pennsylvania
INSURANCE DEPARTMENT

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

THE TRAVELERS INDEMNITY COMPANY
HARTFORD, CT

As of: September 27, 2011
Issued: February 10, 2012

BUREAU OF MARKET ACTIONS
PROPERTY AND CASUALTY DIVISION

VERIFICATION

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

James R. Myers, Examiner-In-Charge

Sworn to and Subscribed Before me

This 9 Day of June , 2011

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
LINDY McMILLEN, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires March 23, 2014

THE TRAVELERS INDEMNITY COMPANY

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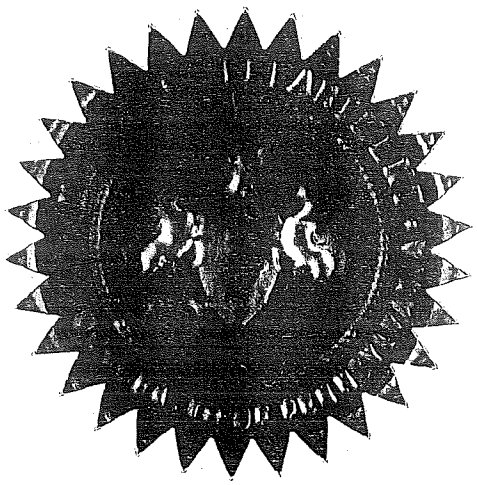
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 27th day of April, 2011, 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 Ronald A. Gallagher, 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 F. Consedine
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
THE TRAVELERS INDEMNITY COMPANY One Tower Square Hartford, CT 06183	:	Sections 641.1A and 671-A of Act 147 of 2002 (40 P.S. §§310.411A and 310.71)
	:	Sections 1, 3(a)(1), 3(a)(5), 3(a)(6), 4(b) and 7(c) of the Act of July 3, 1986, P.L. 396, No. 86 (40 P.S. §§ 3401, 3403, 3404 and 3407)
	:	Sections 5(a)(9)(ii) and 5(a)(9)(iv) of the Unfair Insurance Practices Act, Act of July 22, 1974, P.L. 589, No. 205 (40 P.S. §§ 1171.5)
	:	Sections 4(a) and 4(h) of the Act of June 11, 1947, P.L. 538, No. 246 (40 P.S. §§ 1184)
	:	Title 18, Pennsylvania Consolidated Statutes, Section 4117(k)
	:	Title 31, Pennsylvania Code, Sections 69.43, 69.52(a), 69.52(b), 113.88, 146.5(d), 146.6 and 146.7(a)(1)
	:	Title 75, Pennsylvania Consolidated Statutes, Section 1822
	:	PA Assigned Risk Plan, Sections 16(A) and 16(A)(4)
Respondent.	:	Docket No. MC11-09-014

CONSENT ORDER

AND NOW, this 10th day of February, 2012, 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.

3. Respondent neither admits nor denies that it violated any Pennsylvania insurance laws or regulations.

FINDINGS OF FACT

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

(a) Respondent is The Travelers Indemnity Company, and maintains its address at One Tower Square, Hartford, CT 06183.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from July 1, 2009 through June 30, 2010.

(c) On September 27, 2011, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on October 27, 2011.

(e) The Examination Report notes violations of the following:

(i) 40 P.S. § 310.41.1-A, which prohibits any insurance entity or licensee accepting applications or orders for insurance from any person or securing any insurance business that was sold, solicited or negotiated by any person acting without an insurance producer license;

(ii) 40 P.S. § 310.71, which prohibits producers from transacting business within this Commonwealth without written appointment as required by the Act;

(iii) Section 1 of Act 86 (40 P.S. § 3401), which requires a policy of insurance covering property or casualty risks in this Commonwealth shall provide for not less than 30 days advance notice to the named insured of an increase in renewal premium;

(iv) Section 3(a)(1) of Act 86 (40 P.S. § 3403), which states the midterm cancellation notice shall be forwarded by registered or first class mail or delivered by the insurance company directly to the named insured or insureds;

(v) Section 3(a)(5) of Act 86 (40 P.S. § 3403), which requires that a cancellation notice shall state the specific reasons for cancellation. The reasons shall identify the condition, factor or loss experience, which caused the cancellation. The notice shall provide sufficient information or data for the insured to correct the deficiency;

(vi) Section 3(a)(6) of Act 86 (40 P.S. § 3403), which requires that a cancellation notice shall state that at the insured's request, the insurer shall provide loss information to the insured for at least three years or the period of time during which the insurer has provided coverage to the insured, whichever is less;

(vii) Section 4(b) of Act 86 (40 P.S. § 3404), which requires that unearned premium be returned to the insured not later than 30 days after the effective

date of termination where commercial property or casualty risks are cancelled in mid-term by the insured;

(viii) Section 7(c) of Act 86 (40 P.S. § 3407), which states 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, unless the policy provides for a longer period of notification;

(ix) Section 5(a)(9)(ii) of Act 205 (40 P.S. § 1171.5) prohibits any cancellation or refusal to renew to become effective in a period of less than thirty days from the date of delivery or mailing;

(x) Section 5(a)(9)(iv) of the Unfair Insurance Practices Act, No. 205 (40 P.S. § 1171.5), which requires that a cancellation notice shall advise the insured of his right to request, in writing, within ten days of the receipt of the notice of cancellation or intention not to renew that the Insurance Commissioner review the action of the insurer;

(xi) Sections 4(a) and 4(h) of the Casualty and Surety Rate Regulatory Act, No. 246 (40 P.S. § 1184), 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 this

Commonwealth and prohibits an insurer from making or issuing a contract or policy with rates other than those approved;

(xii) Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), which requires all applications for insurance and all claim forms shall contain or have attached thereto the following notice: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties";

(xiii) Title 31, Pennsylvania Code, Section 69.43, which states an insurer shall pay the provider's usual and customary charge for services rendered when the charge is less than 110% of the Medicare payment or a different allowance as may be determined under § 69.12(b). An insurer shall pay 80% of the provider's usual and customary charge rendered if no Medicare payment exists. In calculating the usual and customary charge, an insurer may utilize the requested payment amount on the provider's bill for services or the data collected by the carrier or intermediaries to the extent that the data is made available. An insurer shall provide a complete explanation of the calculations made in computing its determination of the amount payable, including whether the calculation is based on 110% of the Medicare payment, 80% of the usual

and customary charge or at a different allowance determined by the Commissioner under § 69.12(b). A bill submitted by the provider delineating the services rendered and the information from which a determination could be made by the insurer as to the appropriate payment amount will not be construed as a demand for payment in excess of the permissible payment amount;

