.U.E. report is significantly contributed to by the actions of the insured, in accordance with applicable statutes.

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The following Underwriting and Rating Standard failed:

#	Standard	Regulatory Authority
CH16 1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company Rating Plan.	A.R.S. § 20-385(A)

FINDING #23 – NEW BUSINESS/RENEWAL POLICIES

The Company failed to fully document and accurately apply rating percentage premium increases (i.e. surcharges) used to determine premium. The Company surcharged a policy for the principal operator being in active military duty. The insured was 76 years old and there was no documentation in the file to justify the surcharge. This represents one (1) violation of A.R.S. § 20-385(A).

NEW BUSINESS/RENEWAL POLICIES

Failure to fully document and accurately apply rating percentage premium increases used to determine premium. Violation of A.R.S. § 20-385(A)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
MC Renewal	545	50	1	2%

A two percent (2%) error ratio meets the Standard; therefore, a recommendation is not warranted.

Subsequent Event: The Company issued a refund check to the insured for an overcharge of $29.00 and interest due of $7.08 on October 24, 2019.

FINDING #20 – NEW BUSINESS/RENEWAL POLICIES

The Company applied a MC model year/vehicle age factor to comprehensive and collision coverages that was not filed with the Department. As a result, the Company conducted a self-audit and determined 100 MC new business and 99 MC renewal policies were impacted with overcharges of $14,871.93 and undercharges of $391. The issue began October 18, 2011 for MC new business and on November 18, 2011 for MC renewal policyholders. These represent three (3) violations of A.R.S. § 20-385(A).

NEW BUSINESS/RENEWAL POLICIES

Applied a MC model year/vehicle age factor to comprehensive and collision coverages that was not filed with the Department.
Violation of A.R.S. § 20-385(A)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
MC New Business	282	50	1	2%
MC Renewal	545	50	2	4%
Totals	**827**	**100**	**3**	

A three percent (3%) error ratio meets the Standard. However, the self-audit demonstrated that the Standard was not met; therefore, a recommendation is warranted.

Recommendation #6
Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure MC model year/vehicle age factors are filed with the Department and accurately applied to determine policy premium, in accordance with applicable statutes.

Subsequent Events: The Company submitted SERFF filing #GMMX-132075571 effective 9/13/2019 for new business and 10/19/2019 for renewals to correct the filing issue. In addition, the Company issued refund checks to the insureds for overcharges of $14,872.15 and interest due of $8,981.07 on November 5, 2019.

FINDING #25 – NEW BUSINESS/RENEWAL POLICIES

The Company applied five (5) factors that were not filed with the Department. The factors included an accident forgiveness factor, model year/vehicle age factor, a new business discount factor, bodily injury model year factor and a driver class factor for medical payments coverage. In addition, the Company failed to apply an increased limit factor when computing accidental death and dismemberment coverage premium and failed to apply a multiple RV owner surcharge. Each of the factors, accidental death and dismemberment base rate and multiple RV owner surcharge violations are outlined below.

Accident Forgiveness Factor: The Company applied an accident forgiveness factor that was not filed with the Department. The premium charged to policyholders is not consistent with state filings. The Company conducted a self-audit to determine the total amount of overcharges and interest due to the PPA and RV policyholders. The issue began on June 1, 2013 and affected PPA and RV policyholders. These represent thirty-four (34) violations of A.R.S. § 20-385(A).

NEW BUSINESS/RENEWAL POLICIES
Applied an accident forgiveness factor that was not filed with the Department.
Violation of A.R.S. § 20-385(A)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
PPA New Business	1,836	50	12	24%
PPA Renewal	7,735	50	2	4%
RV New Business	3,573	50	13	26%
RV Renewal	7,259	50	7	14%
Totals	**20,403**	**200**	**34**	

Each of the new business and renewal error ratios noted in the above table do not meet the Standard; therefore, a recommendation is warranted.

