



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

MARKET CONDUCT
EXAMINATION REPORT

OF

**21st CENTURY INDEMNITY
INSURANCE COMPANY**
HARRISBURG, PA

As of: October 24, 2011
Issued: December 16, 2011

**BUREAU OF MARKET ACTIONS
PROPERTY AND CASUALTY DIVISION**

VERIFICATION

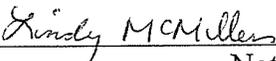
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).



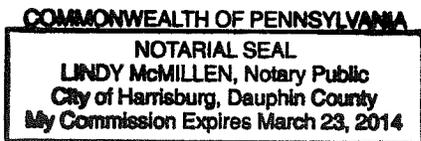
Jerry L. Houston, AIE, CPCU, Examiner-In-Charge

Sworn to and Subscribed Before me

This 23 Day of August , 2011



Notary Public



21st CENTURY INDEMNITY INSURANCE COMPANY

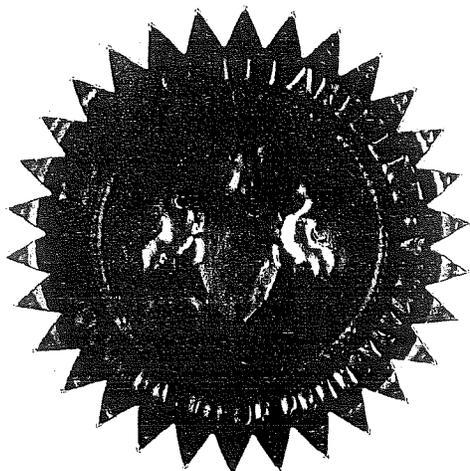
TABLE OF CONTENTS

Order	
I.	Introduction..... 1
II.	Scope of Examination..... 3
III.	Company History/Licensing..... 4
IV.	Underwriting Practices and Procedures..... 6
V.	Underwriting
	A. Private Passenger Automobile..... 7
	B. Assigned Risk..... 10
VI.	Rating
	A. Private Passenger Automobile..... 11
	B. Assigned Risk..... 18
VII.	Claims..... 19
VIII.	Forms..... 27
IX.	Advertising..... 29
X.	Consumer Complaints..... 30
XI.	Licensing..... 31
XII.	Recommendations..... 32
XIII.	Company Response..... 35

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

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 the findings of fact and conclusions of law contained herein. Respondent denies violating any Pennsylvania law or regulation.

FINDINGS OF FACT

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

(a) Respondent is 21st Century Indemnity Insurance Company, and maintains its address at 3 Beaver Valley Road, 5th Floor, Wilmington, DE 19803.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the experience periods from May 1, 2009 through April 30, 2010.

- (c) On October 24, 2011, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on November 22, 2011.
- (e) The Examination Report notes violations of the following:
- (i) Sections 1705(a)(1) & (4) of Act 1990-6, Title 75, Pa.C.S. § 1705, which requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option;
 - (ii) Section 1738(c)(d)(1) and (2) of Act 1990-6, Title 75, Pa.C.S. § 1738, which requires the named insured to be informed that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms;
 - (iii) Section 1791.1(a) of Act 1990-6, Title 75, Pa.C.S. § 1791, which requires that at the time of application for original coverage and every renewal thereafter, an insurer must provide to an insured an itemized invoice listing the minimum motor vehicle insurance coverage levels mandated by the

commonwealth and the premium charge for the insured to purchase the minimum mandated coverages. The invoice must contain the following notice in print of no less than ten-point type: "The laws of the Commonwealth of Pennsylvania, as enacted by the General Assembly, only require you to purchase liability and first-party medical benefit coverages. Any additional coverage or coverages in excess of the limits required by law are provided only at your request as enhancements to basic coverages." The insurer shall provide the itemized invoice to the insured in conjunction with the declaration of coverage limits and premiums for the insured's existing coverages;

- (iv) Section 1791.1(c) of Act 1990-6, Title 75, Pa.C.S. § 1791, which requires an insurer to provide an insured a notice stating that discounts are available for drivers who meet the requirements of Sections 1799, 1799.1 and 1799.2;
- (v) Section 1792(b)(1) of Act 1990-6, Title 75, Pa.C.S. § 1792(b)(1), which requires every private passenger automobile insurance policy providing collision coverage to provide a deductible in the amount of \$500.00 for collision coverage, unless the named insured signs a statement indicating the insured is aware that the purchase of a lower deductible is permissible and that there is an additional cost of purchasing a lower deductible and the insured agrees to accept it;

- (vi) Section 2004 of Act 68 of 1998 (40 P.S. § 991.2004), which requires that no insurer shall cancel a policy of automobile insurance except for nonpayment of premium, suspension or revocation of the named insured's driver license or motor vehicle registration or a determination that the insured has concealed a material fact or has made a material allegation contrary to fact or has made a misrepresentation of material fact and that such concealment, allegation or misrepresentation was material to the acceptance of the risk by the insurer;