(xiv) Title 31, Pennsylvania Code, Section 69.52(a), which requires an insurer to refer a provider's bill to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with PRO procedures, standards and practices, to believe it necessary that a PRO determine the reasonableness and necessity of care, the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care. The insurer shall notify a provider, in writing, when referring bills for PRO review at the time of referral;

(xv) Title 31, Pennsylvania Code, Section 69.52(b), which requires an insurer to pay medical bills for care that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill;

(xvi) Title 31, Pennsylvania Code, Section 113.88, which states the reason given for nonrenewal shall be clear and complete. It shall be stated so that a person of average intelligence and education can understand it. Phrases such as

"losses" or "underwriting reasons" are not sufficiently specific reasons for nonrenewal;

(xvii) Title 31, Pennsylvania Code, Section 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;

(xviii) Title 31, Pennsylvania Code, Section 146.6, requires that every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot 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;

(xix) Title 31, Pennsylvania Code, Section 146.7(a)(1), which requires 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;

(xx) Title 75, Pennsylvania Consolidated Statutes, Section 1822, which requires not later than May 1, 1990, all applications for insurance, renewals and claim forms shall contain a statement that clearly states, in substance, the following: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.00;

(xxi) PA Assigned Risk Plan Rules, Section 16(A), which states upon determination that an applicant does not qualify for a clean risk rate, the designated Company shall notify the insured of the reason for this determination and issue the policy at other than clean risk rates; and

(xxii) PA Assigned Risk Plan Rules, Section 16(A)(4), which states at least 60 calendar days prior to the expiration date of the final renewal, the company shall notify the insured that the period of assignment under the Plan will terminate on said expiration date, and a copy of such notice shall be sent to the producer of record.

CONCLUSIONS OF LAW

5. 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) Respondent's violations of Sections 641.1A and 671-A of Act 147 of 2002 are punishable by the following, under Section 691-A of Act 147 of 2002 (40 P.S. § 310.91):

(i) suspension, revocation or refusal to issue the certificate of qualification or license;

(ii) imposition of a civil penalty not to exceed five thousand dollars ($5,000.00) for every violation of the Act;

(iii) an order to cease and desist; and

(iv) any other conditions as the Commissioner deems appropriate.

(c) Respondent's violations of Sections 1, 3, 4 and 7 of Act 86 (40 P.S. §§ 3401, 3403, 3404 and 3407), are punishable under Section 8 (40 P.S. § 3408) of this act by one or more of the following causes of action:

(i) Order that the insurer cease and desist from the violation.

(ii) Impose a fine or not more than $5,000 for each violation.

(d) Respondent's violations of Sections 5(a)(9)(ii) and 5(a)(9)(iv) of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 1171.5) are punishable

by the following, under Section 9 of the Unfair Insurance Practices Act (40 P.S. § 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 Department for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Department may, under Sections 10 and 11 of the Unfair Insurance Practices Act (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).

(f) Respondent's violations of Sections 4(a) and (h) of the Casualty and Surety Rate Regulatory Act, No. 246 (40 P.S. § 1184) are punishable under Section 16 of the Casualty and Surety Rate Regulatory 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.

(g) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.5, 146.6 and 146.7 are punishable under Sections 9, 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9, 1171.10 and 1171.11), as stated above.

ORDER

6. 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 file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

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

(d) Respondent shall pay Fifteen Thousand Dollars ($15,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

(e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, Bureau of Market Actions, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

7. 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 it may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. Alternatively, in the event 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.

9. 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.

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

11. 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.

12. The signatories, below, represent and warrant that they have full and unqualified legal authority to enter into and execute this Consent Order on behalf of the respective parties, and said Order shall be binding on their heirs, successors and assigns now and in the future.

13. 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: THE TRAVELERS INDEMNITY COMPANY, Respondent

Christine Palmieri, 2nd Vice President
Corporate Compliance & Market Regulation

COMMONWEALTH OF PENNSYLVANIA
By: Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The market conduct examination was conducted at The Travelers Indemnity Company's offices located in Reading, Pennsylvania and Hartford, Connecticut, from November 1, 2010, through April 21, 2011. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

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.

Chester A. Derk, Jr., AIE, HIA
Market Conduct Division Chief

James R. Myers
Market Conduct Examiner

June A. Coleman
Market Conduct Examiner

Constance L. Arnold
Market Conduct Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on The Travelers Indemnity Company, hereinafter referred to as "Company," at their offices located in Reading, Pennsylvania and Hartford, Connecticut. The examination was conducted pursuant to Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of July 1, 2009, through June 30, 2010, 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 and midterm cancellations.
- Rating – Proper use of all classification and rating plans and procedures.

2. Assigned Risk Private Passenger Automobile

- Rating – Proper use of all classification and rating plans and procedures.

3. Property

- Underwriting – Appropriate and timely notices of nonrenewal and midterm cancellations.
- Rating – Proper use of all classification and rating plans and procedures.

4. Commercial Property

- Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, renewals and declinations.

5. Commercial Automobile

- Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, renewals and declinations.

6. Workers' Compensation

- Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, renewals and declinations.

7. Claims

8. Forms

9. Advertising

10. Complaints

11. Producer Licensing

III. COMPANY HISTORY AND LICENSING

The Travelers Indemnity Company was incorporated on March 25, 1903, under the laws of Connecticut and was sponsored by The Travelers Insurance Company. It commenced business on May 12, 1906. A former wholly-owned affiliate, The Travelers Fire Insurance Company (formed in May 1923), was absorbed by merger on December 31, 1956. The Travelers Reinsurance Company of Bermuda, Ltd. was absorbed by merger in 1990. During 1994, the Company sold its non-standard automobile subsidiary, Bankers & Shippers Insurance Company, in order to better focus its attention on core businesses. Additionally, on December 30, 1994, the Company acquired the remaining 50% interest in Gulf Insurance Company from Commercial Credit Corporation, an affiliate.

Ownership of all of the Company's outstanding stock on December 28, 1965, passed from The Travelers Insurance Company to the then newly-formed parent Company, The Travelers Corporation.

The Travelers Corporation surrendered its charter on December 30, 1993, and merged with and into Primerica Corporation, renamed The Travelers Inc., on December 31, 1993. In order to effect this merger, The Travelers Corporation contributed the Company with a cost of $1.7 billion, to The Travelers Insurance Group, Inc., a former subsidiary of The Travelers Corporation, on December 30, 1993. Effective April 1996, the Company's ownership was transferred to the newly formed Travelers Property Casualty Corp. This Company has been established to hold the property/casualty operations of Travelers Group Inc.