Recommendation #7
Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure accident forgiveness factors for PPA and RV business are filed with the Department and accurately applied to determine policy premium, in accordance with applicable statutes. The Company shall refund any overcharges plus interest to the policyholders that were overcharged based on the results of its self-audit. The accident forgiveness factors did not apply to the MC business and it was not affected by this finding.

Subsequent Events: The Company submitted SERFF filing #GMMX-132160775 effective 12/13/2019 for new business and 1/8/2020 for renewals to correct the filing issue. Refunds of $1,293.21 in premium and $317.56 in interest were made for 1,058 unique policies.

Accidental Death and Dismemberment Factor: The Company applied an accidental death and dismemberment base rate that included an increase limit factor for individual plans two (2) through seven (7) and all of its family plans. According to the rating algorithm filed with the Department, the increased limit factor would be applied again to determine premium, resulting in the policyholder being charged twice for the increased limit factor. The Company failed to follow the filed rating algorithm. The Company conducted a self-audit and determined the issue began June 1, 2013 for PPA and RV new business and on December 1, 2013 for PPA and RV renewal policies. There was no change in the premium and no insured was overcharged or undercharged. These represent fifty-three (53) violations of A.R.S. § 20-385(A).

NEW BUSINESS/RENEWAL POLICIES

Did not accurately apply an accidental death and dismemberment base rate that included an increase limit factor.

Violation of A.R.S. § 20-385(A)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
PPA New Business	1,836	50	20	40%
PPA Renewal	7,735	50	10	20%
RV New Business	3,573	50	10	20%
RV Renewal	7,259	50	13	26%
Totals	**20,403**	**200**	**53**	

Each of the new business and renewal error ratios noted in the above table do not meet the Standard; therefore, a recommendation is warranted.

Recommendation #8

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure accidental death and dismemberment base rates for PPA and RV business are filed with the Department and accurately applied to determine policy premium, in accordance with applicable statutes. The MC business was not affected by this finding.

Subsequent Event: The Company submitted SERFF filing #GMMX-132160775 effective 12/13/2019 for new business and 1/18/2020 for renewal business to correct the filing issue.

Model Year/Vehicle Age Factor: The Company applied a PPA model year/vehicle age factor to comprehensive and collision coverage that was not filed with the Department. The Company conducted a self-audit and determined 1,100 PPA new business and 3,786 PPA renewal policies were impacted with overcharges of $2,120.29 and undercharges of $177,999.21. The amount of interest due to the policyholders was $526.37. The issue began May 26, 2017 for PPA new business and on July 1, 2017 for PPA renewal policyholders. These represent fifty-five (55) violations of A.R.S. § 20-385(A).

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NEW BUSINESS/RENEWAL POLICIES

Applied a PPA model year/vehicle age factor to comprehensive and collision coverage that was not filed with the Department.

Violation of A.R.S. § 20-385(A)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
PPA New Business	1,836	50	22	44%
PPA Renewal	7,735	50	33	66%
Totals	**9,571**	**100**	**55**	

The PPA new business and PPA renewal error ratios noted in the above table do not meet the Standard; therefore, a recommendation is warranted.

Recommendation #9

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure PPA model year/vehicle age factors are filed with the Department and accurately applied to determine policy premium, in accordance with applicable statutes.

Subsequent Event: The Company issued refund checks to the insureds for overcharges of $2,120.29 and interest due of $526.37 on November 11, 2019. The refund amounts reflect both PPA model year/vehicle age and the bodily injury model year/vehicle age factors restitution. In addition, the Company submitted SERFF filing #GMMX-131256226 effective 11/10/2017 for new business and 12/16/2017 for renewals to correct the filing issue.

New Business Discount Factor: The Company applied a PPA new business discount factor that was not filed with the Department. The premium charged to policyholders was not consistent with state filings. The Company conducted a self-audit and determined 18,784 PPA new business and 36,965 PPA renewals policies were impacted. All policyholders were undercharged. The issue began August 23, 2013 for PPA new business and PPA renewal policies. These represent ninety-five (95) violations of A.R.S. § 20-385(A).

NEW BUSINESS/RENEWAL POLICIES

Applied a PPA new business discount factor that was not filed with the Department.

