COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

STATE FARM FIRE AND CASUALTY COMPANY
BLOOMINGTON, IL

As of: December 12, 2024
Issued: January 22, 2025

BUREAU OF MARKET ACTIONS
PROPERTY & CASUALTY DIVISION

PENNSYLVANIA INSURANCE DEPARTMENT
EXAMINATION VERIFICATION

I, Richard J. Barr, Market Conduct Examiner from
(Name of Examiner) (Title of Examiner)

the Pennsylvania Insurance Department certify that I was the Examiner-In-Charge of the Report of
(Name of Vendor/Department)

Examination of State Farm Fire and Casualty Company made as of 11/27/2024.
(Name of Examined Company) (Date)

The last date of examination file review was 10/07/2024 and the written Report
(Date)

of Examination was reviewed and accepted by Paul Towsen
(Chief of Market Conduct Examiner)

On 12/12/2024
(Date)

I have reviewed the completed written Report of Examination and certify that the facts and figures recited therein are true and accurate, according to the records, documents and other evidence obtained during the course of the examination.

Richard J. Barr
(Examiner-in Charge)

Pennsylvania Insurance Department
(Name of Vendor/Department)

1321 Strawberry Square, Harrisburg, PA 17120
(Address of Vendor/Department)

Richard J. Barr Digitally signed by Richard J. Barr Date: 2024.11.27 09:10:52 -05'00'
(Examiner in Charge Signature)

11/27/2024
(Date)

IN ORDER TO SATISFY SECTION 40 P.S. § 323.5(b), THAT PROVIDES FOR NO LONGER THAN SIXTY (60) DAYS FROM THE COMPLETION OF THE EXAMINATION, THE EXAMINER IN CHARGE SHALL FILE WITH THE DEPARTMENT A VERIFIED WRITTEN REPORT OF EXAMINATION UNDER OATH.

STATE FARM FIRE AND CASUALTY COMPANY

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

O R D E R

AND NOW, this __3rd___ day of _July___, 2023, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate David J. Buono, Jr., Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.

Michael Humphreys
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
STATE FARM FIRE AND CASUALTY COMPANY	:	
One State Farm Plaza	:	40 P.S. §323.3(a)
Bloomington, IL 61710	:	
	:	40 P.S. §§ 991.2006, 991.2008(b)
	:	
	:	40 P.S. §§1171.5(a)(7)(iii) and 1171.5(a)(9)(ii)
	:	
	:	31 Pa. Code §§59.9(b), 62.3, 62.3(e)(4), 62.3(e)(7), 69.52(e), 146.3, 146.5(a), 146.5(b), 146.5(c), 146.5(d), 146.6, and 146.7(a)(1)
	:	
	:	63 P.S. §861(b)
	:	
	:	75 Pa. C.S. §§1705(a)(4), 1731(b)&(c)(c.1), 1734, and 1738(d)(1) & (2)(e)
	:	
Respondent.	:	Docket No. MC25-01-001

CONSENT ORDER

AND NOW, this 22nd day of January 2025, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. §101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following Findings of Fact:

(a) Respondent is State Farm Fire and Casualty Company, and maintains its address at One State Farm Plaza, Bloomington, IL 61710.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the experience period from July 1, 2022 through June 30, 2023.

(c) On December 12, 2024, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on January 10, 2025.

(e) The Market Conduct Examination of Respondent revealed violations of the following:

(i) All findings and conclusions in the Examination Report, which is attached hereto, are hereby incorporated into this Consent Order

CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

(a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

(b) Violations of 40 P.S.§991.2006 and 991.2008(b) (relating to motor vehicles) of 40 P.S. are punishable by the following, under Section 991.2013: Any individual or insurer who violates any of the provisions of this article may be sentenced to pay a fine not to exceed five thousand dollars ($5,000).

(c) Violations of Section 4 of the Casualty and Surety Rate Regulatory Act, No. 246 (40 P.S. §1184(a)&(h)) are punishable under Section 16 of the Act:

(i) imposition of a civil penalty not to exceed $50 for each violation or not more than $500 for each such willful violation.

(ii) suspension of the license of any insurer which fails to comply with an Order of the Commissioner within the time limited by such Order, or any extension thereof which the Commissioner may grant.

(d) Respondent's violations of 31 Pa. Code §§146.3, 146.5(a), 146.5(c), 146.5(d), 146.6, and 146.7(a)(1) are punishable under Sections1 through 5 and Section 9 of the Unfair Insurance Practices Act (40 P.S. §§1171.1 – 1171.5 and 1171.9):

(i) cease and desist from engaging in the prohibited activity.

(ii) suspension or revocation of the license(s) of Respondent.

(e) In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.1 – 1171.5, the Commissioner may, under (40 P.S. §§1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

(i) for each method of competition, act, or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00).

(ii) for each method of competition, act, or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars ($1,000.00).

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

(a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.

(b) Respondent shall pay Fifty-Nine Thousand Dollars ($59,000.00) in settlement of all violations contained in the Report.

(c) Payment of this matter shall be made at https://www.bpp.ob.pa.gov/Customer. Instructions on how to do this are provided in the attached cover letter to this order. Payment must be made no later than thirty (30) days after the date of this Order.

(d) To determine Respondent's compliance with the full and timely implementation of all recommendations in the Examination Report, the Department may inquire with the Respondent about its implementation of the Recommendations no earlier than twelve (12) months from the date of this Order.

(e) Respondent shall share the Examination Report and this Order with each of its directors and submit affidavits executed by each of its directors, stating under oath that they have received a copy of the Examination Report and this Order. Such affidavits shall be submitted within thirty (30) days of the date of this Order.

(f) Respondent shall comply with all recommendations contained in the attached Report.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: STATE FARM FIRE AND CASUALTY COMPANY
Respondent

Andy Rader
____
Andy Rader, VP of Operations -P&C Underwriting

Gregory Jones
____
Gregory Jones, Operations VP- P&C Claims

David J. Buono
____
DAVID J. BUONO
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination of State Farm Fire and Casualty Company, hereinafter referred to as "Company", was conducted at the Pennsylvania Insurance Department beginning August 15, 2023. There was no onsite portion of the exam.

Pennsylvania Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review those areas of concern in order to determine the potential impact upon Company operations or future compliance. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties.

In certain areas of review listed in this Report, the examiners will refer to "error ratio." This error ratio is calculated by dividing the number of policies with violations by the total number of policies reviewed. For example, if 100 policies are reviewed and it is determined that there are 20 violations on 10 policies, the error ratio would be 10%.

Throughout the course of the examination, Company officials were provided with status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company personnel to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the officers and employees of the Company during the course of the examination is hereby acknowledged.

The following examiners participated in this examination and in preparation of this Report.

Paul Towsen, MCM
Market Conduct Division Chief
Pennsylvania Insurance Department

Richard Barr, MCM
Market Conduct Examiner II, EIC
Pennsylvania Insurance Department

Vern Schmidt, MCM
Market Conduct Examiner II, EIC
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Joe Bieniek, AIE, AMCM, CPCU, CRM
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JoAnn Baldo, CIE, MCM, CPA, HCP
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Eva Priebe, CPCU, MCM, AIE
Market Conduct Examiner
INS Regulatory Insurance Services, Inc.

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on State Farm Fire and Casualty Company, at the Pennsylvania Insurance Department, located in Harrisburg, Pennsylvania. The examination was conducted pursuant to Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act of 1921 and covered the experience period of July 1, 2022 through June 30, 2023, unless otherwise noted. The purpose of the examination was to determine the Company's compliance with Pennsylvania insurance laws and regulations.

The examination focused on Company operations in the following areas:

1. Private Passenger Automobile
   - Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, declinations, and rescissions.
   - Rating – Proper use of all classification and rating plans and procedures.

2. Personal Property
   - Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, declinations, and rescissions.
   - Rating – Proper use of all classification and rating plans and procedures.

3. Claims

4. Complaints

5. Underwriting Practices and Procedures

6. Forms

7. Data Integrity

III. COMPANY HISTORY

State Farm Fire and Casualty Company (hereinafter referred to "SFFCC") was organized on June 12, 1935, under the laws of the State of Illinois. SFFCC, incorporated as State Farm Fire Insurance Company, was licensed and commenced business on June 29, of the same year. The present title was adopted on July 1, 1950, when the Company merged with the State Farm Casualty Company. SFFCC is the predominant writer of the Group's non-automobile property and casualty insurance in all states except California, Florida and Texas. The State Farm Group, the nation's largest automobile insurer, offers multiple lines of property, casualty and life and health insurance throughout the United States through an exclusive agency force. The affiliated entities are listed on Schedule Y from the Annual Statement. Corporate offices are located in Bloomington, Illinois. SFFCC is a wholly owned subsidiary of SFMAIC. SFFCC is licensed in all 50 states and District of Columbia.

LICENSING

State Farm Fire and Casualty Company's last Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2024. The Company is licensed in all fifty states and the District of Columbia. The Company's 2022 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $935,733,992. Premium volume related to the areas of this review were: Homeowners Multiple Peril $745,861,950; Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (Personal Injury Protection) $0; Other Private Passenger Auto Liability $37,889,745; and Private Passenger Auto Physical Damage $32,498,698.

IV. UNDERWRITING

A. Private Passenger Automobile

1. Nonrenewals

A nonrenewal is considered to be any policy that was not renewed, for a specific reason, at the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited, and Section 2006 (40 P.S. §991.2006), which establishes the requirements which must be met regarding the form and conditions of the cancellation notice.

From the universe of 2,113 private passenger automobile policies which were nonrenewed during the experience period, 74 files were selected for review. All 74 files requested were received and reviewed. The one violation noted was based on one file, resulting in an error ratio of 1%.

The following finding and concern were noted.

1 Violation 40 P.S. §991.2006

A cancellation or refusal to renew by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the insured at the address shown in the policy a written notice of the cancellation or refusal to review. The Company failed to have proof in the file to indicate the insured requested cancellation for the file noted.

2. <u>Mid-term Cancellations</u>

A mid-term cancellation is any policy that terminates at any time other than the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited, and Section 2006 (40 P.S. §991.2006), which establishes the requirements which must be met regarding the form and conditions of the cancellation notice.

From the universe of 14,535 private passenger automobile policies which were cancelled during the experience period, 100 files were selected for review. All 100 files requested were received and reviewed. There were no violations noted.

3. <u>60-Day Cancellations</u>

A 60-day cancellation is considered to be any policy, which was cancelled within the first 60 days of the inception date of the policy.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited. These files were also reviewed for compliance with Act 68, Section 2002(b)(3) (40 P.S. §991.2002(b)(3)), which requires an insurer who cancels a policy of automobile insurance in the first 60 days, to supply the insured with a written statement of the reason for cancellation.

From the universe of 5,292 automobile policies that were cancelled within the first 60 days of new business, 100 files were selected for review. All

100 files requested were received and reviewed. There were no violations noted.

The following concern was noted:

CONCERN: The Company indicates they cancelled the policy. The Company sent a letter rescinding the offer to reinstate policy contained in a nonpayment notice. The letter of withdrawal was sent three days after the policy terminated for premium due and did not contain the right to review.

4. Declinations

A declination is any application that is received by the Company and was declined to be written.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited.

From the universe of 6,205 declinations for private passenger auto insurance, 98 were selected for review. All 98 files requested were received and reviewed. The nine violations noted were based on nine files, resulting in an error ratio of 9%.

The following findings were made:

9 Violations 40 P.S. §991.2008(b)

> Any applicant for a policy who is refused such policy by an insurer shall be given a written notice of refusal to write by the insurer. Such notice shall state the specific reason or

reasons of the insurer for refusal to write a policy for the applicant. Within 30 days of the receipt of such reasons, the applicant may request in writing to the Insurance Commissioner that he review the action of the insurer in refusing to write a policy for the applicant. The Company failed to provide a specific reason for the declination on nine of the files noted.