LICENSING

The Travelers Indemnity Company's Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2011. The Company is licensed in all states except California. The Company's 2010 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $91,677,424. Premium volume related to the areas of this review were: Fire $4,856,064; Farm Owners Multiple Peril $321,489; Homeowners Multiple Peril $28,782,981; Commercial Multiple Peril (non-liability portion) $9,767,647; Commercial Multiple Peril (liability portion) $6,164,723; Workers' Compensation $8,527,505; Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (personal injury protection) $751,418; Other Private Passenger Auto Liability $3,498,459 and Private Passenger Auto Physical Damage $2,109,389; Commercial Automobile Direct Written Premium was reported as Commercial Auto No-Fault (personal injury protection) $222,531; Other Commercial Auto Liability $4,188,616; Commercial Auto Physical Damage $1,342,781.

IV. 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. Agency bulletins and underwriting guides were furnished for private passenger automobile, homeowners, dwelling fire, personal articles policies and commercial lines. 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.

No violations were noted.

V. UNDERWRITING

A. Private Passenger Automobile

1. Midterm Cancellations

A midterm 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 535 private passenger automobile files identified as midterm cancellations, 50 files were selected for review. All 50 files were received and reviewed. Of the 50 files reviewed, 46 files were identified as midterm cancellations and 4 files were identified as nonrenewals. No violations were noted.

3. 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 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.

The universe of 27 private passenger automobile files identified as nonrenewals was selected for review. All 27 files were received and reviewed. No violations were noted.

B. Property

1. Midterm Cancellations

A midterm cancellation is any policy termination that occurs at any time other than the 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 4,365 property policies which were cancelled midterm during the experience period, 210 files were selected for review. The property policies consisted of homeowners, tenant homeowners and condominiums. All 210 files were received and reviewed. The 3 violations noted were based on 3 files, resulting in an error ratio of 1%.

The following findings were made:

3 Violations *Act 205, Section 5(a)(9)(ii) [40 P.S. §1171.5(a)(9)(ii)*

Requires that a cancellation notice shall 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 notice of cancellation or any evidence of an insured request for cancellation and

compliance could not be determined for the 3 files noted.

2. Nonrenewals

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

The primary purpose of the review was to determined 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 66 property policies which were nonrenewed during the experience period, 26 files were selected for review. The property policies consisted of homeowner and tenant homeowner policies. All 26 files were received and reviewed. No violations were noted.

C. Commercial Property

1. 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 86, Section 7 (40 P.S. §3407), which requires an insurer, who cancels a policy that is in effect less than 60 days, to provide 30 days notice of termination no later than the 60th day unless the policy provides for a longer period of notification.

The universe of 4 commercial property policies cancelled within the first 60 days was selected for review. All 4 files were received and reviewed. The files consisted of commercial package and commercial fire policies. The 3 violations noted were based on 3 files, resulting in an error ratio of 75%.

The following findings were made:

3 Violations Act 86, Section 7(c) [40 P.S. §3407(c)]

This act does not apply to commercial property and casualty insurance policies that are in effect less than 60 days, unless they are renewals. 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, unless the policy provides for a longer period of notification. The 3 files noted did not provide at least 30 days' notice of cancellation to the insured.

2. Midterm Cancellations

A midterm cancellation is any policy termination that occurs at any time other than the twelve-month policy anniversary date.

The purpose of the review was to determine compliance with Act 86, Section 2 (40 P.S. §3402), which prohibits cancellation except for specific reasons and Section 3 (40 P.S. §3403), which establishes the requirements which must be met regarding the form and condition of the cancellation notice.

From the universe of 129 commercial property policies cancelled midterm during the experience period, 26 files were selected for review. The

commercial property files consisted of commercial package, commercial fire and farm policies. All 26 files were received and reviewed. The 4 violations noted were based on 4 files, resulting in an error ratio of 15%.

The following findings were made:

4 Violations *Act 86, Section 4(b) [40 P.S. §3404(b)]*

Requires that unearned premium be returned to the insured not later than 30 days after the effective date of termination where commercial property or casualty risks are cancelled in mid-term by the insured. The Company did not return the unearned premium to the insured within 30 days after the effective date of termination for the 4 files noted.

3. 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 review was conducted to determine compliance with Act 86, Section 3 (40 P.S. §3403), which establishes the requirements that must be met regarding the form and condition of the nonrenewal notice.

The universe of 30 commercial property policies nonrenewed during the experience period was selected for review. The commercial property policies consisted of commercial package, commercial fire and farm policies. All 30 files were received and reviewed. The 3 violations noted were based on 3 files, resulting in an error ratio of 10%.

The following findings were made:

3 Violations *Act 86, Section 3(a)(5) [40 P.S. 3403(a)(5)]*

Requires that a nonrenewal notice shall state the specific reasons for the nonrenewal. The reasons shall identify the condition, factor or loss experience, which caused the nonrenewal. The notice shall provide sufficient information or date for the insured to correct the deficiency.

AND

Title 31, Pa. Code, Section 113.88

The reason given for nonrenewal shall be clear and complete. It shall be stated so that a person of average intelligence and education can understand it. Phrases such as "losses" or "underwriting reasons" are not sufficiently specific reasons for nonrenewal. The reason for nonrenewal was not specific for the 3 files noted.

4. 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 86, Section 1 (40 P.S. §3401), which requires 30 days advance notice of an increase in renewal premium.

From the universe of 1,780 commercial property policies renewed during the experience period, 40 files were selected for review. The commercial property policies consisted of commercial fire and commercial package policies. All 40 files were received and reviewed. The 3 violations noted were based on 3 files, resulting in an error ratio of 8%.

The following findings were made:

3 Violations *Act 86, Section 1 [40 P.S. §3401]*

This section provides that notwithstanding any other provision of law, a policy of insurance covering commercial property or casualty risks in this Commonwealth shall provide for not less than 30 days advance notice to the named insured of an increase in renewal premium. This section does not apply to policies written on a retrospective rating plan. The Company did not provide at least 30 days advance notice to the named insured of an increase in renewal premium for the 3 files noted.

D. Commercial Automobile

1. 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 86, Section 7 (40 P.S. §3407), which requires an insurer, who cancels a policy that is in effect less than 60 days, to provide 30 days notice of termination no later than the 60th day unless the policy provides for a longer period of notification.

The universe of 1 commercial automobile policy cancelled within the first 60 days of new business was selected for review. The file was received and reviewed. No violations were noted.

2. Midterm Cancellations

A midterm cancellation is any policy termination that occurs at any time other than the twelve-month policy anniversary date.

The purpose of the review was to determine compliance with Act 86, Section 2 (40 P.S. §3402), which prohibits cancellation except for specified reasons and Section 3 (40 P.S. §3403), which establishes the requirements, which must be met regarding the form and condition of the cancellation notice.

From the universe of 36 commercial automobile policies which were cancelled during the experience period, 10 files were selected for review. All 10 files were received and reviewed. The 5 violations noted were based on 5 files, resulting in an error ratio of 50%.