Violation of A.R.S. § 20-385(A)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
PPA New Business	1,836	50	50	100%
PPA Renewal	7,735	50	45	90%
Totals	**9,571**	**100**	**95**	

The PPA new business and PPA renewal error ratios noted in the above table do not meet the Standard; therefore, a recommendation is warranted.

Recommendation #10

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure PPA new business discount factors are filed with the Department and accurately applied to determine policy premium, in accordance with applicable statutes.

Rating System Audits: Multiple RV Owner Surcharge: During an internal rating system audit, the Company determined it failed to apply a multiple recreational vehicle (RV) owner surcharge. The issue began April 1, 2011 for RV new business and RV renewal policyholders. This represents one (1) violation of A.R.S. § 20-385(A).

As this was an audit of the rating system process, any error or exception identified in the areas of a procedure or form use does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #11

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure RV surcharges filed with the Department are accurately applied to determine policy premium, in accordance with applicable statutes.

Subsequent Event: The Company conducted a self-audit and determined one (1) RV new business and three (3) RV renewal policies were impacted with undercharges of $391. The Company resolved this system failure on June 7, 2018.

Rating System Audits: Bodily Injury Model Year Factor: During an internal rating system audit, the Company determined it applied an incorrect bodily injury model year factor for 2017. The issue was resolved by updating the factor table effective July 12, 2018. The Company conducted a self-audit and determined 200 PPA new business and 475 PPA renewal policies were impacted with undercharges of $32,036.88. The issue began October 7, 2016 for PPA new business and PPA renewal policyholders. This represents one (1) violation of A.R.S. § 20-385(A).

As this was an audit of the rating system process, any error or exception identified in the areas of a procedure or form use does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #12

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure PPA bodily injury model year factors are accurately applied to determine policy premium, in accordance with applicable statutes.

Subsequent Event: The Company submitted SERFF Filing # GMMX-131256226 effective 11/10/2017 for new business and 12/16/2017 for renewal business to correct the filing issue.

Rating System Audits: Driver Class Factor for Medical Payments Coverage: During a Company's rating system audit, the Company determined the driver class factor table for medical payments coverage failed by showing a different factor than what was applied. The factor tables for the May 26, 2017 rate revision was resolved August 9, 2018. The Company conducted a self-audit and determined 1,271 RV new business and 2,219 RV renewal policies were impacted with undercharges of $17,079. The issue began May 26, 2017 for RV new business and RV renewal policyholders. This represents one (1) violation of A.R.S. § 20-385(A).

As this was an audit of the rating system process, any error or exception identified in the areas of a procedure or form use does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #13
Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure PPA driver class factor for medical payments coverage are accurately applied to determine policy premium, in accordance with applicable statutes.

Subsequent Event: The Company corrected the issue by modifying its system to match its filing effective 8/9/2018.

The following Underwriting and Rating Standard failed:

#	Standard	Regulatory Authority
AZ 1	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

FINDING #21 – NEW BUSINESS/RENEWAL POLICIES

The Company failed to provide the specific reason for the adverse underwriting decision in writing or advise the person, in writing, that upon written request the person may receive the specific reason in writing. These represent twenty-three (23) violations of A.R.S. § 20-2110(A).

NEW BUSINESS/RENEWAL POLICIES
Failure to provide the specific reason for the adverse underwriting decision in writing.
Violation of A.R.S. § 20-2110(A)

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
MC New Business	282	50	2	4%
PPA New Business	1,836	50	1	2%
PPA Renewal	7,735	50	10	20%
RV New Business	3,573	50	3	6%
RV Renewal	7,259	50	7	14%
Totals	**20,685**	**250**	**23**	

The PPA renewal and RV renewal error ratios as noted in the above table do not meet the Standard; therefore, a recommendation is warranted.

Recommendation #14
Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure it provides the specific reason for the adverse underwriting decision in writing or advise the person, in writing, that upon written request the person may receive the specific reason in writing, in accordance with applicable statutes.