The following concern was noted:

CONCERN: Declination letters sent to the applicants are not accurately reflecting the reasons for declinations. The Company should require that letters provided to the applicants are clear as to the reason(s) why they are being declined. The Company is responsible for the agent's actions when declining an applicant.

5. Rescissions

A rescission is any policy which was void ab initio by the Company.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited. The review also determines compliance with the rescission requirements established by the Supreme Court of Pennsylvania in Erie Insurance Exchange v. Lake.

The universe of 14 private passenger automobile policies that were identified by the Company as rescissions during the experience period was selected for review. All 14 files requested were received and reviewed. There were no violations noted.

B. Personal Property

1. Nonrenewals

A nonrenewal is considered to be any policy that was not renewed, for a specific reason, at the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine personal lines compliance with Act 205, Unfair Insurance Practices Act, Section 5(a)(9) [40 P.S. §1171.5(a)(9)], which establishes the conditions under which cancellation of a policy is permissible along with the form requirements of the nonrenewal notice.

From the universe of 2,579 property policies, which were nonrenewed during the experience period, 238 files were selected for review. The property policies consisted of homeowners, tenant homeowners, condominium, manufactured homeowner and owner-occupied dwelling fire. All 238 files requested were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 1%.

The following findings were made:

1 violation 40 P.S. §1171.5(a)(9)(ii)

State the date, not less than thirty days after the date of delivery or mailing on which such cancellation or refusal to renew shall become effective. The Company failed to provide a sufficient notice of termination for the file noted.

1 violation 31 Pa. Code §59.9(b)

The period of 60 days referred to in section 5(a)(9) and (c)(3) of The Unfair Insurance Practices Act (40 P. S. § 1171.5(a)(9) and (c)(3)) is intended to provide to insurers a reasonable period of time, if desired, to investigate thoroughly a particular risk while extending coverage during the period of investigation. An insurer may cancel the policy provided it gives at least 30 days notice of the termination and provided it gives notice no later than the 60th day. The insurer's decision to cancel during this 60-day period must not violate section 5(a)(7)(iii) of The Unfair Insurance Practices Act (40 P. S. § 1171.5(a)(7)(iii)). The Company failed to provide the cancellation notice for the file noted.

2. Mid-term Cancellations

A mid-term cancellation is any policy that terminates at any time other than the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine personal lines compliance with Act 205, Unfair Insurance Practices Act, Section 5(a)(9) [40 P.S. §1171.5(a)(9)], which establishes the conditions under which cancellation of a policy is permissible along with the form requirements of the cancellation notice.

From the universe of 83,236 property policies which were cancelled midterm during the experience period, 350 files were selected for review. The property policies consisted of homeowners, tenant homeowners, condominium, manufactured homeowner and owner-occupied dwelling

fire. All 350 files requested were received and reviewed. The 3 violations noted were based on 3 files, resulting in an error ratio of 1%.

1 violation 40 P.S. §323.3(a)

State the date, not less than thirty days after the date of delivery or mailing on which such cancellation or refusal to renew shall become effective. The Company failed to provide a complete underwriting file for the file noted.

2 violations 40 P.S. §1171.5(a)(7)(iii)

Making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status. The terms "underwriting standards and practices" or "eligibility rules" do not include the promulgation of rates if made or promulgated in accordance with the appropriate rate regulatory act of this commonwealth and regulations promulgated by the commissioner pursuant to such act. The Company failed to treat individuals of the same class and essentially the same hazard with regard to underwriting standards and practices by denying backdated request for two of the files noted.

The following concern was noted:

CONCERN: The Company did not originally terminate the policy as requested. The insured endured numerous requests and visits to the agent to resolve the matter.

3. <u>60-Day Cancellations</u>

A 60-day cancellation is considered to be any policy, which was cancelled within the first 60 days of the inception date of the policy.

The primary purpose of the review was to determine compliance with Act 205, Unfair Insurance Practices Act, Section 5(a)(7)(iii) [40 P.S. §1171.5(a)(7)(iii)], which prohibits an insurer from canceling a policy for discriminatory reasons and Title 31, Pennsylvania Code, Section 59.9(b), which requires an insurer who cancels a policy in the first 60 days to provide at least 30 days' notice of the termination.

From the universe of 9,397 property policies, which were cancelled in the first 60 days of new business, 270 files were selected for review. The property policies consisted of homeowners and tenant homeowners. All 270 files requested were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 1%.

The following findings were made:

2 Violations *31 Pa. Code §59.9(b*

The period of 60 days referred to in Section 5(a)(9) and (c)(3) of the Unfair Insurance Practices Act (40 P.S. §1171.5(a)(9) and (c)(3)) is intended to provide to insurers a reasonable period of time, if desired, to investigate thoroughly a particular risk while extending coverage during the period of

investigation. An insurer may cancel the policy provided it gives at least 30 days notice of the termination and provided it gives notice no later than the 60th day. The insurer's decision to cancel during this 60-day period must not violate Section 5(a)(7)(iii) of the Unfair Insurance Practices Act. The Company failed to provide 30 days' notice of cancellation for the two files noted.

4. Declinations

A declination is any application that is received by the Company and was declined to be written.

The primary purpose of the review was to determine compliance with Act 205, Unfair Insurance Practices Act, Section 5 [40 P.S. §1171.5], which defines unfair methods of competition and unfair or deceptive acts or practices.

From the universe of 454 property policies which were declined by the Company during the experience period, 95 files were selected for review. All 95 files requested were received and reviewed. The property policies consisted of homeowners, condo, tenant homeowners, and manufactured home. There were no violations noted.

5. Rescissions

A rescission is any policy which was void ab initio by the Company.

The primary purpose of the review was to determine compliance with Act 205, which establishes conditions under which action by the insurer is

prohibited. The review also determines compliance with the rescission requirements established by the Supreme Court of Pennsylvania in Erie Insurance Exchange v. Lake.

The universe of five property policies which were rescissions by the Company during the experience period were selected for review. The property policies consisted of five tenant homeowners. All five files requested were received and reviewed. There were no violations noted.

V. RATING

A. Private Passenger Automobile

1. New Business

New business, for the purpose of this examination, is defined as policies written for the first time by the Company during the experience period.

The primary purpose of the review was to measure compliance with The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time. Files were also reviewed to determine compliance with all provisions of the Motor Vehicle Financial Responsibility Law (75 Pa. C.S. §§1701 – 1799.7) and Act 68, Section 2005(c) (40 P.S. §991.2005(c)), which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other additional amount that is charged as a result of a claim having been made under a policy of insurance, or as a result of any other factors.

The Company uses an automated system to process and issue personal automobile policies. In order to verify the automated system, several policies were manually rated to ensure the computer had been programmed correctly. Once the computer programming had been verified, only the input data needed to be verified. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the

examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile Rating – New Business without Surcharges

From the universe of 29,914 private passenger automobile policies identified as new business without surcharges by the Company, 100 files were selected for review. All 100 files requested were received and reviewed. The 13 violations noted were based on 9 files, resulting in an error ratio of 9%.

The following findings were made:

6 Violations 75 Pa. C.S. §1705(a)(4)

Requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option. The Company failed to provide a signed and dated limited tort option selection form for the six files noted.

7 Violations 75 Pa. C.S. §1738(d)(1)&(2)(e)

Stacking of uninsured and underinsured benefits and option to waive. (d) Forms- (1) The named insured shall be informed that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the written rejection form. (2) The named insured shall be informed that he may exercise the waiver of stacked limits of underinsured motorist coverage by signing the written rejection form. (e) Signature

and date. – The forms described in subsection (d) must be signed by the first named insured and dated to be valid. Any rejection form that does not comply with this section is void. The Company failed to provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for seven files noted.

Private Passenger Automobile Rating – New Business with Surcharges

From the universe of 198 private passenger automobile policies identified as new business with surcharges by the Company, 49 files were selected for review. All 49 files requested were received and reviewed. The 10 violations noted were based on 5 files, resulting in an error ratio of 10%.

The following findings were made:

5 Violation *75 Pa. C.S. §1705(a)(4)*

Requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option. The Company failed to provide a signed and dated limited tort option selection form for the five files noted.

1 Violation *75 Pa. C.S. §1731(b)&(c)(c.1)*

Insurers shall print the rejection forms required by subsections (b) and (c) on separate sheets in prominent type and location. The forms must be signed by the first named insured and dated to be valid. The signatures on the forms

may be witnessed by an insurance agent or broker. Any rejection form that does not specifically comply with this section is void. If the insurer fails to produce a valid rejection form, uninsured or underinsured coverage, or both, as the case may be, under that policy shall be equal to the bodily injury liability limits. On policies in which either uninsured or underinsured coverage has been rejected, the policy renewals must contain notice in prominent type that the policy does not provide protection against damages caused by uninsured or underinsured motorists. Any person who executes a waiver under State Farm Fire & Casualty Insurance Company Automobile Rating New Business With Surcharges – Section 4 Page 6 subsection (b) or (c) shall be precluded from claiming liability of any person based upon inadequate information. The Company failed to provide signed written rejection forms for UM and UIM coverages for the file noted.

1 Violation *75 Pa. C.S. §1734*

Request for lower (or higher) limits of coverage. A named insured may request in writing the issuance of coverages under section 1731 (relating to availability, scope, and amount of coverage) in amounts equal to or less than the limits of liability for bodily injury. The Company failed to provide written request for UM/UIM limits not equal to BI Liability coverage for the file noted.

3 Violations *75 Pa. C.S. §1738(d)(1)&(2)(e)*

Stacking of uninsured and underinsured benefits and option to waive. (d) Forms- (1) The named insured shall be informed

that he may exercise the waiver of the stacked limits of uninsured that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the written rejection form. (2) The named insured shall be informed that he may exercise the waiver of the stacked limits of underinsured motorist coverage by signing the written rejection form. (e) Signature and date. – The forms described in subsection (d) must be signed by the first named insured and dated to be valid. Any rejection form that does not comply with this section is void. The Company failed to provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for the three files noted.

2. Renewals

A renewal is considered to be any policy, which was previously written by the Company and renewed on the normal twelve-month anniversary date.

The purpose of the review was to measure compliance with The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan, and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time. Files were also reviewed to determine compliance with Act 68 of 1998, Section 2005(c) (40 P.S. §991.2005(c)), which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other

additional amount that is charged as a result of a claim having been made under a policy of insurance, or as a result of any other factors.

The Company processes and issues personal automobile policies using an automated system. In order to verify the automated system, several policies were manually rated to ensure the computer had been programmed correctly. Once the computer programming had been verified, only the input data needed to be verified. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile – Renewals without Surcharges

From the universe of 3,392 private passenger automobile policies identified as renewals without surcharges, 100 files were selected for review. All 100 files requested were received and reviewed. Three out of 100 were manually rated. There were no violations noted.

Private Passenger Automobile – Renewals with Surcharges

From the universe of 123 private passenger automobile policies identified as renewals with surcharges, 50 files were selected for review. All 50 files requested were received and reviewed. Three out of 50 were manually rated. There were no violations noted.

B. Personal Property

1. New Business

New business, for the purpose of this examination, is defined as policies written for the first time by the Company during the experience period.

The purpose of the review was to measure compliance with Act 247, the Fire, Marine, and Inland Marine Rate Regulatory Act, Sections 4(a) and (i) (40 P.S. §1224(a), (i)), which require every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time.