The following findings were made:

5 Violations *Act 86, Section 4(b) [40 P.S. §3404(b)]*

Requires that unearned premium be returned to the insured not later than 30 days after the effective date of termination where commercial property or casualty risks are cancelled in mid-term by the insured. The Company failed to return unearned premium to the insured within 30 days for the 5 files noted.

3. 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 review was conducted to determine compliance with Act 86, Section 3 (40 P.S. §3403), which establishes the requirements that must be met regarding the form and condition of the nonrenewal notice.

The universe of 21 commercial automobile policies nonrenewed during the experience period was selected for review. All 21 files were received and reviewed. The violation noted resulted in an error ratio of 5%.

The following finding was made:

1 Violation *Act 86, Section 3(a)(1) [40 P.S. §3403(a)(1)]*
Requires that a nonrenewal notice be forwarded by registered mail or first class mail or delivered by the insurance company directly to the named insured or insureds. The Company did not provide any documentation to substantiate a notice was mailed, reason for nonrenewal or if the notice met format requirements for the file noted.

The following concern was made:

CONCERN: The examiners identified a file where notes indicated that if other lines of business were not written with Travelers, the Company would have to request coverage be placed elsewhere. Requiring supporting business is not acceptable and the Company must ensure this practice will not occur in the future.

4. 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 86, Section 1 (40 P.S. §3401), which requires 30 days advance notice of an increase in renewal premium.

From the universe of 564 commercial automobile policies renewed during the experience period, 15 files were selected for review. All 15 files were received and reviewed. No violations were noted.

E. Workers' Compensation

1. 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 86, Section 7 (40 P.S. §3407), which requires an insurer, who cancels a policy that is in effect less than 60 days, to provide 30 days notice of termination no later than the 60th day unless the policy provides for a longer period of notification.

The universe of 12 workers' compensation policies cancelled within the first 60 days of new business was selected for review. All 12 files were received and reviewed. No violations were noted.

2. Midterm Cancellations

A midterm cancellation is any policy termination that occurs at any time other than the twelve-month anniversary date.

The purpose of the review was to determine compliance with Insurance Company Law, Section 653 (40 P.S. §813), which prohibits midterm

cancellation with exceptions for nonpayment of premium or by request of the insured.

From the universe of 46 workers' compensation policies identified as midterm cancellations by the Company, 10 files were selected for review. All 10 files were received and reviewed. No violations were noted.

3. Nonrenewals

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

The review was conducted to determine compliance with Act 86, Section 3 (40 P.S. §3403), which establishes notice requirements for nonrenewals.

From the universe of 25 workers' compensation policies nonrenewed during the experience period, 8 files were selected for review. All 8 files were received and reviewed. The violation resulted in an error ratio of 13%.

The following finding was made:

1 Violation *Act 86, Section 3(a)(6) [40 P.S. §3403(a)(6)]*

Requires that a nonrenewal notice shall state that at the insured's request, the insurer shall provide loss information to the insured for at least three years or the period of time during which the insurer has provided coverage to the insured, whichever is less. The Company did not provide an offer of loss information on the notice for the file noted.

4. 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 86, Section 1 (40 P.S. §3401), which requires 30 days advance notice of an increase in renewal premium.

From the universe of 698 workers' compensation policies renewed during the experience period, 15 files were selected for review. All 15 files were received and reviewed. The violation resulted in an error ratio of 7%.

The following finding was made:

1 Violation *Act 86, Section 1 [40 P.S. §3401]*

This section provides that notwithstanding any other provision of law, a policy of insurance covering commercial property or casualty risks in this Commonwealth shall provide for not less than 30 days advance notice to the named insured of an increase in renewal premium. This section does not apply to policies written on a retrospective rating plan. The Company did not provide at least 30 days advance notice to the named insured of an increase in renewal premium for the file noted.

F. Commercial Declinations

1. Declinations

A declination is any application that is received and the Company declines to write the coverage.

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

From the universe of 1,048 commercial applications declined by the Travelers Group during the experience period, 75 files were selected for review. The files consisted of all types of commercial lines. All 75 files were received and reviewed. No violations were noted.

The following concerns were made:

CONCERN: The examiners identified two files where the Company declined to quote because it was a mono-line Workers Compensation account. Requiring supporting business is not acceptable and the Company must ensure this practice will not occur in the future.

CONCERN: The Company provided declination files but 4 files did not have a declination reason included with the file. The Company must maintain all files so that compliance can be determined.

VI. 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 Act 246, Sections 4(a) and (h) [40 P.S. §1184], 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 that time. Files were also reviewed to determine compliance with all provisions of Act 6 of 1990 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 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.

The Company did not issue any new business during the experience period.

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 246, Sections 4(a) and (h) (40 P.S. §1184), 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, 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 3,142 private passenger automobile policies renewed without surcharges during the experience period, 25 files were selected for review. All 25 files were received and reviewed. No violations were noted.

Private Passenger Automobile – Renewals With Surcharges

The universe of 39 private passenger automobile policies renewed with surcharges during the experience period was selected for review. All 39 files were received and reviewed. The 2 violations noted were based on 2 files, resulting in an error ratio of 5%.

The following findings were made:

2 Violations *Act 246, The Casualty and Surety Rate Regulatory Act, Section 4 (40 P.S. §1184)*

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 of issue. The Company failed to use filed and approved rates. The Company applied improper territory factors, which resulted in undercharges of $485.

B. Private Passenger Automobile – Assigned Risk

Travelers reports its premium writings for private passenger automobile to the Pennsylvania Assigned Risk Plan. As a result, the Company receives all assignments from the Pennsylvania Assigned Risk Plan.

1. New Business

New business, for the purpose of this examination, was defined as policies written for the first time by the Company during the experience period. The primary purpose of the review was to determine compliance with Act 246, The Casualty and Surety Rate Regulatory Act, Sections 4(a) and (h) [40 P.S. §1184], 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. Review was also made of all the rules and rates of the Assigned Risk Plan, compliance with all provisions of Act 6 of 1990, as well as Title 75, Pa. C.S. Sections 1741, 1742, 1743 and 1744 [40 P.S. §1741, 1742, 1743 and 1744], which establishes the Assigned Risk Plan and requires insurers to abide by the rules of the Plan.

Assigned Risk Private Passenger Automobile – New Business – Clean

From the universe of 279 assigned risk private passenger automobile new business policies written as clean during the experience period, 25 files were selected for review. All 25 files were received and reviewed. No violations were noted.

Assigned Risk Private Passenger Automobile – New Business – Other Than Clean

From the universe of 183 assigned risk private passenger automobile new business policies written as other than clean during the experience period, 25 files were selected for review. All 25 files were received and reviewed. The 6 violations noted were based on 6 files, resulting in an error ratio of 24%.