Subsequent Event: The Company provided documentation that procedures are in place to ensure it provides specific reasons for the adverse underwriting decision in accordance with applicable statutes.

The following Underwriting and Rating Standard passed with comment:

#	Standard	Regulatory Authority
CH164	The Company's underwriting practices are not unfairly discriminatory. The Company adheres to applicable statutes, rules and regulations in its application of mass marketing plans.	A.R.S. § 20-448

FINDING #22 – NEW BUSINESS/RENEWAL POLICIES

The Company permitted an unfair discrimination between insureds by applying a military surcharge when rating the policy. These represent three (3) violations of A.R.S. § 20-448.

NEW BUSINESS/RENEWAL POLICIES

Permitted an unfair discrimination between insureds by applying a military surcharge.

Violation of A.R.S. § 20-448

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
MC New Business	282	50	1	2%
MC Renewal	545	50	2	4%
Totals	**827**	**100**	**3**	

The MC new business and RV renewal error ratios as noted in the above table meet the Standard; therefore, a recommendation is not warranted.

The following Underwriting and Rating Standard failed:

#	Standard	Regulatory Authority
AZ 7	The regulated entity has developed and implemented written policies, standards and procedures for the management of the marketing of its insurance products through all of its authorized producers.	A.R.S. § 20-460

FINDING #26 – NEW BUSINESS/RENEWAL POLICIES

The Company was asked to provide its processes/practices that were in place to ensure the compliance with A.R.S. § 20-460 to make all products available to the sales agents. The Company stated, "Of the programs that we are actively accepting new business, none of these programs are exclusive to a specific set of insurance producers. The Company's sales team has dialogue with prospective producers to discuss their business needs and gives them access to the products to meet their business needs. This same dialogue continues with existing producers to ensure that agencies have access to programs that will meet their business needs."

The Company failed to have in place processes or practices to ensure it makes all products available to all of its authorized insurance producers. The practice of providing access to only those products that the Company perceives to meet the insurance producer business needs violates A.R.S. § 20-460.

NEW BUSINESS AND RENEWAL POLICIES

Failure to ensure that all products are made available to all authorized insurance producers.
Violation of A.R.S. § 20-460

Underwriting and Rating	Population	Sample	# of Exceptions	% to Sample
N/A	N/A	N/A	1	N/A

Any error or exception identified in the areas of a procedure or form use does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #15

Within ninety (90) days of the filed date of this report, provide the Department with documentation that the Company procedures and controls are in place to ensure it makes all products available to all of its authorized insurance producers, in accordance with applicable statutes.

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CLAIMS PROCESSING

Motorcycle (MC), Private Passenger Automobile (PPA) and Recreational Vehicle (RV)

The examiners reviewed:

1. Fifty (50) paid claims from a population of 1,633;
2. Fifty (50) denied/closed without payment claims from a population of 890 claims; and
3. Fifty (50) subrogation claims from a population of 95 claims.

The following Claims Processing Standards were met:

#	Standard	Regulatory Authority
CH16 3	Claims are resolved in a timely manner.	A.R.S. § 20-461, A.A.C. R20-6-801
CH16 10	Canceled benefit checks and drafts reflect appropriate claim handling practices.	A.R.S. § 20-461
CH17 1	The Company uses reservation of rights and excess of loss letters, when appropriate.	A.R.S. § 20-461, A.A.C. R20-6-801
CH17 2	Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.	A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801
AZ 3	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
AZ 4	Adjusters used in the settlement of claims are properly licensed.	A.R.S. §§ 20-321 through 20-321.02

The following Claims Processing Standard passed with comment:

#	Standard	Regulatory Authority
CH16 11	Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.	A.R.S. § 20-461

PAID CLAIMS

The following Claims Processing Standard failed:

#	Standard	Regulatory Authority
CH16 7	The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations.	A.R.S. § 20-466.03

FINDING #2 – PAID CLAIMS

The Company failed to include the required fraud wording on the estimates of physical damage. A.R.S. § 20-466.03 requires the fraud wording to be included on claims forms that are provided to an insured or any other person making a claim. These represent four (4) violations of A.R.S. § 20-466.03(A).