Homeowner Rating – New Business without Surcharges

From the universe of 54,565 homeowner policies written as new business without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. There were no violations noted during the exam. There were no violations noted.

Homeowner Rating – New Business with Surcharges

The universe of seven homeowner policies written as new business with surcharges during the experience period were selected for review. All seven files selected were received and reviewed. There were no violations noted.

Tenant Homeowner Rating – New Business without Surcharges

From the universe of 61,360 tenant homeowner policies written as new business without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. There were no violations noted.

Tenant Homeowner Rating – New Business with Surcharges

The universe of one tenant homeowner policy written as new business with surcharges during the experience period was selected for review. The one

file requested was received and reviewed. There were no violations noted.

Condominium Rating – New Business without Surcharges

From the universe of 2,273 condominium policies written as new business without surcharges during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. Three of the 75 files were selected for manual rating. There were no violations noted.

Condominium Rating – New Business with Surcharges

The Company did not have any condominium policies written as new business with surcharges during the experience period. No files were reviewed; therefore, no violations were given.

Manufactured Home Rating – New Business without Surcharges

From the universe of 1,656 manufactured homeowner policies written as new business without surcharges during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. Out of the 50 files, three files were selected to be manually rated. There were no violations noted.

Manufactured Home Rating – New Business with Surcharges

The Company did not have any manufactured homeowner policies written as new business with surcharges during the experience period. No files were reviewed; therefore, no violations were given.

Dwelling Fire Home Rating – New Business with and without Surcharges

From the universe of 2,247 dwelling fire policies written as new business during the experience period, 74 files were selected for review. 74 were

without surcharge and zero were with surcharge. All 74 files selected were received and reviewed. There were no violations noted.

2. Renewals

A renewal is considered to be any policy, which was previously written by the Company and renewed on the normal twelve-month anniversary date.

The purpose of the review was to measure compliance with Act 247, the Fire, Marine, and Inland Marine Rate Regulatory Act, Sections 4(a) and (i) (40 P.S. §1224(a), (i)), which require every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time.

Homeowner Rating – Renewals without Surcharges

From the universe of 604,444 homeowner policies renewed without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. Three out of the 100 were manually rated. There were no violations noted.

Homeowner Rating – Renewals with Surcharges

From the universe of 1,915 homeowner policies renewed with surcharges during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. Three of the 50 files were selected to be manually rated. There were no violations noted.

Tenant Homeowner Rating – Renewals without Surcharges

From the universe of 197,325 tenant homeowner policies renewed without surcharges by the Company during the experience period, 100 files were selected for review. All 100 files requested were received and reviewed. There were no violations noted.

Tenant Homeowner Rating – Renewals with Surcharges

From the universe of 170 tenant homeowner policies renewed with surcharges by the Company during the experience period, 25 files were selected for review. All 25 files requested were received and reviewed. Three files out of the 25 files were selected to be manually rated. There were no violations noted.

Condominium Rating – Renewals without Surcharges

From the universe of 29,922 condominium policies renewed without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. There were no violations noted.

Condominium Rating – Renewals with Surcharges

From the universe of 136 condominium policies renewed with surcharges during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. Three out of the 50 policies were manually rated. There were no violations noted.

Manufactured Home Rating – Renewals without Surcharges

From the universe of 16,749 manufactured homeowner policies renewed without surcharges during the experience period, 100 files were selected for

review. All 100 files selected were received and reviewed. Three out of the 100 files were manually rated. There were no violations noted.

Manufactured Home Rating – Renewals with Surcharges

The Company did not have any manufactured homeowner policies written as renewal business with surcharges during the experience period. No files were reviewed; therefore, no violations were given.

Dwelling Fire Home Rating – Renewals with and without Surcharges

From the universe of 19,842 dwelling fire policies written as renewal business during the experience period, 113 files were selected for review. Of the files reviewed, 100 were without surcharge and 13 were with surcharge. All 113 files selected were received and reviewed. Three files out of the 113 were manually rated. There were no violations noted.

VI. CLAIMS

The Company was requested to provide copies of all established written claim handling procedures utilized during the experience period. Written claim handling procedures were received and reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature.

The Claims review consisted of the following areas of review:

A. Automobile Property Damage Claims
B. Automobile Comprehensive Claims
C. Automobile Collision Claims
D. Automobile Total Loss Claims
E. Automobile First Party Medical Claims
F. Automobile First Party Medical Claims Referred to a PRO
G. Homeowner Claims
H. Tenant Homeowner Claims
I. Condominium Claims
J. Manufactured Homeowner Claims
K. Dwelling Fire Home Claims

The primary purpose of the review was to determine compliance with 31 Pa. Code, Chapter 146, Unfair Claims Settlement Practices. The files were also reviewed to determine compliance with Act 205, Section 4 (40 P.S. §1171.4) and Section 5(a)(10)(vi) of the Unfair Insurance Practices Act (40 P.S. §1171.5(a)(10)(vi)).

A. Automobile Property Damage Claims

From the universe of 4,262 private passenger automobile property damage claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 8 violations noted were based on 6 files, resulting in an error ratio of 6%.

The following findings were made:

1 Violation *31 Pa. Code §146.5(a)*

Failure to acknowledge pertinent communications. (a) Every insurer, upon receiving notification of a claim, shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge the claim within ten working days for the claim file noted.

5 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be

expected. The Company did not provide timely status letters for the five claim files noted.

2 Violations *63 P.S. § 861(b)*

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the two claim files noted.

B. Automobile Comprehensive Claims

From the universe of 1,288 private passenger automobile comprehensive claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The four violations noted were based on two files, resulting in an error ratio of 4%.

The following findings were made:

2 Violations *31 Pa. Code §62.3*

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards for the two claim files noted.

2 Violations *63 P.S. § 861(b)*

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs

and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the two claim files noted.

The following concerns were noted:

CONCERN: The Company issues automatic closing letters when claims are still open causing confusion to the insureds.

CONCERN: The Company issues status letters were unnecessarily sent to the insured/claimant several days after the claim was paid.

CONCERN: Status Letters are automatically generated, and the letter sent to the insured/claimant does not specifically describe the delay reason. The letter lists eight possible delay reasons.

CONCERN: In seven samples reviewed there was no communication to inform the insured/claimant why the claim was closed without payment.

C. Automobile Collision Claims

From the universe of 3,482 private passenger automobile collision claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The seven violations noted were based on six files, resulting in an error ratio of 6%.

The following findings were made:

1 Violation   31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards for the claim file noted.

1 Violation   63 P.S. § 861(b)

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the claim file noted.

3 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the three claim files noted.

2 Violations 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party

claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to accept or deny the claim within 15 working days for the two claim files noted.

The following concerns were noted:

CONCERN: The Company issues automatic closing letters when claims are still open causing confusion to the insureds.

CONCERN: The Company issues status letters were unnecessarily sent to the insured/claimant several days after the claim was paid.

CONCERN: Status Letters are automatically generated, and the letter sent to the insured/claimant does not specifically describe the delay reason. The letter lists eight possible delay reasons.

CONCERN: In two claims reviewed, the tax rate of the insured/claimant location outside of Pennsylvania is used in initial appraisals but was not adjusted to the Pennsylvania tax rate when the vehicle is repaired in Pennsylvania.

CONCERN: Closing letters are not timely sent when a claim is Closed Without Payment ("CWP").

D. Automobile Total Loss Claims

From the universe of 1,813 private passenger automobile total loss claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The 23 violations noted were based on 14 files, resulting in an error ratio of 28%.

The following findings were made:

6 Violations *31 Pa. Code §62.3*

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards for the six claim files noted.

6 Violations *63 P.S. § 861(b)*

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the six claim files noted.

1 Violation *31 Pa. Code §62.3(e)(4)*

Applicable standards for appraisal. (e) The appraised value of the loss shall be the replacement value of the motor vehicle if the cost of repairing a motor vehicle exceeds its appraised value less salvage value, or the motor vehicle cannot be repaired to its predamaged condition. (4) Applicable sales tax

on the replacement cost of a motor vehicle shall be included as part of the replacement value. The Company failed to apply proper sales tax on the total loss appraisal for the claim file noted.

8 Violations *31 Pa. Code §62.3(e)(7)*

Applicable standards for appraisal. (e) The appraised value of the loss shall be the replacement value of the motor vehicle if the cost of repairing a motor vehicle exceeds its appraised value less salvage value, or the motor vehicle cannot be repaired to its predamaged condition. (7) The appraiser is responsible for ensuring that a copy of the total loss evaluation report be sent within 5 working days to the consumer by the appraiser after the appraisal is completed. If a settlement offer is extended before the consumer receives the total loss evaluation report, the consumer shall be advised of the total loss evaluation report's contents and of the consumer's right to be sent a copy within 5 days after its completion. The Company failed to send the evaluation to the insured within five working days for the eight claim files noted.

2 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be

expected. The Company did not provide timely status letters for the two claim files noted.

The following concern was noted:

CONCERN: Status Letters are automatically generated, and the letter sent to the insured/claimant does not specifically describe the delay reason. The letter lists multiple possible delay reasons.

CONCERN: The Company issued the closing letter, in error, one day after the claim was opened. This practice can cause confusion and concern to the insured.

CONCERN: The Company issued settlement letters that included the valuations as an enclosure and the amount listed in the total loss settlement letters did not match the valuation amounts in the enclosed valuations. This practice can cause confusion and concern to the insured.

E. Automobile First Party Medical Claims

From the universe of 2,336 private passenger automobile first party medical claims reported during the experience period, 50 claim files were selected for review. All 50 files requested were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 4%.

The following findings were made:

2 Violations 31 Pa Code §146.5(d)

Requires an insurer, upon receiving notification of a claim,

shall provide within ten working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable requirements of the insurer. The Company did not provide the necessary claim forms to the claimant within ten working days for the two claim files noted.

F. Automobile First Party Medical Claims Referred to a PRO

The universe of one automobile first party medical claims that were referred to a peer review organization by the Company was selected received and reviewed. The Company was also asked to provide a copy of all peer review contracts in place during the experience period. The one violation noted were based on one file, resulting in an error ratio of 100%.

The following findings were made:

1 Violation *31 Pa. Code §69.52(e)*

Requires an insurer to pay bills that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill. The Company failed to pay medical bills within 30 days for the claim noted. The Company failed to provide PRO report to provider and insured within five days of receipt for the claim file noted.

G. Homeowner Claims

From the universe of 38,875 homeowner claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 11 violations noted were based on 11 files, resulting in an error ratio of 11%.

The following findings were made:

2 Violations *31 Pa. Code §146.3*

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The Company failed to maintain a complete claim file for two claim files noted.

9 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the nine claim files noted.

The following concern was noted:

CONCERN: The Company included New Jersey statute in the 30/45 status letters for several claims, which were for a loss that occurred in Pennsylvania. Applying New Jersey statutes is inappropriate handling of these claim and reference to such statutes in the status letters is misleading to the insured.

H. Tenant Homeowner Claims

From the universe of 3,546 tenant homeowner claims reported during the experience period, 100 were selected for review. All 100 claims requested were received and reviewed. The five violations noted were based on five files, resulting in an error ratio of 5%.

4 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the four claim files noted.

1 Violation 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to accept or deny the claim within 15 working days for the claim file noted.

The following concern was noted:

CONCERN: The Company included New Jersey statute in the 30/45 status letters for several claims, which were for a loss that occurred in Pennsylvania. Applying New Jersey statutes is inappropriate handling of these claim and reference to such statutes in the status letters is misleading to the insured.

I. Condominium Claims

From the universe of 1,421 homeowner claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 4%.

1 Violation 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the claim file noted.

1 Violation 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the

claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to accept or deny the claim within 15 working days for the claim file noted.