The following findings were made:

6 Violations *PA Assigned Risk Plan, Personal Automobile Part, Section 16(A)*

Upon determination that an applicant does not qualify for a clean risk rate, the designated Company shall notify the insured of the reason for this determination and issue the policy at other than clean risk rates. The Company failed to notify the insured of the reason for issuance of the policy at other than clean risk rates.

Assigned Risk Private Passenger Automobile – Renewals – Clean

From the universe of 193 assigned risk private passenger automobile renewal policies written as clean during the experience period, 25 files were selected for review. All 25 files were received and reviewed. The 7 violations noted were based on 7 files, resulting in an error ratio of 28%.

The following findings were made:

7 Violations *PA Assigned Risk Plan, Personal Automobile Part, Section 16(A)(4)*

End of Assignment Period – At least 60 calendar days prior to the expiration date of the final renewal, the Company shall notify the insured that the period of assignment under the Plan will terminate on said expiration date. A copy of such notice shall be sent to the producer of record.

AND

Adjudications: *Konek/PA National, P91-05-55 (1992)*
Allstate/Charlier, P192-01-01 (1992)
Wansley/Colonial, P00-03-030 (2000)
Manley/Nationwide, P00-02-012 (2000)
Hughes/AAA, PH00-09-025 (2000)

When computing the time period required for notice prior to termination which occurs at 12:01 a.m. on the terminal day, the first and terminal days are excluded. The Company failed to send an End of Assignment notice to the insured at least 60 calendar days prior to the expiration date of the final renewal for the 7 files noted.

Assigned Risk Private Passenger Automobile – Renewals – Other Than Clean

From the universe of 195 assigned risk private passenger automobile renewal policies written as other than clean during the experience period, 25 files were selected for review. All 25 files were received and reviewed. Of the 25 files reviewed, only 4 files had actual renewals issued. The remaining 21 files indicated that the renewal quote was not taken. The 2 violations noted were based on 2 files, resulting in an error ratio of 8%.

The following findings were made:

1 Violation *PA Assigned Risk Plan, Personal Automobile Part, Section 16(A)*

Upon determination that an applicant does not qualify for a clean risk rate, the designated Company shall notify the insured of the reason for this determination and issue the policy at other than clean risk rates. The Company failed to notify the insured of the reason for issuance of the policy at other than clean risk rates.

1 Violation *PA Assigned Risk Plan, Personal Automobile Part, Section 16(A)(4)*

End of Assignment Period – At least 60 calendar days prior to the expiration date of the final renewal, the Company shall notify the insured that the period of assignment under the Plan will terminate on said expiration date. A copy of such notice shall be sent to the producer of record.

AND

Adjudications: Konek/PA National, P91-05-55 (1992)
Allstate/Charlier, P192-01-01 (1992)
Wansley/Colonial, P00-03-030 (2000)
Manley/Nationwide, P00-02-012 (2000)
Hughes/AAA, PH00-09-025 (2000)

When computing the time period required for notice prior to termination which occurs at 12:01 a.m. on the terminal day, the first and terminal days are excluded. The Company failed to send an End of Assignment notice to the insured at least 60 calendar days prior to the expiration date of the final renewal for the file noted.

C. Homeowners

1. New Business

New business, for the purpose of this examination, was 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 246, Sections 4(a) and (h) (40 P.S. §1184), 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.

The Company did not write any new business during the experience period.

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 determine compliance with Act 246, Sections 4(a) and (h) (40 P.S. §1184), 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 31,704 homeowner policies renewed without surcharges during the experience period, 25 files were selected for review. All 25 files were received and reviewed. No violations were noted.

Homeowner Rating – Renewals With Surcharges

From the universe of 445 homeowner policies renewed with surcharges during the experience period, 25 files were selected for review. All 25 files were received and reviewed. No violations were noted.

D. Tenant Homeowners

1. New Business

New business, for the purpose of this examination, was 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 246, Sections 4(a) and (h) (40 P.S. §1184), 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.

The Company did not write any new business during the experience period.

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 determine compliance with Act 246, Sections 4(a) and (h) (40 P.S. §1184), 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.

Tenant Homeowner Rating – Renewals Without Surcharges

From the universe of 10,475 tenant homeowner policies renewed without surcharges during the experience period, 25 files were selected for review. All 25 files were received and reviewed. The violation resulted in an error ratio of 4%.

The following finding was made:

1 Violation *Act 246, The Casualty and Surety Rate Regulatory Act, Section 4 (40 P.S. §1184)*

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 of issue. The Company rated the policy with an incorrect territory which resulted in an overcharge of $7.

Tenant Homeowner Rating – Renewals With Surcharges

From the universe of 31 tenant homeowner policies renewed with surcharges during the experience period, 10 files were selected for review. All 10 files were received and reviewed. No violations were noted.

E. Condominium

1. New Business

New business, for the purpose of this examination, was 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 246, Sections 4(a) and (h) (40 P.S. §1184), 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.

The Company did not write any new business during the experience period.

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 determine compliance with Act 246, Sections 4(a) and (h) (40 P.S. §1184), 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.

Condominium Rating – Renewals Without Surcharges

From the universe of 372 condominium policies renewed without surcharges during the experience period, 25 files were selected for review. All 25 files were received and reviewed. No violations were noted.

Condominium Rating – Renewals With Surcharges

The universe of 4 condominium policies renewed with surcharges during the experience period was selected for review. All 4 files were received and reviewed. No violations were noted.

VII. 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. No violations were noted.

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 Clams
H. Tenant Homeowner Claims

The primary purpose of the review was to determine compliance with Title 31, Pennsylvania 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) [40 P.S. §1171.5(a)(10)(vi)], Unfair Insurance Practices Act.

A. Automobile Property Damage Claims

From the universe of 315 private passenger automobile property damage claims reported during the experience period, 35 files were selected for review. The files consisted of voluntary automobile and assigned risk. All 35 files were received and reviewed. The 2 violations noted were based on

2 files, resulting in an error ratio of 6%.

The following findings were made:

2 Violations *Title 31, Pa. Code, Section 146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot 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 a timely status letter for the 2 claims noted.

B. Automobile Comprehensive Claims

From the universe of 182 private passenger automobile comprehensive claims reported during the experience period, 26 files were selected for review. The files consisted of voluntary automobile and assigned risk. All 26 files were received and reviewed. No violations were noted.

C. Automobile Collision Claims

From the universe of 247 private passenger automobile collision claims reported during the experience period, 26 files were selected for review. All 26 files were received and reviewed. No violations were noted.

D. Automobile Total Loss Claims

From the universe of 80 private passenger automobile total loss claims reported during the experience period, 31 files were selected for review. All 31 files were received and reviewed. The violation resulted in an error

ratio of 3%.