PAID CLAIMS

Failure to include the required fraud wording on the estimates of physical damage.
Violation of A.R.S. § 20-466.03(A)

Population	Sample	# of Exceptions	% to Sample
1,633	50	4	8%

An eight percent (8%) error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #16

Within ninety (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 provides the required fraud wording on claims forms, in accordance with the applicable state statutes and rules.

Subsequent Event: The Company provided documentation to the Department that the required fraud wording is on claims forms.

The following Claims Processing Standard passed with comment:

#	Standard	Regulatory Authority
CH16 11	Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offer substantially less than is due under the policy.	A.R.S. § 20-461

FINDING #3 – PAID CLAIMS

The Company failed to make an appropriate total loss offer and compelled its insured to institute litigation to recover amounts due under an insurance policy. The claim was resolved for a significant amount more than the original total loss offer after the insured retained an attorney. This represents one (1) violation of A.R.S. § 20-461(A)(8).

PAID CLAIMS

Failure to make an appropriate total loss offer and compelled its insured to institute litigation.
Violation of A.R.S. § 20-461(A)(8)

Population	Sample	# of Exceptions	% to Sample
1,633	50	1	2%

A two percent (2%) error ratio meets the Standard; therefore a recommendation is not warranted.

The following Claims Processing Standard failed:

#	Standard	Regulatory Authority
CH16 4	The Company responds to claim correspondence in a timely manner.	A.R.S. § 20-461, A.A.C. R20-6-801

FINDING #4 – PAID CLAIMS

The Company failed to respond within (ten) 10 working days to communications received from claimants. Delays occurred in responding to claimants for completing estimates after receiving pictures of damages, responding to counter offers, or responding to correspondence/phone calls. These represent nine (9) violations of A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(3).

PAID CLAIMS

Failure to respond within ten (10) working days to communications received from claimants.
Violation of A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(3)

Population	Sample	# of Exceptions	% to Sample
1,633	50	9	18%

An eighteen percent (18%) error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #17

Within ninety (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 responds within ten (10) working days to communications received from claimants, in accordance with the applicable state statutes and rules.

PAID AND DENIED/CLOSED WITHOUT PAYMENT CLAIMS

The following Claims Processing Standard failed:

#	Standard	Regulatory Authority
CH16 2	Timely investigations are conducted.	A.R.S. § 20-461, A.A.C. R20-6-801

FINDING #5 – PAID AND DENIED/CLOSED WITHOUT PAYMENT CLAIMS

The Company failed to investigate claims within thirty (30) days. There were unnecessary delays to assess liability, address the claimant's damages or to address the estimate of damages when the investigation could have been reasonably completed. The Company requested additional pictures of damages or resubmission of claim forms multiple times. These represent eleven (11) violations of A.R.S. § 20-461(A)(3) and A.A.C. R20-6-801(F).

PAID AND DENIED/CLOSED WITHOUT PAYMENT CLAIMS

Failure to investigate claims within 30 days.

Violation of A.R.S. § 20-461(A)(3) and A.A.C. R20-6-801(F)

Claims Processing	Population	Sample	# of Exceptions	% to Sample
Paid	1,633	50	7	14%
Denied/Closed without Payment	890	50	4	8%
Totals	**2,523**	**100**	**11**	

The paid and denied/closed without payment error ratios as noted in the above table do not meet the Standard; therefore, a recommendation is warranted.

Recommendation #18

Within ninety (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 completes investigation of a claim within thirty (30) days after notification of claim, in accordance with the applicable state statutes and rules.

Subsequent Event: The Company provided a copy of Claims Compliance Communication sent to all claims staff on 2/14/2020 explaining procedures to ensure the Company completes investigation of a claim within thirty (30) days after notification of claim.