J. Manufactured Homeowner Claims

From the universe of 1,011 manufactured homeowner claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The six violations noted were based on six files, resulting in an error ratio of 12%.

The following findings were made:

1 Violation 31 Pa. Code §146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The Company failed to provide a complete file for the claim file noted.

5 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30

days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the five claim files noted.

The following concern was noted:

CONCERN: The Company included New Jersey statute in the 30/45 status letters for several claims, which were for a loss that occurred in Pennsylvania. Applying New Jersey statutes is inappropriate handling of these claim and reference to such statutes in the status letters is misleading to the insured.

K. Dwelling Fire Home Claims

From the universe of 58,035 dwelling fire claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 21 violations noted were based on 15 files, resulting in an error ratio of 15%.

The following findings were made:

4 Violations 31 Pa. Code §146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed.

The Company failed to provide a complete file for the four claim files noted.

2 Violations 31 Pa. Code §146.5(c)

Failure to acknowledge pertinent communications. An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected. The Company failed to provide a complete file for the two claim files noted.

7 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the seven claim files noted.

8 Violation 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or

exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to accept or deny the claim within 15 working days for the six of the claim files noted and failed to provide the policy provision, condition, or exclusion for two of the claim files noted.

The following concern was noted:

CONCERN: The Company included New Jersey statute in the 30/45 status letters for several claims, which were for a loss that occurred in Pennsylvania. Applying New Jersey statutes is inappropriate handling of these claim and reference to such statutes in the status letters is misleading to the insured.

CONCERN: In one claim the Company included a reference to a California regulation in the closing letter to the insured, which was for a loss that occurred in Pennsylvania. Applying California regulations is inappropriate handling of this claim and reference to such regulations in the closing letter is misleading to the insured.

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of their consumer complaint logs for the preceding four years. The Company identified 656 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the universe of 656 complaint files, 60 files were selected for review. All 60 files requested were received and reviewed.

The purpose of the review was to determine compliance with the Unfair Insurance Practices Act, (40 P.S. §§1171.1 – 1171.5). Section 5(a)(11) of the Act (40 P.S. §1171.5(a)(11)), requires a company to maintain a complete record of all complaints received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. The individual complaint files were reviewed for the relevancy to applicable statues and to verify compliance with 31 Pa. Code §146.5(b)(c).

The following findings were made:

2 Violations *31 Pa. Code §146.5(b)*

Every insurer, upon receipt of any inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry. The Company failed to provide the Department with an adequate response to their inquiry within 15 working days for the two files noted.

The following synopsis reflects the nature of the 60 complaints that were received.

Number	Category	Percent
20	Cancellation/Nonrenewal	33%
25	Claims Related	42%
6	Customer Service	10%
5	Billing and Payment	8%
3	Premium/Price/Setup	5%
1	Agency Conduct	2%
60		100%

VIII. UNDERWRITING PRACTICES AND PROCEDURES

As part of the examination, the Company was requested to supply manuals, underwriting guides, bulletins, directives, or other forms of underwriting procedure communications for each line of business being reviewed. Underwriting guides and supplements were furnished for homeowners, tenant homeowners and condominium. The purpose of this review was to identify any inconsistencies which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. There were no violations noted.

IX. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy forms used in order to verify compliance with the Insurance Company Law, Section 354 (40 P.S. §477b), Approval of Policies, Contracts, etc., Prohibiting the Use Thereof Unless Approved. During the experience period of the examination, Section 354 provided that it shall be unlawful for any insurance company to issue, sell, or dispose of any policy contract or certificate covering fire, marine, title and all forms of casualty insurance or use applications, riders, or endorsements in connection therewith, until the forms have been submitted to and formally approved by the Insurance Commissioner. All underwriting and claim files were also reviewed to verify compliance with 75 Pa. C.S. §1822, which requires all insurers to provide an insurance fraud notice on all applications for insurance, all claims forms and all renewals of coverage and 18 Pa. C.S. §4117(k)(1), which requires all insurers to provide an insurance fraud notice on all applications for insurance and all claim forms. There were no violations noted.

X. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary examination packet in accordance with NAIC uniformity standards and provided specific information relative to the exam. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure its accuracy and completeness to determine compliance with Insurance Department Act of 1921, Section 904(b) (40 P.S. §323.3(a)). Several data integrity issues were found during the exam.

The data integrity issue of each area of review is identified below.

Tenant Homeowners Renewals With Surcharge

Situation: As the examiners reviewed the Tenant Homeowner Renewals with surcharge policy files of the rating section of the exam, it was noted that not all the 25 files selected for review were Tenant with surcharge files.

Finding: Of the 25 midterm cancellation files reviewed, one file was identified as Tenant Homeowner Renewal without a surcharge.

Condominium New Business Without Surcharge

Situation: As the examiners reviewed the Condominium (Condo) New Business without surcharge policy files of the rating section of the exam, it was noted that not all the 75 files selected for review were Condo without surcharge.

Finding: Of the 75 Condo New Business without surcharge files reviewed, one file was identified as Condo New Business with a surcharge.

Collision Claims

Situation: As the examiners reviewed the Collision files of the claims section of the exam, it was noted that not all the 100 files selected for review were Collision claims.

Finding: Of the 100 Collision claim files reviewed, one file was identified as Total Loss claim.

Auto 60-Day Cancellations

Situation: As the examiners reviewed the 60-Day Cancellations of the auto underwriting section of the exam, it was noted that not all the 100 files selected for review were 60-Day Cancellations.

Finding: Of the 100 60-Day Cancellation files reviewed, three files were identified as Midterm Cancellations.

The following finding was made:

General Violation *40 P.S. §323.3(a)*

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business, and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of

that company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The violation was the result of a failure to exercise sufficient due diligence to ensure compliance with the Insurance Department Act of 1921.

XI. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other statutory or regulatory violations, noted in the Report.

1. The Company must review 18 Pa. C.S.§4117(k)(1) to ensure that violations regarding the requirement of a fraud warning on all claim forms, as noted in the Report, do not occur in the future.

2. The Company must reinforce its internal data controls to ensure that notices of cancellation are maintained in accordance with 31 Pa. Code §59.9(b), so that violations noted in the Report do not occur in the future.

3. Company must review 31 Pa. Code §62.3 with its claim staff to ensure all appraisal requirements are met so the violations, as noted in the Report, do not occur in the future.

4. The Company must review 31 Pa. Code §62.3(e)(4) with its claim staff to ensure a copy of the total loss evaluation is provided to the insured within 5 working days so the violation, as noted in the Report, does not occur in the future.

5. The Company must review 31 Pa. Code §62.3(e)(7) with its claim staff to ensure that a copy of the total loss evaluation is provided to the insured within 5 working days, so that violations, as noted in the Report, do not occur in the future.

6. The Company must review 31 Pa. Code §69.52(e) with its claim staff to ensure that the insured is provided a copy of a PRO evaluation in a timely manner, so that the violation noted in the Report does not occur in the future.

7. The Company must review 31 Pa Code §146.3 with its claim staff to ensure the claims department maintains complete claim files.

8. The Company must review 31 Pa Code §146.5(a) with its claim staff to ensure that the claims department promptly acknowledges the claim within 10 working days, so that the violation noted in the Report does not occur in the future.

9. The Company must review 31 Pa Code §146.5(b) with its claim staff to ensure that the claims department promptly provides the Department with an adequate response to its inquiry within 15 working days, so that violations noted in the Report do not occur in the future.

10. The Company must review 31 Pa Code §146.5(c) with its claim staff to ensure that the claims department promptly responds to a claimant's communications within 10 days working days, so that violations noted in the Report do not occur in the future.

11. The Company must review 31 Pa Code §146.5(d) with its claim staff to ensure that the claims department promptly provides the required claim forms for first party medical claims within 10 days of receiving the claim notification, so that violations noted in the Report do not occur in the future.

12. The Company must review 31 Pa Code §146.6 with its claim staff to ensure that the claims department promptly provides the required 30/45 day status letter to claimants, so the violations noted in the Report do not occur in the future.

13. The Company must review 31 Pa Code §146.7(a)(1) with its claim staff to ensure the claims department promptly sends denial letters to insureds within the required 15 working days of receiving proofs of loss and to provide the policy provision, condition, or exclusion.

14. The Company must reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.3(a), so that violations noted in the Report do not occur in the future.

15. The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notice requirements of 40 P.S. §§991.2006 and 991.2008(b), so that the violations noted in the Report do not occur in the future.

16. The Company must review and revise internal control procedures to ensure compliance with 40 P.S. §1171.5(a)(7)(iii) so that underwriting standards are consistently applied to individuals of the same class and/or hazard who are requesting backdating.

17. The Company must review 40 P.S. §1171.5(a)(9)(ii) and take appropriate actions to ensure that sufficient notice of termination is provided, so that the violations noted in the Report do not occur in the future.

18. The Company must review 63 P.S. §861(b) with its claim staff to ensure violations for missing appraiser name and appraiser license information on auto appraisal copies as noted in the Report, do not occur in the future.

19. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to elect a tort option and that signed tort option selection forms are obtained and retained with the underwriting file. This is to ensure that violations noted under 75 Pa. C.S. §1705(a)(4) do not occur in the future.

20. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to exercise the waiver for uninsured and underinsured motorist coverage forms are obtained and retained with the underwriting file. This is to ensure that violations noted under 75 Pa. C.S. §1731(b) & (c)(c.1) do not occur in the future.

21. The Company must review 75 Pa. C.S. §1734 with its underwriting staff to ensure insureds are provided written requests for lower UM/UIM limits.

22. The Company must revise underwriting procedures to ensure that the insured is aware that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms. This is to ensure that violations, as noted in the Report under 75 Pa. C.S. §1738(d)(1) and (2)(e) do not occur in the future.

XII. COMPANY RESPONSE

PENNSYLVANIA INSURANCE DEPARTMENT
EXAMINATION VERIFICATION

I, Richard J. Barr, Market Conduct Examiner from
(Name of Examiner) (Title of Examiner)

the Pennsylvania Insurance Department certify that I was the Examiner-In-Charge of the Report of
(Name of Vendor/Department)

Examination of State Farm Fire and Casualty Company made as of 11/27/2024.
(Name of Examined Company) (Date)

The last date of examination file review was 10/07/2024 and the written Report
(Date)

of Examination was reviewed and accepted by Paul Towsen
(Chief of Market Conduct Examiner)

On 12/12/2024
(Date)

I have reviewed the completed written Report of Examination and certify that the facts and figures recited therein are true and accurate, according to the records, documents and other evidence obtained during the course of the examination.

Richard J. Barr
(Examiner-in Charge)

Pennsylvania Insurance Department
(Name of Vendor/Department)

1321 Strawberry Square, Harrisburg, PA 17120
(Address of Vendor/Department)

Richard J. Barr Digitally signed by Richard J. Barr
Date: 2024.11.27 09:10:52 -05'00'
(Examiner in Charge Signature)

11/27/2024
(Date)

IN ORDER TO SATISFY SECTION 40 P.S. § 323.5(b), THAT PROVIDES FOR NO LONGER THAN SIXTY (60) DAYS FROM THE COMPLETION OF THE EXAMINATION, THE EXAMINER IN CHARGE SHALL FILE WITH THE DEPARTMENT A VERIFIED WRITTEN REPORT OF EXAMINATION UNDER OATH.

STATE FARM FIRE AND CASUALTY COMPANY

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I. INTRODUCTION

The Market Conduct Examination of State Farm Fire and Casualty Company, hereinafter referred to as "Company", was conducted at the Pennsylvania Insurance Department beginning August 15, 2023. There was no onsite portion of the exam.