The following finding was made:

1 Violation *Title 31, Pa. Code, Section 146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot 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 a timely status letter for the claim noted.

E. Automobile First Party Medical Claims

From the universe of 110 private passenger automobile first party medical claims reported during the experience period, 40 files were selected for review. All 40 files were received and reviewed. The 7 violations noted were based on 4 files, resulting in an error ratio of 10%.

The following findings were made:

1 Violation *Title 31, Pa. Code, Section 69.43*

An insurer shall pay the provider's usual and customary charge for services rendered when the charge is less than 110% of the Medicare payment or a different allowance as may be determined under §69.12(b). An insurer shall pay 80% of the provider's usual and customary charge rendered if no Medicare payment exists. In calculating the usual and

customary charge, an insurer may utilize the requested payment amount on the provider's bill for services or the data collected by the carrier or intermediaries to the extent that the data is made available. An insurer shall provide a complete explanation of the calculations made in computing its determination of the amount payable including whether the calculation is based on 110% of the Medicare payment, 80% of the usual and customary charge or at a different allowance determined by the Commissioner under §69.12(b). A bill submitted by the provider delineating the services rendered and the information from which a determination could be made by the insurer as to the appropriate payment amount will not be construed as a demand for payment in excess of the permissible payment amount. The Company failed to have medical bills repriced or adjusted for cost containment.

2 Violations *Title 31, Pa. Code, Section 69.52(b)*

Requires an insurer to pay bills for care 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 2 files noted.

3 Violations *Title 31, Pa. Code, Section 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 failed to send the

application for benefits within 10 working days for the 3 files noted.

1 Violation *Title 75, Pa. C.S. §1716*

Payment of Benefits. Benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of benefits. If reasonable proof is not supplied as to all benefits, the portion supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Overdue benefits shall bear interest at the rate of 12% per annum from the date the benefits become due. In the event the insurer is found to have acted in an unreasonable manner in refusing to pay the benefits when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended. The Company did not pay interest on a first party medical bill, when the bill was not paid within 30 days.

F. Automobile First Party Medical Claims Referred to a PRO

The universe of 2 automobile first party medical claims referred to a peer review organization by the Company was selected for review. Both files were received and reviewed. The Company was also asked to provide a copy of all peer review contracts in place during the experience period. The contracts were received and reviewed. The violation resulted in an error ratio of 50%.

The following finding was made:

1 Violation *Title 31, Pa. Code, Section 69.52(a)*

Requires an insurer to refer a provider's bill to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with PRO procedures, standards and practices, to believe it necessary that a PRO determine the reasonableness and necessity of care, the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care. The insurer shall notify a provider, in writing, when referring bills for PRO review at the time of referral. The Company failed to provide a written notice to a provider when referring bills for a PRO review at the time of referral.

G. Homeowner Claims

From the universe of 3,931 homeowner claims reported during the experience period, 50 files were selected for review. All 50 files were received and reviewed. The 2 violations noted were based on 2 files, resulting in an error ratio of 4%.

The following findings were made:

2 Violations *Title 31, Pa. Code, Section 146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot 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 2 claims

noted.

H. Tenant Homeowner Claims

From the universe of 200 tenant homeowner claims reported during the experience period, 25 files were selected for review. All 25 files were received and reviewed. The violation resulted in an error ratio of 4%.

The following finding was made:

1 Violation *Title 31, Pa. Code, Section 146.7(a)(1)*

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. The Company failed to have a copy of the denial letter in the claim file.

VIII. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy forms used in order to verify compliance with 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 Act 165 of 1994 [18 Pa. CS §4117(k)(1)] and Title 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.

The following findings were made:

3 Violations *Title 75, Pa. C.S. §1822*

Warning notice on application for insurance and claim forms. Not later than May 1, 1990, all applications for insurance, renewals and claim forms shall contain a statement that clearly states in substance the following: "Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000."

AND

Act 165 of 1994 [18 Pa. C.S. §4117(k)(1)]

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The Company failed to provide the required Pennsylvania fraud notice on a full and final release claim form, a written statement claim form, and a power of attorney claim form.

The following concern was made:

Concern: The Company maintains a State Termination Guide-Pennsylvania Auto for form and mailing requirements. There are edition dates of March 21, 2008 and August 28, 2009. In both guides, under Summary of Additional State Guidelines – "Does the state have any required language that must be included on notices?, the first bullet item states the cancellation or nonrenewal notice shall advise the insured of his/her right to request a review of our action within 10 days of the receipt of the reasons." The statement should be changed to read within 30 days of the receipt of the reason.

IX. ADVERTISING

The Company was requested to provide copies of all advertising, sales material and internet advertisements in use during the experience period.

The purpose of this review was to determine compliance with Act 205, Section 5 [40 P.S. §1171.5], which defines unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, as well as Title 31, Pennsylvania Code, Section 51.2(c) and Section 51.61.

The Company provided 88 pieces of advertising which included brochures, magazine and newspaper ads and agent kits. Internet advertising was also reviewed. No violations were noted.

X. 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 30 consumer complaints received during the experience period and provided all consumer complaint logs requested. The 30 complaint files reported were requested, received and reviewed.

The purpose of the review was to determine compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5(a)(11) of the Act 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 following findings were made:

2 Violations *Title 31, Pa. Code, Section 146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot 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 2 claims noted.

1 Violation *Act 205, Section 5(a)(9)(ii) [40 P.S. §1171.5(a)(9)(ii)]*

Requires that a cancellation notice shall 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 30 days notice of cancellation for the file noted.

3 Violations *Act 205, Section 5(a)(9)(iv) [40 P.S. §1171.5(a)(9)(iv)]*

Requires that a cancellation notice shall advise the insured of his right to request, in writing, within ten days of the receipt of the notice of cancellation or intention not to renew that the Insurance Commissioner review the action of the insurer. The Company failed to advise the insured of their right to request by the Commissioner within 10 days of receipt of notice. The 3 files provided advised the insured of their right of review within 30 days of receipt of notice.

The following synopsis reflects the nature of the 30 complaints that were reviewed.

• 14	Cancellation/Nonrenewal	47%
• 13	Claims	43%
• 2	Billing/Collections	7%
• 1	Miscellaneous	3%
30		100%

XI. LICENSING

In order to determine compliance by the Company and its agency force with the licensing requirements applicable to Section 641.1(a) [40 P.S. §310.41(a) and Section 671-A [40 P.S. §310.71] of the Insurance Department Act No. 147, the Company was requested to furnish a list of all active producers during the experience period and a listing of all producers terminated during the experience period. Underwriting files were checked to verify proper licensing and appointment.