The following Claims Processing Standard failed:

#	Standard	Regulatory Authority
CH166	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	A.A.C. R20-6-801

FINDING #1 – PAID CLAIMS

The Company failed to pay the proper tax rate on a total loss claim which resulted in an underpayment of $609. This represents one (1) violation of A.A.C. R20-6-801(H)(1)(b).

PAID CLAIMS

Failure to pay the proper tax rate on the total loss claims.

Violation of A.A.C. R20-6-801(H)(1)(b)

Population	Sample	# of Exceptions	% to Sample
1,633	50	1	2%

A two percent (2%) error ratio meets the Standard; therefore a recommendation is not warranted.

Subsequent Event: The Company refunded the insured for the underpayment of $609 on September 18, 2019 and paid the interest of $115.46 on November 14, 2019.

FINDING #6 – PAID CLAIMS

In five (5) instances, a claim was paid late and interest was owed. The Company failed to pay the interest of ten percent (10%) on a first party claim not paid within thirty (30) days after the receipt of an acceptable proof of loss for all five (5) claims. These represent five (5) violations of A.R.S. § 20-462(A).

PAID CLAIMS

Failure to pay the interest of ten percent (10%) on claims paid late.
Violation of A.R.S. § 20-462(A)

Population	Sample	# of Exceptions	% to Sample
5	5	5	100%

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

Recommendation #19

Within ninety (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 pays the interest of ten percent (10%) on a first party claim not paid within thirty (30) days after the receipt of an acceptable proof of loss, in accordance with the applicable state statutes and rules.

Subsequent Event: The Company issued interest payments to the five claimants totaling $7,335.39 on October 10, November 13, and November 19, 2019.

FINDING #7 – PAID CLAIMS

The Company failed to affirm or deny claims within fifteen (15) working days after receiving a properly executed proof of loss for two (2) claims. The Company continued to investigate each claim, but failed to send a letter every forty-five (45) days explaining the reasons why more time is needed to investigate the claim. These represent two (2) violations of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(G)(1)(b).

PAID CLAIMS

Failure to affirm or deny the claims within fifteen (15) working days after receiving proof of loss.
Violation of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(G)(1)(b)

Population	Sample	# of Exceptions	% to Sample
1,633	50	2	4%

A four percent (4%) error ratio meets the Standard; therefore, a recommendation is not warranted.

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FINDING #14 –DENIED/CLOSED WITHOUT PAYMENT CLAIMS

The Company failed to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear. In one (1) file, the claims adjuster informed the claimant that there was "no going back" after they stated that they will not pursue the property damage claim. This represents one (1) violation of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(D)(4).

DENIED/CLOSED WITHOUT PAYMENT CLAIMS

Failure to effectuate prompt, fair and equitable settlement of claims.
Violation of A.R.S. § 20-461(A)(6) and A.A.C. R20-6-801(D)(4)

Population	Sample	# of Exceptions	% to Sample
890	50	1	2%

A two percent (2%) error ratio meets the Standard; therefore, a recommendation is not warranted.

SUBROGATION CLAIMS

The following Claims Processing Standard failed:

#	Standard	Regulatory Authority
CH16 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

FINDING #9 –SUBROGATION CLAIMS

The Company failed to acknowledge subrogation claims within ten (10) working days. The Company's practice was to acknowledge the subrogation claim by sending the insured an acknowledgement letter. In nine (9) files, the Company failed to send acknowledgement letter. In two (2) files, the acknowledgement letter was sent twelve (12) days after the subrogation claim was opened. These represent eleven (11) violations of A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(1).

SUBROGATION CLAIMS

Failure to acknowledge the subrogation claim within ten (10) working days.
Violation of A.R.S. § 20-461(A)(2) and A.A.C. R20-6-801(E)(1)

Population	Sample	# of Exceptions	% to Sample
95	50	11	22%

A twenty-two percent (22%) error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #20

Within ninety (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 acknowledges a subrogation claim within ten (10) working days, in accordance with the applicable state statutes and rules.