Pennsylvania Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review those areas of concern in order to determine the potential impact upon Company operations or future compliance. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties.

In certain areas of review listed in this Report, the examiners will refer to "error ratio." This error ratio is calculated by dividing the number of policies with violations by the total number of policies reviewed. For example, if 100 policies are reviewed and it is determined that there are 20 violations on 10 policies, the error ratio would be 10%.

Throughout the course of the examination, Company officials were provided with status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company personnel to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the officers and employees of the Company during the course of the examination is hereby acknowledged.

The following examiners participated in this examination and in preparation of this Report.

Paul Towsen, MCM
Market Conduct Division Chief
Pennsylvania Insurance Department

Richard Barr, MCM
Market Conduct Examiner II, EIC
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Market Conduct Examiner
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II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on State Farm Fire and Casualty Company, at the Pennsylvania Insurance Department, located in Harrisburg, Pennsylvania. The examination was conducted pursuant to Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act of 1921 and covered the experience period of July 1, 2022 through June 30, 2023, unless otherwise noted. The purpose of the examination was to determine the Company's compliance with Pennsylvania insurance laws and regulations.

The examination focused on Company operations in the following areas:

1. Private Passenger Automobile
   - Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, declinations, and rescissions.
   - Rating – Proper use of all classification and rating plans and procedures.

2. Personal Property
   - Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, declinations, and rescissions.
   - Rating – Proper use of all classification and rating plans and procedures.

3. Claims

4. Complaints

5. Underwriting Practices and Procedures

6. Forms

7. Data Integrity

III. COMPANY HISTORY

State Farm Fire and Casualty Company (hereinafter referred to "SFFCC") was organized on June 12, 1935, under the laws of the State of Illinois. SFFCC, incorporated as State Farm Fire Insurance Company, was licensed and commenced business on June 29, of the same year. The present title was adopted on July 1, 1950, when the Company merged with the State Farm Casualty Company. SFFCC is the predominant writer of the Group's non-automobile property and casualty insurance in all states except California, Florida and Texas. The State Farm Group, the nation's largest automobile insurer, offers multiple lines of property, casualty and life and health insurance throughout the United States through an exclusive agency force. The affiliated entities are listed on Schedule Y from the Annual Statement. Corporate offices are located in Bloomington, Illinois. SFFCC is a wholly owned subsidiary of SFMAIC. SFFCC is licensed in all 50 states and District of Columbia.

LICENSING

State Farm Fire and Casualty Company's last Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2024. The Company is licensed in all fifty states and the District of Columbia. The Company's 2022 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $935,733,992. Premium volume related to the areas of this review were: Homeowners Multiple Peril $745,861,950; Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (Personal Injury Protection) $0; Other Private Passenger Auto Liability $37,889,745; and Private Passenger Auto Physical Damage $32,498,698.

IV. UNDERWRITING

A. Private Passenger Automobile

1. Nonrenewals

A nonrenewal is considered to be any policy that was not renewed, for a specific reason, at the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited, and Section 2006 (40 P.S. §991.2006), which establishes the requirements which must be met regarding the form and conditions of the cancellation notice.

From the universe of 2,113 private passenger automobile policies which were nonrenewed during the experience period, 74 files were selected for review. All 74 files requested were received and reviewed. The one violation noted was based on one file, resulting in an error ratio of 1%. The following finding and concern were noted.

1 Violation *40 P.S. §991.2006*

A cancellation or refusal to renew by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the insured at the address shown in the policy a written notice of the cancellation or refusal to review. The Company failed to have proof in the file to indicate the insured requested cancellation for the file noted.

2. <u>Mid-term Cancellations</u>

A mid-term cancellation is any policy that terminates at any time other than the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited, and Section 2006 (40 P.S. §991.2006), which establishes the requirements which must be met regarding the form and conditions of the cancellation notice.

From the universe of 14,535 private passenger automobile policies which were cancelled during the experience period, 100 files were selected for review. All 100 files requested were received and reviewed. There were no violations noted.

3. <u>60-Day Cancellations</u>

A 60-day cancellation is considered to be any policy, which was cancelled within the first 60 days of the inception date of the policy.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited. These files were also reviewed for compliance with Act 68, Section 2002(b)(3) (40 P.S. §991.2002(b)(3)), which requires an insurer who cancels a policy of automobile insurance in the first 60 days, to supply the insured with a written statement of the reason for cancellation.

From the universe of 5,292 automobile policies that were cancelled within the first 60 days of new business, 100 files were selected for review. All

100 files requested were received and reviewed. There were no violations noted.

The following concern was noted:

CONCERN: The Company indicates they cancelled the policy. The Company sent a letter rescinding the offer to reinstate policy contained in a nonpayment notice. The letter of withdrawal was sent three days after the policy terminated for premium due and did not contain the right to review.

4. Declinations

A declination is any application that is received by the Company and was declined to be written.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited.

From the universe of 6,205 declinations for private passenger auto insurance, 98 were selected for review. All 98 files requested were received and reviewed. The nine violations noted were based on nine files, resulting in an error ratio of 9%.

The following findings were made:

9 Violations 40 P.S. §991.2008(b)

> Any applicant for a policy who is refused such policy by an insurer shall be given a written notice of refusal to write by the insurer. Such notice shall state the specific reason or

reasons of the insurer for refusal to write a policy for the applicant. Within 30 days of the receipt of such reasons, the applicant may request in writing to the Insurance Commissioner that he review the action of the insurer in refusing to write a policy for the applicant. The Company failed to provide a specific reason for the declination on nine of the files noted.

COMPANY RESPONSE: AGREE. We think it's worth noting that agent declination letters state "No reasons provided for this Consumer History Report" due to consumer report information not being available as a result of a system delay/issues in processing the consumer reports and the agent generated the declination letter during the system delay. We will work with agents to submit these requests when the system can process information to provide to customers.

The following concern was noted:

CONCERN: Declination letters sent to the applicants are not accurately reflecting the reasons for declinations. The Company should require that letters provided to the applicants are clear as to the reason(s) why they are being declined. The Company is responsible for the agent's actions when declining an applicant.

COMPANY RESPONSE: Please see the response above.

5. Rescissions

A rescission is any policy which was void ab initio by the Company.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited. The review also determines compliance with the rescission requirements established by the Supreme Court of Pennsylvania in Erie Insurance Exchange v. Lake.

The universe of 14 private passenger automobile policies that were identified by the Company as rescissions during the experience period was selected for review. All 14 files requested were received and reviewed. There were no violations noted.

B. Personal Property

1. Nonrenewals

A nonrenewal is considered to be any policy that was not renewed, for a specific reason, at the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine personal lines compliance with Act 205, Unfair Insurance Practices Act, Section 5(a)(9) [40 P.S. §1171.5(a)(9)], which establishes the conditions under which cancellation of a policy is permissible along with the form requirements of the nonrenewal notice.

From the universe of 2,579 property policies, which were nonrenewed during the experience period, 238 files were selected for review. The property policies consisted of homeowners, tenant homeowners, condominium, manufactured homeowner and owner-occupied dwelling fire. All 238 files requested were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 1%.

The following findings were made:

1 violation *40 P.S. §1171.5(a)(9)(ii)*

State the date, not less than thirty days after the date of delivery or mailing on which such cancellation or refusal to renew shall become effective. The Company failed to provide a sufficient

notice of termination for the file noted.

1 violation *31 Pa. Code §59.9(b)*

The period of 60 days referred to in section 5(a)(9) and (c)(3) of The Unfair Insurance Practices Act (40 P. S. § 1171.5(a)(9) and (c)(3)) is intended to provide to insurers a reasonable period of time, if desired, to investigate thoroughly a particular risk while extending coverage during the period of investigation. An insurer may cancel the policy provided it gives at least 30 days notice of the termination and provided it gives notice no later than the 60th day. The insurer's decision to cancel during this 60-day period must not violate section 5(a)(7)(iii) of The Unfair Insurance Practices Act (40 P. S. § 1171.5(a)(7)(iii)). The Company failed to provide the cancellation notice for the file noted.

2. Mid-term Cancellations

A mid-term cancellation is any policy that terminates at any time other than the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine personal lines compliance with Act 205, Unfair Insurance Practices Act, Section 5(a)(9) [40 P.S. §1171.5(a)(9)], which establishes the conditions under which cancellation of a policy is permissible along with the form requirements of the cancellation notice.

From the universe of 83,236 property policies which were cancelled midterm during the experience period, 350 files were selected for review. The property policies consisted of homeowners, tenant homeowners, condominium, manufactured homeowner and owner-occupied dwelling

fire. All 350 files requested were received and reviewed. The 3 violations noted were based on 3 files, resulting in an error ratio of 1%.

1 violation 40 P.S. §323.3(a)

State the date, not less than thirty days after the date of delivery or mailing on which such cancellation or refusal to renew shall become effective. The Company failed to provide a complete underwriting file for the file noted.

COMPANY RESPONSE:

DISAGREE: This policy was canceled during the underwriting review period, the declarations page was therefore not issued or necessary.

2 violations 40 P.S. §1171.5(a)(7)(iii)

Making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status. The terms "underwriting standards and practices" or "eligibility rules" do not include the promulgation of rates if made or promulgated in accordance with the appropriate rate regulatory act of this commonwealth and regulations promulgated by the commissioner pursuant to such act. The Company failed to treat individuals of the same class and essentially the same hazard with regard to underwriting standards and practices by denying backdated request for two of the files noted.

The following concern was noted:

CONCERN: The Company did not originally terminate the policy as requested. The insured endured numerous requests and visits to the agent to resolve the matter.

3. 60-Day Cancellations

A 60-day cancellation is considered to be any policy, which was cancelled within the first 60 days of the inception date of the policy.

The primary purpose of the review was to determine compliance with Act 205, Unfair Insurance Practices Act, Section 5(a)(7)(iii) [40 P.S. §1171.5(a)(7)(iii)], which prohibits an insurer from canceling a policy for discriminatory reasons and Title 31, Pennsylvania Code, Section 59.9(b), which requires an insurer who cancels a policy in the first 60 days to provide at least 30 days' notice of the termination.

From the universe of 9,397 property policies, which were cancelled in the first 60 days of new business, 270 files were selected for review. The property policies consisted of homeowners and tenant homeowners. All 270 files requested were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 1%.

The following findings were made:

2 Violations *31 Pa. Code §59.9(b*

The period of 60 days referred to in Section 5(a)(9) and (c)(3) of the Unfair Insurance Practices Act (40 P.S. §1171.5(a)(9) and (c)(3)) is intended to provide to insurers a reasonable period of time, if desired, to investigate thoroughly a particular risk while extending coverage during the period of

investigation. An insurer may cancel the policy provided it gives at least 30 days notice of the termination and provided it gives notice no later than the 60th day. The insurer's decision to cancel during this 60-day period must not violate Section 5(a)(7)(iii) of the Unfair Insurance Practices Act. The Company failed to provide 30 days' notice of cancellation for the two files noted.

4. Declinations

A declination is any application that is received by the Company and was declined to be written.

The primary purpose of the review was to determine compliance with Act 205, Unfair Insurance Practices Act, Section 5 [40 P.S. §1171.5], which defines unfair methods of competition and unfair or deceptive acts or practices.

From the universe of 454 property policies which were declined by the Company during the experience period, 95 files were selected for review. All 95 files requested were received and reviewed. The property policies consisted of homeowners, condo, tenant homeowners, and manufactured home. There were no violations noted.

5. Rescissions

A rescission is any policy which was void ab initio by the Company.