The following findings were made:

2 Violations *Insurance Department Act, No. 147, Section 641.1A [40 P.S. §310.41a]*

(a) Any insurance entity or licensee accepting applications or orders for insurance from any person or securing any insurance business that was sold, solicited or negotiated by any person acting without an insurance producer license shall be subject to civil penalty of no more than $5,000.00 per violation in accordance with this act. This section shall not prohibit an insurer from accepting an insurance application directly from a consumer or prohibit the payment or receipt of referral fees in accordance with this act.

The following producers were found to be writing and /or soliciting policies but were not found in Insurance Department records as holding a Pennsylvania producer license.

Fred S. Smails Insurance
Phillips Insurance Agency, Inc.

10 Violations Insurance Department Act, No. 147, Section 671-A (40 P.S. §310.71)

(a) Representative of the insurer – An insurance producer shall not act on behalf of or as a representative of the insurer unless the insurance producer is appointed by the insurer. An insurance producer not acting as a representative of an insurer is not required to be appointed.

(b) Representative of the consumer – An insurance producer acting on behalf of or representing an insurance consumer shall execute a written agreement with the insurance consumer prior to representing or acting on their behalf that:

(1) Delineates the services to be provided; and

(2) Provides full and complete disclosure of the fee to be paid to the insurance producer by the insurance consumer.

(c) Notification to Department – An insurer that appoints an insurance producer shall file with the Department a notice of appointment. The notice shall state for which companies within the insurer's holding company system or group the appointment is made.

(d) Termination of appointment – Once appointed, an insurance producer shall remain appointed by an insurer until such time as the insurer terminates the appointment in writing to the insurance producer or until the insurance producer's license is suspended, revoked or otherwise terminated.

(e) Appointment fee – An appointment fee of $12.50 will be billed annually to the insurer for each producer appointed by the insurer during the preceding calendar year regardless of the length of time the producer held the appointment with the insurer. The appointment fee may be modified by regulation.

(f) Reporting – An insurer shall, upon request, certify to the

Department the names of all licensees appointed by the insurer.

The following producers were found to be writing policies but were not found in Insurance Department records as having an appointment. The Company failed to file a notice of appointment and submit appointment fees to the Department.

Agri Ins. Mgmt Svcs.
J S Braddock Agency
KBS International Corp
Business Risk Specialist
Coffey & Company, Inc.
Performance Insurance
Charity First AJG Co.
Allen Financial Ins. Group
Boulevard Insurance LLC
A C Marmo & Sons, Inc.

X. 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 Act 205, Section 5(a)(9) [40 P.S. §1171.5(a)(9)] to ensure that violations regarding the requirements for cancellation notices, as noted in the Report, do not occur in the future.

2. The Company must review Act 86, Section 1 [40 P.S. §3401], to ensure that violations regarding notification to the insured of an increase in premium do not occur in the future.

3. The Company must review and revise internal control procedures to ensure compliance relative to commercial cancellation and nonrenewal requirements of Act 86, Sections 3, 4 and 7 [40 P.S. §§3403, 3404 and 3407], so that the violations noted in the Report do not occur in the future.

4. The Company must review Act 246, Section 4(a) and (h) [40 P.S. §1184] and take appropriate measures to ensure the rating violation listed in the report does not occur in the future.

5. The premium overcharge noted in the rating section of this report must be refunded to the insured and proof of such refund must be provided to the Insurance Department within 30 days of the report issue date.

6. The Company must review the Pennsylvania Assigned Risk Plan, Section 16, and take appropriate measures to ensure the violations listed in the report, do not occur in the future.

7. The Company should review and revise internal control procedures to ensure compliance with the claims handling requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices so that the violations relating to providing claim forms, status letters and denials, as noted in the Report, do not occur in the future.

8. The Company must review Title 31, Pa. Code, Section 69.52(b) with its claim staff to ensure that first party medical bills are paid within 30 days.

9. The Company must review the first party medical claims, which have not been paid within 30 days. Those claims that have not been paid within 30 days shall bear interest at the rate of 12% per annum from the date the benefits become due as required by Title 75, Pa. C.S. §1716. The interest amount must be paid to the claimant and proof of such payment must be provided to the Insurance Department within 30 days of the Report issue date.

10. The Company must review Title 31, Pa. Code, Section 69.52(a) with its claim staff to ensure that providers are notified in writing when referring bills for PRO review at the time of referral.

11. The Company must review Title 31, Pa. Code, Section 69.43 with its claim staff to ensure that provider bills are repriced for cost containment as required.

12. The Company must ensure that all claim forms contain the required fraud warning notice.

13. The Company must ensure all producers are properly licensed and appointed, as required by Section 641.1(a) and Section 671-A [40 P.S. §310.41(a) and 40 P.S. §310.71] of the Insurance Department Act No. 147, prior to accepting any business from any producer.

X. COMPANY RESPONSE

TRAVELERS

Libby Magnus
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Corporate Compliance & Market Conduct
385 Washington St, NB15C
St. Paul, MN 55102

October 27, 2011

Via Email (carnold@pa.gov) and regular mail

Constance Arnold
Pennsylvania Insurance Department
Bureau of Market Actions
Property and Casualty Market Conduct Division
1227 Strawberry Square, Harrisburg, PA 17120

RE: Company response to final report –The Travelers Indemnity Company

Dear Ms. Arnold:

Thank you for allowing us the opportunity to respond to the final report for The Travelers Indemnity Company. Please find enclosed our response for your review and consideration.

We appreciate the professionalism and courteous approach afforded by you and the entire exam team throughout the review.

If you have any questions or concerns, please feel free to contact me directly.

Sincerely,

Libby Magnus

Libby Magnus, MCM
Director, Corporate Compliance &
Market Conduct
(651)310-2117

X. RECOMMENDATIONS

1. The Company must review Act 205, Section 5(a)(9) [40 P.S.§1171.5(a)(9)] to ensure that violations regarding the requirements for cancellation notices, as noted in the Report, do not occur in the future.

   Company Response: *The Company accepts this recommendation. The company will reinforce existing procedures with staff pertaining to retaining proof of or documenting insured request cancellations.*

2. The company must review Act 86, Section 1 [40 P.S. §3401], to ensure that violations regarding notification to the insured of an increase in premium do not occur in the future.

   Company Response: *The Company agrees with the Department's findings and will review current procedures to ensure compliance with Act 86. We have already reviewed our internal procedures and have sent various reminders to the field regarding state requirements on premium increase notices. Random audits of renewal notices have been and will continue to be conducted throughout the year to monitor company adherence to your state's statutory requirements.*

3. The Company must review and revise internal control procedures to ensure compliance relative to commercial cancellation and nonrenewal requirements of Act 86, Sections 3, 4 and 7 [40 P.S. §3403, 3404 and 3407], so that the violations noted in the Report do not occur in the future.