The following Claims Processing Standard failed:

#	Standard	Regulatory Authority
CH16 5	Claim files are adequately documented in order to be able to reconstruct the claim.	A.R.S. § 20-461, A.A.C. R20-6-801

FINDING #10 –SUBROGATION CLAIMS

The Company failed to provide complete subrogation files such that the examiners could reconstruct the claim events. Due to missing notes or documentation for six (6) files, the examiners could not determine the date the insured was reimbursed or the date the claim was closed. These represent six (6) violations of A.A.C R20-6-801(C).

SUBROGATION CLAIMS

Failure to provide complete claim files to reconstruct the claim events.

Violation of A.A.C R20-6-801(C)

Population	Sample	# of Exceptions	% to Sample
95	50	6	12%

A twelve percent (12%) error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #21

Within ninety (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 provides complete claim files in such detail that pertinent events and the dates of such events can be reconstructed, in accordance with the applicable state statutes and rules.

Subsequent Event: The Company provided a copy of Claims Compliance Communication sent to all its claims staff on 2/14/2020 explaining procedures to ensure the Company provides complete claim files in such detail that pertinent events and the dates of such events can be reconstructed.

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SUMMARY OF PROPERTY AND CASUALTY STANDARDS

A. Operations and Management

#	STANDARD	PASS	PASS WITH COMMENT	FAIL
CH163	Reporting of a fraudulent claim by the Company to the Department of Insurance. (A.R.S. § 20-466)			X

B. Complaint Handling

#	STANDARD	PASS	PASS WITH COMMENT	FAIL
CH163	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		
CH164	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		

C. Underwriting and Rating

#	STANDARD	PASS	PASS WITH COMMENT	FAIL
CH161	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
CH162	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
CH164	The Company's underwriting practices are not unfairly discriminatory. The Company adheres to applicable statutes, rules and regulations in its application of mass marketing plans. (A.R.S. § 20-448)		X	
CH165	All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the insurance department (if applicable). (A.R.S. § 20-398)	X		
CH169	Rescissions are not made for non-material misrepresentations. (A.R.S. §§ 20-463, 20-1109)	X		
AZ 1	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

Underwriting and Rating (cont'd)

#	STANDARD	PASS	PASS WITH COMMENT	FAIL
AZ 2	No insurer shall increase the motor vehicle insurance premium of an insured as a result of an accident not caused or significantly contributed to by the actions of the insured. Any insurer which increases the premium as a result of accident involvement shall notify the insured of the reason for such increase. (A.R.S. § 20-263)			X
AZ 5	All advertising, sales, and policyholder materials are in compliance with applicable statutes, rules and regulations. (A.R.S. §§ 20-442, 20-443 and 20-444(B))			X
AZ 6	Policyholder 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 and 20-1632.01)			X
AZ 7	The regulated entity has developed and implemented written policies, standards and procedures for the management of the marketing of its insurance products through all of its authorized producers. (A.R.S. § 20-460)			X

D. Claims Processing

#	STANDARD	PASS	PASS WITH COMMENT	FAIL
CH16 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
CH16 2	Timely investigations are conducted. (A.R.S. § 20-461, A.A.C. R20-6-801)			X
CH16 3	Claims are resolved in a timely manner. (A.R.S. §20-461, A.A.C. R20-6-801)	X		
CH16 4	The Company responds to claim correspondence in a timely manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)			X
CH16 5	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
CH16 6	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. (A.R.S. §§ 20-268, 20-461, 20-462, 20-468, 20-469, A.A.C. R20-6-801)			X
CH16 7	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

Claims Processing (cont'd)

#	STANDARD	PASS	PASS WITH COMMENT	FAIL
CH1610	Canceled benefit checks and drafts reflect appropriate claim handling practices. (A.R.S. § 20-461)	X		
CH1611	Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offer substantially less than is due under the policy. (A.R.S. § 20-461(A)(8))		X	
CH171	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		
CH172	Deductible reimbursement to insureds 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		
AZ 3	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. Arizona Rule. (A.A.C. R20-6-801)	X		
AZ 4	Adjusters used in the settlement of claims are properly licensed. (A.R.S. §§ 20-321 through 20-321.02)	X		

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