The primary purpose of the review was to determine compliance with Act 205, which establishes conditions under which action by the insurer is prohibited. The review also determines compliance with the rescission

requirements established by the Supreme Court of Pennsylvania in Erie Insurance Exchange v. Lake.

The universe of five property policies which were rescissions by the Company during the experience period were selected for review. The property policies consisted of five tenant homeowners. All five files requested were received and reviewed. There were no violations noted.

V. RATING

A. Private Passenger Automobile

1. New Business

New business, for the purpose of this examination, is defined as policies written for the first time by the Company during the experience period.

The primary purpose of the review was to measure compliance with The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time. Files were also reviewed to determine compliance with all provisions of the Motor Vehicle Financial Responsibility Law (75 Pa. C.S. §§1701 – 1799.7) and Act 68, Section 2005(c) (40 P.S. §991.2005(c)), which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other additional amount that is charged as a result of a claim having been made under a policy of insurance, or as a result of any other factors.

The Company uses an automated system to process and issue personal automobile policies. In order to verify the automated system, several policies were manually rated to ensure the computer had been programmed correctly. Once the computer programming had been verified, only the input data needed to be verified. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile Rating – New Business without Surcharges

From the universe of 29,914 private passenger automobile policies identified as new business without surcharges by the Company, 100 files were selected for review. All 100 files requested were received and reviewed. Th 13 violations noted were based on 9 files, resulting in an error ratio of 9%.

The following findings were made:

6 Violations 75 Pa. C.S. §1705(a)(4)

Requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option. The Company failed to provide a signed and dated limited tort option selection form for the six files noted.

COMPANY RESPONSE:
AGREE that no form was in these files. However, there is no violation of the law in any of these files. In the event of a covered loss, State Farm would treat the customer as if full

tort had been selected. It's important to note that the customer had the opportunity to make a tort election and did not do so.

7 Violations 75 Pa. C.S. § 1738 (d)(1)&(2)(e)

Stacking of uninsured and underinsured benefits and option to waive. (d) Forms- (1) The named insured shall be informed that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the written rejection form. (2) The named insured shall be informed that he may exercise the waiver of stacked limits of underinsured motorist coverage by signing the written rejection form. (e) Signature and date. – The forms described in subsection (d) must be signed by the first named insured and dated to be valid. Any rejection form that does not comply with this section is void. The Company failed to provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for seven files noted.

AGREE that no form was in these files. It's important to note that named insureds in these files were offered the opportunity to purchase or reject UM/UIM coverage as required in the statute. Because the customers did not return the signed forms, in the event of a covered loss, State Farm would treat the customer as if UM/UIM limits equal to BI limits has been selected. Therefore, we do not believe there is a violation of the law. State Farm has instructed the agent to reach out and confirm the customer's selection and obtain any corresponding forms.

CONCERN: The file lacks a signature for limited tort.

COMPANY RESPONSE: See our response above.

<u>Private Passenger Automobile Rating – New Business with Surcharges</u>

From the universe of 198 private passenger automobile policies identified as new business with surcharges by the Company, 49 files were selected for review. All 49 files requested were received and reviewed. The 10

violations noted were based on 5 files, resulting in an error ratio of 10%.

The following findings were made:

5 Violations 75 Pa. C.S. §1705(a)(4)

Requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option. The Company failed to provide a signed and dated limited tort option selection form for the five files noted.

COMPANY RESPONSE:

AGREE that no form was in these files. There is no violation of the law in any of these files. In the event of a covered loss, State Farm would treat the customer as if full tort had been selected. It's important to note that the customers had the opportunity to make a tort election and did not do so.

1 Violations 75 Pa. C.S. § 1731 (b)&(c)(c.1)

Insurers shall print the rejection forms required by subsections (b) and (c) on separate sheets in prominent type and location. The forms must be signed by the first named insured and dated to be valid. The signatures on the forms may be witnessed by an insurance agent or broker. Any rejection form that does not specifically comply with this section is void. If the insurer fails to produce a valid rejection form, uninsured or underinsured coverage, or both, as the case may be, under that policy shall be equal to the bodily injury liability limits. On policies in which either uninsured or underinsured coverage has been rejected, the policy renewals

must contain notice in prominent type that the policy does not provide protection against damages caused by uninsured or underinsured motorists. Any person who executes a waiver under State Farm Fire & Casualty Insurance Company Automobile Rating New Business With Surcharges – Section 4 Page 6 subsection (b) or (c) shall be precluded from claiming liability of any person based upon inadequate information. The Company failed to provide signed written rejection forms for UM and UIM coverages for the file noted.

COMPANY RESPONSE:

AGREE that no form was in these files. However, the named insured was offered the opportunity to purchase or reject UM/UIM coverage as required in the statute. Because the customer did not return the signed forms, in the event of a covered loss, State Farm would treat the customer as if UM/UIM limits equal to BI limits has been selected. State Farm has instructed the agent to reach out and confirm the customer's selection and obtain any corresponding forms.

1 Violations 75 Pa. C.S. §1734

Request for lower (or higher) limits of coverage. A named insured may request in writing the issuance of coverages under section 1731 (relating to availability, scope, and amount of coverage) in amounts equal to or less than the limits of liability for bodily injury. The Company failed to provide written request for UM/UIM limits not equal to BI Liability coverage for the file noted.

COMPANY RESPONSE:

AGREE that no form was in these files. However, the named insured was offered the opportunity to purchase or reject UM/UIM coverage as required in the statute. Because the customer did not return the

signed forms, in the event of a covered loss, State Farm would treat the customer as if UM/UIM limits were equal to BI limits. State Farm instructed the agent to reach out and confirm the customer's selection and obtain any corresponding forms.

3 Violations 75 Pa. C.S. §1738 (d)(1)&(2)(e)

Stacking of uninsured and underinsured benefits and option to waive. (d) Forms- (1) The named insured shall be informed that he may exercise the waiver of the stacked limits of uninsured that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the written rejection form. (2) The named insured shall be informed that he may exercise the waiver of the stacked limits of underinsured motorist coverage by signing the written rejection form. (e) Signature and date. – The forms described in subsection (d) must be signed by the first named insured and dated to be valid. Any rejection form that does not comply with this section is void. The Company failed to provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for the three files noted.

COMPANY RESPONSE:

AGREE. However, the customer was informed that they may exercise the waiver of the stacked limits of underinsured motorist coverage by signing the written rejection form. Because the customer did not return the signed form, in the event of a covered loss, State Farm would treat the customer as if stacked UIM limits has been selected. Therefore, there is no violation of the law. State Farm has instructed the agent to reach out and confirm the customer's selection and obtain any corresponding forms.

2. Renewals

A renewal is considered to be any policy, which was previously written by

the Company and renewed on the normal twelve-month anniversary date.

The purpose of the review was to measure compliance with The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan, and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time. Files were also reviewed to determine compliance with Act 68 of 1998, Section 2005(c) (40 P.S. §991.2005(c)), which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other additional amount that is charged as a result of a claim having been made under a policy of insurance, or as a result of any other factors.

The Company processes and issues personal automobile policies using an automated system. In order to verify the automated system, several policies were manually rated to ensure the computer had been programmed correctly. Once the computer programming had been verified, only the input data needed to be verified. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile – Renewals without Surcharges

From the universe of 3,392 private passenger automobile policies identified as renewals without surcharges, 100 files were selected for review. All 100 files requested were received and reviewed. Three out of 100 were

manually rated. There were no violations noted.

Private Passenger Automobile – Renewals with Surcharges

From the universe of 123 private passenger automobile policies identified as renewals with surcharges, 50 files were selected for review. All 50 files requested were received and reviewed. Three out of 50 were manually rated. There were no violations noted.

B. Personal Property

1. New Business

New business, for the purpose of this examination, is defined as policies written for the first time by the Company during the experience period.

The purpose of the review was to measure compliance with Act 247, the Fire, Marine, and Inland Marine Rate Regulatory Act, Sections 4(a) and (i) (40 P.S. §1224(a), (i)), which require every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time.

Homeowner Rating – New Business without Surcharges

From the universe of 54,565 homeowner policies written as new business without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. There were no violations noted during the exam. There were no violations noted.

Homeowner Rating – New Business with Surcharges

The universe of seven homeowner policies written as new business with

surcharges during the experience period were selected for review. All seven files selected were received and reviewed. There were no violations noted.

Tenant Homeowner Rating – New Business without Surcharges

From the universe of 61,360 tenant homeowner policies written as new business without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. There were no violations noted.

Tenant Homeowner Rating – New Business with Surcharges

The universe of one tenant homeowner policy written as new business with surcharges during the experience period was selected for review. The one file requested was received and reviewed. There were no violations noted.

Condominium Rating – New Business without Surcharges

From the universe of 2,273 condominium policies written as new business without surcharges during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. Three of the 75 files were selected for manual rating. There were no violations noted.

Condominium Rating – New Business with Surcharges

The Company did not have any condominium policies written as new business with surcharges during the experience period. No files were reviewed; therefore, no violations were given.

Manufactured Home Rating – New Business without Surcharges

From the universe of 1,656 manufactured homeowner policies written as new business without surcharges during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed.

Out of the 50 files, three files were selected to be manually rated. There were no violations noted.

Manufactured Home Rating – New Business with Surcharges

The Company did not have any manufactured homeowner policies written as new business with surcharges during the experience period. No files were reviewed; therefore, no violations were given.

Dwelling Fire Home Rating – New Business with and without Surcharges

From the universe of 2,247 dwelling fire policies written as new business during the experience period, 74 files were selected for review. 74 were without surcharge and zero were with surcharge. All 74 files selected were received and reviewed. There were no violations noted.

2. Renewals

A renewal is considered to be any policy, which was previously written by the Company and renewed on the normal twelve-month anniversary date.

The purpose of the review was to measure compliance with Act 247, the Fire, Marine, and Inland Marine Rate Regulatory Act, Sections 4(a) and (i) (40 P.S. §1224(a), (i)), which require every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time.

Homeowner Rating – Renewals without Surcharges

From the universe of 604,444 homeowner policies renewed without

surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. Three out of the 100 were manually rated. There were no violations noted.

Homeowner Rating – Renewals with Surcharges

From the universe of 1,915 homeowner policies renewed with surcharges during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. Three of the 50 files were selected to be manually rated. There were no violations noted.

Tenant Homeowner Rating – Renewals without Surcharges

From the universe of 197,325 tenant homeowner policies renewed without surcharges by the Company during the experience period, 100 files were selected for review. All 100 files requested were received and reviewed. There were no violations noted.

Tenant Homeowner Rating – Renewals with Surcharges

From the universe of 170 tenant homeowner policies renewed with surcharges by the Company during the experience period, 25 files were selected for review. All 25 files requested were received and reviewed. Three files out of the 25 files were selected to be manually rated. There were no violations noted.

Condominium Rating – Renewals without Surcharges

From the universe of 29,922 condominium policies renewed without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. There were no violations noted.

Condominium Rating – Renewals with Surcharges

From the universe of 136 condominium policies renewed with surcharges during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. Three out of the 50 policies were manually rated. There were no violations noted.

Manufactured Home Rating – Renewals without Surcharges

From the universe of 16,749 manufactured homeowner policies renewed without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. Three out of the 100 files were manually rated. There were no violations noted.

Manufactured Home Rating – Renewals with Surcharges

The Company did not have any manufactured homeowner policies written as renewal business with surcharges during the experience period. No files were reviewed; therefore, no violations were given.

Dwelling Fire Home Rating – Renewals with and without Surcharges

From the universe of 19,842 dwelling fire policies written as renewal business during the experience period, 113 files were selected for review. Of the files reviewed, 100 were without surcharge and 13 were with surcharge. All 113 files selected were received and reviewed. Three files out of the 113 were manually rated. There were no violations noted.