   Company Response*: The Company agrees with the Department's findings relative to Act 86, Sections 3 and 4 specific to policyholder notice and the return of estimated premium. One item of note, Travelers had previously instituted procedures regarding the issuance of refunds upon cancellation. In addition, a bulletin was released throughout the organization reiterating the need to process insured request cancellations in a timely fashion. The release of the new procedures and bulletin coincided with the start of this 2010 exam. As a result, policies included in this exam sample were cancelled under the old procedures. We expect fewer errors in the refund process going forward and will continue to monitor for any trends or training opportunities.*

   Specific to Act 86, Section 7 {40 P.S. §3407], after further review of this issue the Company continues to respectfully disagree with the summary findings. The violations referenced improper notice of cancellation for non-payment of premium. Pennsylvania Statute PA § 40 Section 3407 states that it does not apply to policies that are in effect less than 60 days unless they are renewals. Pennsylvania Statute PA § 40 Section 3403 indicates if an insured failed to pay a premium when due the notice of cancellation shall be forwarded directly to the named insured at least15 days in

advance of the effective date of termination. As such, the Company feels Section 3403 applies to cancellation for nonpayment of premium from either a new or renewal insured. In addition, it does not seem reasonable that an insurer is subject to the same notice period for cancellation for nonpayment of premium and for cancellation for any other reason. It seems more valid to interpret the statutes in such a way that the notice period for cancellation for non payment is a lesser notice period and should be the same amount of time regardless of new or renewal status.

Given the foregoing, the position of the Company is that Section 3403 applies to cancellation for nonpayment of premium from either a new or renewal insured. And, since all of the notices met the 15 day notice standard in Section 3403, it is the position of the Company that we are in compliance with Pennsylvania law with respect to this issue.

Given our differing positions on this issue, it is clear that the statutory references are vague and open to different interpretations. As such, the Company respectfully submits that our position on how the statutes apply to this issue is a reasonable one and that these criticisms should not be fineable offenses.

4. The Company must review Act 246, Section 4(a) and (h) [40 P.S. 1184] and take appropriate measures to ensure the rating violation listed in the report does not occur in the future.

   Company Response: *The Company accepts this recommendation. In regard to the rating of Automobile policies with surcharges, a system fix has been put in place to prevent future occurrences and to ensure impacted policies will be corrected upon renewal. The impacted policies were undercharged; therefore, no refund is needed. The Tenant Homeowner policy cited in the violation has been corrected back to the term where the error occurred. The Company would like to note that the error occurred as a result of human error and not as a result of a deficient practice or procedure.*

5. The premium overcharge noted in the rating section of this report must be refunded to the insured and proof of such refund must be provided to the Insurance Department within 30 days of the report issue date.

   Company Response: *The Company accepts this recommendation and would like it noted that the premium has been refunded from the policy term that the rating error occurred.*

6. The company must review the Pennsylvania Assigned Risk Plan, Section 16, and take appropriate measures to ensure the violations listed in the report, do not occur in the future.

***Company Response**: The Company accepts this recommendation and is implementing controls to ensure compliance with Pennsylvania Assigned Risk Plan Section 16. On July 29, 2011 the company implemented a process relative to the issuance of letters when new business policies are issued at other than clean rates. All insureds with new business policies issued at other than clean rates will receive a letter. The Company is also in the process of revising its procedures regarding the issuance of end of assignment letters to ensure the 60 day requirement is met. The company will reinforce current practices and procedures pertaining to other than clean letters sent at renewal.*

7. The Company should review and revise internal control procedures to ensure compliance with the claims handling requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices so that the violations relating to providing claim forms, status letters and denials, as noted in the Report, do not occur in the future.

***Company Response**: The Company accepts this recommendation. Although Travelers believes these findings were isolated instances, the Company will review and revise internal control procedures to ensure compliance with the claims handling requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices so that the violations relating to providing claim forms, status letters and denials, as noted in the Report, do not occur in the future.*

8. The Company must review Title 31, Pa. Code, Section 69.52(b) with its claim staff to ensure that first party medical bills are paid within 30 days.

***Company Response:** The Company accepts this recommendation. Although Travelers believes these findings were isolated instances, the Company will pay bills for care that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill.*

9. The Company must review the first party medical claims, which have not been paid within 30 days. Those claims that have not been paid within 30 days shall bear interest at the rate of 12% per annum from the date the benefits become due as required by Title 75, Pa. C.S. §1716. The interest amount must be paid to the claimant and proof of such payment must be provided to the Insurance Department within 30 days of the Report issue date.

Company Response: *The Company accepts this recommendation. Although Travelers believes this finding was an isolated instance, the Company will review Title 75, PA C.S. 1716 to ensure benefits are paid within 30 days after the Company receives reasonable proof of the amount of benefits. Interest was paid to the claimant as soon as the violation was noted.*

10. The Company must review Title 31, Pa. Code, Section 69.52(a) with its claim staff to ensure that providers are notified in writing when referring bills for PRO review at the time of referral.

Company Response: *The Company accepts this recommendation. While the Company believes that the written notice it sent to the providers when it referred bills for a PRO were timely, the Company will review Title 31, PA. Code, Section 69.52(a) to ensure such notice is given to the provider at the time the referral is made to the PRO.*

11. The Company must review Title 31, Pa. Code, Section 69.43 with its claim staff to ensure that provider bills are repriced for cost containment as required.

Company Response: *The Company accepts this recommendation. Although Travelers believes this finding was an isolated instance, the Company will review Title 31 PA. Code, Section 69.43 to ensure medical bills are repriced or adjusted for cost containment.*

12. The Company must ensure that all claim forms contain the required fraud warning notice.

Company Response: *The Company accepts this recommendation. Although Travelers believes these findings were isolated instances, the Company will review Title 75, PA. C.S. 1822 – and Act 165 of 1994 [18 Pa. C.S. §4117ek) (1)] to ensure claim forms shall contain a statement that clearly states in substance the following: "Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000." Any person who knowingly and with Intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

13. The Company must ensure all producers are properly licensed and appointed, as required by Section 641.1(a) and Section 671-A [40 P.S.§310.41(a) and 40 P.S. §310.71] of the Insurance Department Act No. 147, prior to accepting any business from any producer.

Company Response: *The Company accepts this recommendation. We acknowledge the comments regarding Pennsylvania requirements and will evaluate the circumstances regarding these isolated incidents. The licensing process has begun for those producers needing a license. Appointments have been completed or are still in process if the license is being pursued.*

One producer, Boulevard Insurance, LLC, will not be appointed because it was determined that they no longer write business in Pennsylvania. The policy is no longer written with Travelers.