VI. CLAIMS

The Company was requested to provide copies of all established written claim handling procedures utilized during the experience period. Written claim handling procedures were received and reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or

unusual in nature.

The Claims review consisted of the following areas of review:

A. Automobile Property Damage Claims
B. Automobile Comprehensive Claims
C. Automobile Collision Claims
D. Automobile Total Loss Claims
E. Automobile First Party Medical Claims
F. Automobile First Party Medical Claims Referred to a PRO
G. Homeowner Claims
H. Tenant Homeowner Claims
I. Condominium Claims
J. Manufactured Homeowner Claims
K. Dwelling Fire Home Claims

The primary purpose of the review was to determine compliance with 31 Pa. Code, Chapter 146, Unfair Claims Settlement Practices. The files were also reviewed to determine compliance with Act 205, Section 4 (40 P.S. §1171.4) and Section 5(a)(10)(vi) of the Unfair Insurance Practices Act (40 P.S. §1171.5(a)(10)(vi)).

A. Automobile Property Damage Claims

From the universe of 4,262 private passenger automobile property damage claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 8 violations noted were based on 6 files, resulting in an error ratio of 6%.

The following findings were made:

1 Violation *31 Pa. Code §146.5(a)*

Failure to acknowledge pertinent communications. (a) Every insurer, upon receiving notification of a claim, shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge the claim within ten working days for the claim file noted.

COMPANY RESPONSE:

AGREE. The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 Pa. Code §146.5(a).

5 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such

investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the five claim files noted.

COMPANY RESPONSE:

AGREE. The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 Pa. Code §146.6.

2 Violations *63 P.S. § 861(b)*

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the two claim files noted.

COMPANY RESPONSE:

AGREE: As to appraisals, upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

B. Automobile Comprehensive Claims

From the universe of 1,288 private passenger automobile comprehensive claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The four violations noted were based on two files, resulting in an error ratio of 4%.

The following findings were made:

2 Violations *31 Pa. Code §62.3*

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards for the two claim files noted.

2 Violations *63 P.S. § 861(b)*

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the two claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania

Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

The following concerns were noted:

CONCERN: The Company issues automatic closing letters when claims are still open causing confusion to the insureds.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

CONCERN: The Company issues status letters were unnecessarily sent to the insured/claimant several days after the claim was paid.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

CONCERN: Status Letters are automatically generated, and the letter sent to the insured/claimant does not specifically describe the delay reason. The letter lists eight possible delay reasons.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

CONCERN: In seven samples reviewed there was no communication to inform the insured/claimant why the claim was closed without payment.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion,

and is compliant with Pennsylvania law and regulations.

C. Automobile Collision Claims

From the universe of 3,482 private passenger automobile collision claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The seven violations noted were based on six files, resulting in an error ratio of 6%.

The following findings were made:

1 Violation 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards for the claim file noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

1 Violation 63 P.S. § 861(b)

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the

appraiser's license number for the claim file noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

3 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the three claim files noted.

COMPANY RESPONSE:

AGREE: State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 Pa. Code §146.6.

2 Violations *31 Pa. Code §146.7(a)(1)*

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the

claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to accept or deny the claim within 15 working days for the two claim files noted.

COMPANY RESPONSE:

AGREE: The Company will review 31 Pa Code §146.7(a)(1) with its claim staff to ensure the claims department promptly sends denial letters to insureds within the required 15 working days of receiving proofs of loss and monitor timeliness of work product.

The following concerns were noted:

CONCERN: The Company issues automatic closing letters when claims are still open causing confusion to the insureds.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

CONCERN: The Company issues status letters were unnecessarily sent to the insured/claimant several days after the claim was paid.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

CONCERN: Status Letters are automatically generated, and the letter sent to the insured/claimant does not specifically describe the delay reason. The

letter lists eight possible delay reasons.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

CONCERN: In two claims reviewed, the tax rate of the insured/claimant location outside of Pennsylvania is used in initial appraisals but was not adjusted to the Pennsylvania tax rate when the vehicle is repaired in Pennsylvania.

DISAGREE: these violations did not have a tax rate violation which we agreed we violated. Is this concern related to another section? Suggest removing.

CONCERN: Closing letters are not timely sent when a claim is Closed Without Payment ("CWP").

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

D. Automobile Total Loss Claims

From the universe of 1,813 private passenger automobile total loss claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The 23 violations noted were based on 14 files, resulting in an error ratio of 28%.

The following findings were made:

6 Violations 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute.

The Company failed to provide an appraisal that meets all applicable standards for the six claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

6 Violations *63 P.S. § 861(b)*

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the six claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

1 Violation *31 Pa. Code §62.3(e)(4)*

Applicable standards for appraisal. (e) The appraised value of the loss shall be the replacement value of the motor vehicle if the cost of repairing a motor vehicle exceeds its appraised value less salvage value, or the motor vehicle cannot be repaired to its predamaged condition. (4) Applicable sales tax on the replacement cost of a motor vehicle shall be included as part of the replacement value. The Company failed to apply proper sales tax on the total loss appraisal for the claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa. Code §62.3(e)(4) with its claim staff and monitor timeliness of work product.

8 Violations *31 Pa. Code §62.3(e)(7)*

Applicable standards for appraisal. (e) The appraised value of the loss shall be the replacement value of the motor vehicle if the cost of repairing a motor vehicle exceeds its appraised value less salvage value, or the motor vehicle cannot be repaired to its predamaged condition. (7) The appraiser is responsible for ensuring that a copy of the total loss evaluation report be sent within 5 working days to the consumer by the appraiser after the appraisal is completed. If a settlement offer is extended before the consumer receives the total loss evaluation report, the consumer shall be advised of the total loss evaluation report's contents and of the consumer's right to be sent a copy within 5 days after its completion. The Company failed to send the evaluation to

the insured within five working days for the eight claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa. Code §62.3(e)(7) with its claim staff and monitor timeliness of work product.

2 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the two claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 Pa. Code §146.6.

The following concern was noted:

CONCERN: Status Letters are automatically generated, and the letter sent to the insured/claimant does not specifically describe the delay reason. The letter lists multiple possible delay reasons.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

CONCERN: The Company issued the closing letter, in error, one day after the claim was opened. This practice can cause confusion and concern to the insured.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

CONCERN: The Company issued settlement letters that included the valuations as an enclosure and the amount listed in the total loss settlement letters did not match the valuation amounts in the enclosed valuations. This practice can cause confusion and concern to the insured.

COMPANY RESPONSE: State Farm is reviewing its processes and procedures concerning the automated letters that are sent to insureds/claimants to help ensure that our correspondence is timely, specific when applicable, does not create or add additional confusion, and is compliant with Pennsylvania law and regulations.

E. Automobile First Party Medical Claims

From the universe of 2,336 private passenger automobile first party medical claims reported during the experience period, 50 claim files were selected for review. All 50 files requested were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 4%.

The following findings were made:

2 Violations 31 Pa Code §146.5(d)

Requires an insurer, upon receiving notification of a claim, shall provide within ten working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable

requirements of the insurer. The Company did not provide the necessary claim forms to the claimant within ten working days for the two claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa Code §146.5(d) with its claim staff to ensure that the claims department promptly provides the required claim forms for first party medical claims within 10 days of receiving the claim notification, so that violations noted in the Report do not occur in the future.

F. Automobile First Party Medical Claims Referred to a PRO

The universe of one automobile first party medical claims that were referred to a peer review organization by the Company was selected received and reviewed. The Company was also asked to provide a copy of all peer review contracts in place during the experience period. The one violation noted were based on one file, resulting in an error ratio of 100%.

The following findings were made:

1 Violation *31 Pa. Code §69.52(e)*

Requires an insurer to pay bills that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill. The Company failed to pay medical bills within 30 days for the claim noted. The Company failed to provide PRO report to provider and insured within five days of receipt for the claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, in addition to examiner recommendation, State Farm will implement the following action plan:

a. In review of the Peer review procedures (PRO), Section Managers have confirmed there is a clear understanding of the Peer review requirements in 31 Pa. Code §69.52(a, b and e) and the noted violations were primarily influenced by a failure to maintain timeliness of work. This is being addressed immediately.

b. As such, the additional steps will be taken:

i. Section Manager will review the PRO violations with Team Managers in an upcoming staff meeting and reiterate expectations

ii. Team Managers will complete an upskilling/review session with all Claim Specialists to verify understanding of the expectations.

iii. Team Managers will monitor the timeliness of Claim Specialists submission of PRO requests by setting calendars for follow-up on status.

iv. Team Managers will also monitor the timeliness of any denials based on PRO reports by providing specific direction to the Claim Specialists and setting a Team Manager calendar to monitor for accurate and timely handling.

v. Section Manager will discuss findings/results of the Team Manager monitoring on a quarterly basis.

G. Homeowner Claims

From the universe of 38,875 homeowner claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 11 violations noted were based on 11 files, resulting in an error ratio of 11%.

The following findings were made:

2 Violations *31 Pa. Code §146.3*

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The Company failed to maintain a complete

claim file for two claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will review 31 Pa Code §146.3 with its claim staff to ensure all documentation is properly contained within the claim file.

9 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the nine claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 Pa. Code §146.6.

The following concern was noted:

CONCERN: The Company included New Jersey statute in the 30/45 status letters for several claims, which were for a loss that occurred in Pennsylvania. Applying New Jersey statutes is inappropriate handling of these claim and reference to such statutes in the status letters is misleading to the insured.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all Pennsylvania statutory requirements; accordingly, State Farm will work with claim staff to reiterate the importance of accuracy in providing information to customers. Further, this appears to be an unintentional oversight and is not indicative of our overall claim handling. State Farm will review the appropriate Jurisdictional References, processes and procedures with its claim staff where necessary to avoid similar oversights in the future.

H. Tenant Homeowner Claims

From the universe of 3,546 tenant homeowner claims reported during the experience period, 100 were selected for review. All 100 claims requested were received and reviewed. The five violations noted were based on five files, resulting in an error ratio of 5%.

4 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the four claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will work to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

1 Violation 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the

following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to accept or deny the claim within 15 working days for the claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 Pa. Code 31 Pa. Code §146.7 (a)(1).

The following concern was noted:

CONCERN: The Company included New Jersey statute in the 30/45 status letters for several claims, which were for a loss that occurred in Pennsylvania. Applying New Jersey statutes is inappropriate handling of these claim and reference to such statutes in the status letters is misleading to the insured.

AGREE: The Company practice is to comply with all Pennsylvania statutory requirements; accordingly, State Farm will work with claim staff to reiterate the importance of accuracy in providing information to customers. Further, this appears to be an unintentional oversight and is not indicative of our overall claim handling. State Farm will review the appropriate Jurisdictional References, processes and procedures with

its claim staff where necessary to avoid similar oversights in the future.

I. Condominium Claims

From the universe of 1,421 homeowner claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 4%.

1 Violation 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will work to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

1 Violation 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion

unless reference to the provision, condition, or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to accept or deny the claim within 15 working days for the claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 Pa. Code 31 Pa. Code §146.7 (a)(1).

J. Manufactured Homeowner Claims

From the universe of 1,011 manufactured homeowner claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The six violations noted were based on six files, resulting in an error ratio of 12%.

The following findings were made:

1 Violation 31 Pa. Code §146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The Company failed to provide a complete file for the claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will

review 31 Pa Code §146.3 with its claim staff to ensure all documentation is properly contained within the claim file.

5 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the five claim files noted.

COMPANY RESPONSE:
AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 Pa. Code §146.6.

The following concern was noted:

CONCERN: The Company included New Jersey statute in the 30/45 status letters for several claims, which were for a loss that occurred in Pennsylvania. Applying New Jersey statutes is inappropriate handling of these claim and reference to such statutes in the status letters is misleading to the insured.

AGREE: The Company practice is to comply with all Pennsylvania statutory requirements; accordingly, State Farm will work with claim staff to reiterate the importance of accuracy in providing information to customers. Further, this appears to be an unintentional oversight and is not indicative of our overall claim handling. State Farm will review the appropriate Jurisdictional References, processes and procedures with

its claim staff where necessary to avoid similar oversights in the future.

K. Dwelling Fire Home Claims

From the universe of 58,035 dwelling fire claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 21 violations noted were based on 15 files, resulting in an error ratio of 15%.

The following findings were made:

4 Violations 31 Pa. Code §146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The Company failed to provide a complete file for the four claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will review 31 Pa Code §146.3 with its claim staff to ensure all documentation is properly contained within the claim file.

2 Violations 31 Pa. Code §146.5(c)

Failure to acknowledge pertinent communications. An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected. The Company failed to provide a complete file for the two claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will review 31 Pa Code §146.5(c) with its claim staff to ensure that violations noted do not occur in the future.

7 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the seven claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will work to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6. Please note we disagree with one of the violations because the claim closed before the 45 time period became applicable.

8 Violation 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer

shall contain a copy of the denial. The Company failed to accept or deny the claim within 15 working days for the six of the claim files noted and failed to provide the policy provision, condition, or exclusion for two of the claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 Pa. Code 31 Pa. Code §146.7 (a)(1).

The following concern was noted:

CONCERN: The Company included New Jersey statute in the 30/45 status letters for several claims, which were for a loss that occurred in Pennsylvania. Applying New Jersey statutes is inappropriate handling of these claim and reference to such statutes in the status letters is misleading to the insured.

AGREE: The Company practice is to comply with all Pennsylvania statutory requirements; accordingly, State Farm will work with claim staff to reiterate the importance of accuracy in providing information to customers. Further, this appears to be an unintentional oversight and is not indicative of our overall claim handling. State Farm will review the appropriate Jurisdictional References, processes and procedures with its claim staff where necessary to avoid similar oversights in the future.

CONCERN: In one claim the Company included a reference to a California regulation in the closing letter to the insured, which was for a loss that occurred in Pennsylvania. Applying California regulations is inappropriate handling of this claim and reference to such regulations in the closing letter is misleading to the insured.

AGREE: The Company practice is to comply with all Pennsylvania statutory requirements; accordingly, State Farm will work with claim staff to reiterate the importance of accuracy in providing information to customers. Further, this appears to be an unintentional oversight and is not indicative of our overall claim handling. State Farm will review the appropriate Jurisdictional References, processes and procedures with its claim staff where necessary to avoid similar oversights in the future.

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of their consumer complaint logs for the preceding four years. The Company identified 656 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the universe of 656 complaint files, 60 files were selected for review. All 60 files requested were received and reviewed.

The purpose of the review was to determine compliance with the Unfair Insurance Practices Act, (40 P.S. §§1171.1 – 1171.5). Section 5(a)(11) of the Act (40 P.S. §1171.5(a)(11)), requires a company to maintain a complete record of all complaints received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. The individual complaint files were reviewed for the relevancy to applicable statues and to verify compliance with 31 Pa. Code §146.5(b)(c).

The following findings were made:

2 Violations 31 Pa. Code §146.5(b)

Every insurer, upon receipt of any inquiry from the Department

respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry. The Company failed to provide the Department with an adequate response to their inquiry within 15 working days for the two files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa Code §146.5(b) with its complaint staff to ensure the complaints department promptly sends responses within the required 15 working days.

The following synopsis reflects the nature of the 60 complaints that were received.

20	Cancellation/Nonrenewal	33%
25	Claims Related	42%
6	Customer Service	10%
5	Billing and Payment	8%
3	Premium/Price/Setup	5%
1	Agency Conduct	2%
60		100%

VIII. UNDERWRITING PRACTICES AND PROCEDURES

As part of the examination, the Company was requested to supply manuals, underwriting guides, bulletins, directives, or other forms of underwriting procedure communications for each line of business being reviewed. Underwriting guides and supplements were furnished for homeowners, tenant homeowners and condominium. The purpose of this review was to identify any inconsistencies which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. There were no violations noted.

IX. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy forms used in order to verify compliance with the Insurance Company Law, Section 354 (40 P.S. §477b), Approval of Policies, Contracts, etc., Prohibiting the Use Thereof Unless Approved. During the experience period of the examination, Section 354 provided that it shall be unlawful for any insurance company to issue, sell, or dispose of any policy contract or certificate covering fire, marine, title and all forms of casualty insurance or use applications, riders, or endorsements in connection therewith, until the forms have been submitted to and formally approved by the Insurance Commissioner. All underwriting and claim files were also reviewed to verify compliance with 75 Pa. C.S. §1822, which requires all insurers to provide an insurance fraud notice on all applications for insurance, all claims forms and all renewals of coverage and 18 Pa. C.S. §4117(k)(1), which requires all insurers to provide an insurance fraud notice on all applications for insurance and all claim forms. There were no violations noted

X. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary examination packet in accordance with NAIC uniformity standards and provided specific information relative to the exam. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure its accuracy and completeness to determine compliance with Insurance Department Act of 1921, Section 904(b) (40 P.S. §323.3(a)). Several data integrity issues were found during the exam.

The data integrity issue of each area of review is identified below.

Tenant Homeowners Renewals With Surcharge

Situation: As the examiners reviewed the Tenant Homeowner Renewals with surcharge policy files of the rating section of the exam, it was noted that not all the 25 files selected for review were Tenant with surcharge files.

Finding: Of the 25 midterm cancellation files reviewed, one file was identified as Tenant Homeowner Renewal without a surcharge.

Condominium New Business Without Surcharge

Situation: As the examiners reviewed the Condominium (Condo) New Business without surcharge policy files of the rating section of the exam, it was noted that not all the 75 files selected for review were Condo without surcharge.

Finding: Of the 75 Condo New Business without surcharge files reviewed, one file was identified as Condo New Business with a surcharge.

<u>Collision Claims</u>

Situation: As the examiners reviewed the Collision files of the claims section of the exam, it was noted that not all the 100 files selected for review were Collision claims.

Finding: Of the 100 Collision claim files reviewed, one file was identified as Total Loss claim.

Auto 60-Day Cancellations

Situation: As the examiners reviewed the 60-Day Cancellations of the auto underwriting section of the exam, it was noted that not all the 100 files selected for review were 60-Day Cancellations.

Finding: Of the 100 60-Day Cancellation files reviewed, three files were identified as Midterm Cancellations.

The following finding was made:

General Violation 40 P.S. 323.3(a)

> Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business, and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of

that company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The violation was the result of a failure to exercise sufficient due diligence to ensure compliance with the Insurance Department Act of 1921.

COMPANY RESPONSE:

DISAGREE. The company disagrees with the examiner’s assertion. These claims appropriately came in as Collision claims and the vehicles were later determined to be a Total Loss. While the handlers in each of the identified claims did not check the “confirmed Total Loss” box, the files were handled as a Total Loss, and a Total Loss payment was issued with a Total Loss reason code which would have been reported to the National Motor Vehicle Title Information System (NMVTIS) if applicable.

XI. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other statutory or regulatory violations, noted in the Report.

1. The Company must review 18 Pa. C.S.§4117(k)(1) to ensure that violations regarding the requirement of a fraud warning on all claim forms, as noted in the Report, do not occur in the future.

2. The Company must reinforce its internal data controls to ensure that notices of cancellation are maintained in accordance with 31 Pa. Code §59.9(b), so that violations noted in the Report do not occur in the future.

3. Company must review 31 Pa. Code §62.3 with its claim staff to ensure all appraisal requirements are met so the violations, as noted in the Report, do not occur in the future.

4. The Company must review 31 Pa. Code §62.3(e)(4) with its claim staff to ensure a copy of the total loss evaluation is provided to the insured within 5 working days so the violation, as noted in the Report, does not occur in the future.

5. The Company must review 31 Pa. Code §62.3(e)(7) with its claim staff to ensure that a copy of the total loss evaluation is provided to the insured within 5 working days, so that violations, as noted in the Report, do not occur in the future.

6. The Company must review 31 Pa. Code §69.52(e) with its claim staff to ensure that the insured is provided a copy of a PRO evaluation in a timely manner, so that the violation noted in the Report does not occur in the future.

7. The Company must review 31 Pa Code §146.3 with its claim staff to ensure the claims department maintains complete claim files.

8. The Company must review 31 Pa Code §146.5(a) with its claim staff to ensure that the claims department promptly acknowledges the claim within 10 working days, so that the violation noted in the Report does not occur in the future.

9. The Company must review 31 Pa Code §146.5(b) with its claim staff to ensure that the claims department promptly provides the Department with an adequate response to its inquiry within 15 working days, so that violations noted in the Report do not occur in the future.

10. The Company must review 31 Pa Code §146.5(c) with its claim staff to ensure that the claims department promptly responds to a claimant's communications within 10 days working days, so that violations noted in the Report do not occur in the future.

11. The Company must review 31 Pa Code §146.5(d) with its claim staff to ensure that the claims department promptly provides the required claim forms for first party medical claims within 10 days of receiving the claim notification, so that violations noted in the Report do not occur in the future.

12. The Company must review 31 Pa Code §146.6 with its claim staff to ensure that the claims department promptly provides the required 30/45 day status letter to claimants, so the violations noted in the Report do not occur in the future.

13. The Company must review 31 Pa Code §146.7(a)(1) with its claim staff to ensure the claims department promptly sends denial letters to insureds within the required 15 working days of receiving proofs of loss and to provide the policy provision, condition, or exclusion.

14. The Company must reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.3(a), so that violations noted in the Report do not occur in the future.

15. The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notice requirements of 40 P.S. §§991.2006 and 991.2008(b), so that the violations noted in the Report do not occur in the future.

16. The Company must review and revise internal control procedures to ensure compliance with 40 P.S. §1171.5(a)(7)(iii) so that underwriting standards are consistently applied to individuals of the same class and/or hazard who are requesting backdating.

17. The Company must review 40 P.S. §1171.5(a)(9)(ii) and take appropriate actions to ensure that sufficient notice of termination is provided, so that the violations noted in the Report do not occur in the future.

18. The Company must review 63 P.S. §861(b) with its claim staff to ensure violations for missing appraiser name and appraiser license information on auto appraisal copies as noted in the Report, do not occur in the future.

19. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to elect a tort option and that signed tort option selection forms are obtained and retained with the underwriting file. This is to ensure that violations noted under 75 Pa. C.S. §1705(a)(4) do not occur in the future.

20. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to exercise the waiver for uninsured and underinsured motorist coverage forms are obtained and retained with the underwriting file. This is to ensure that violations noted under 75 Pa. C.S. §1731(b) & (c)(c.1) do not occur in the future.

21. The Company must review 75 Pa. C.S. §1734 with its underwriting staff to ensure insureds are provided written requests for lower UM/UIM limits.

22. The Company must revise underwriting procedures to ensure that the insured is aware that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms. This is to ensure that violations, as noted in the Report under 75 Pa. C.S. §1738(d)(1) and (2)(e) do not occur in the future.

XII. COMPANY RESPONSE

State Farm's individual responses to each concern or criticism is outlined above. We encourage the Insurance Department to remove those violations or concerns that are below the NAIC benchmark error rate and do not demonstrate a pattern or practice of the company before publishing the final report.