- (vii) Section 2008(b) of Act 68 of 1998 (40 P.S. § 991.2008), which requires any applicant for a policy who is refused such policy by an insurer shall be given a written notice of refusal to write by the insurer. Such notice shall state the specific reason or reasons of the insurer for refusal to write a policy for the applicant. Within 30 days of the receipt of such reasons, the applicant may request in writing to the Commissioner that he review the action of the insurer in refusing to write a policy for the applicant;

- (viii) Section 5(a)(4) of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.5(a)(4)), which prohibits entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in unreasonable restraint of, or monopoly in, the business of insurance;

(ix) Title 31, Pennsylvania Code, Section 69.42, which states an insurer shall make payments to providers in accordance with the Medicare Program as applied in this Commonwealth by the carrier and intermediaries. Care covered under the Medicare Program shall be reimbursed at 110% of the Medicare payment or a different allowance as may be determined under § 69.12(b). Medicare co-insurance and deductibles may not be excluded in payments made by the insurer;

(x) 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;

(xi) 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;

(xii) Title 31, Pennsylvania Code, Section 69.52(e), which requires an insurer to provide copies of the Peer Review Organization's written analysis to the provider and the insured within 5 days of receipt;

(xiii) 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;

(xiv) Title 31, Pennsylvania Code, Section 146.6 states that if an investigation cannot 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;

- (xv) 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;

- (xvi) Section 1161(a) and (b) of Title 75, Pa. C.S., which states an insurer who owns, possesses or transfers a vehicle located or registered in the Commonwealth which qualifies as a salvage vehicle shall make application to the Department for a certificate of salvage for that vehicle;

- (xvii) Title 75, Pennsylvania Consolidated Statutes, Section 1716, states that 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; and

- (xviii) 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.

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 2004 and 2008 of Act 68 of 1998 are punishable by the following, under Section 2013 of the Act (40 P.S. § 991.2013):
Any individual or insurer who violates any of the provisions of this article may be sentenced to pay a fine not to exceed five thousand dollars (\$5,000.00).
- (c) Respondent's violations of Section 5(a)(4) 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.

- (d) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Commissioner 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).

- (e) 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 described 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 Thirty-Five Thousand Dollars (\$35,000.00) 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 Conduct, 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 the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

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

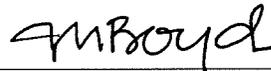
9. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

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.

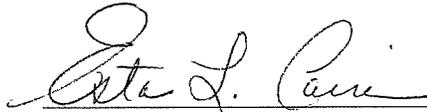
11. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

12. 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.

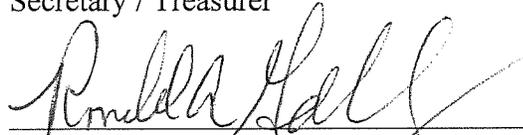
BY: 21st CENTURY INDEMNITY INSURANCE
COMPANY, Respondent



President / Vice President



Secretary / Treasurer



RONALD A. GALLAGHER, JR.
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The market conduct examination was conducted at 21st Century Indemnity Insurance Company's office located in Wilmington, Delaware, from December 6, 2010, through March 11, 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 undersigned participated in this examination and in preparation of this Report.

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

Jerry Houston, AIE, CPCU
Market Conduct Examiner

Constance L. Arnold
Market Conduct Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on 21st Century Indemnity Insurance Company, hereinafter referred to as “Company,” at their office located in Wilmington, Delaware. 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 May 1, 2009, through April 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, midterm cancellations, 60-day cancellations and rescissions.
 - Rating – Proper use of all classification and rating plans and procedures.
2. Claims
3. Forms
4. Advertising
5. Complaints
6. Producer Licensing

III. COMPANY HISTORY AND LICENSING

21st Century Indemnity Insurance Company was incorporated in Wisconsin, in 1980, and re-domesticated to be a Pennsylvania corporation in 1996. The Company was known as the Colonial Penn Madison Insurance Company from 1994, until July 1, 2002, when its name was changed to GE Indemnity Insurance Company. On August 29, 2003, the Company was sold by GE Financial Assurance Holdings, Inc., a subsidiary of the General Electric Company, to Lexington Insurance Company, an indirect subsidiary of American International Group, Inc. Effective April 1, 2004, the Company's name was changed to AIG Indemnity Insurance Company. Effective July 1, 2009, the Company and other member companies in the 21st Century Personal Auto Group (PAG) were acquired by Farmers Group Inc., (FGI), a subsidiary of Zurich Financial Services Group from AIG. Subsequently on July 1, 2009, FGI sold the PAG entities to Farmers Insurance Exchange (FIE) (80%), Truck Insurance Exchange (Truck) (10%) and Fire Insurance Exchange (Fire) (10%). As a result of the acquisition by FIE, Truck and Fire, the Company became one of the Farmers Property and Casualty Companies (the Farmers P&C Companies). Effective April 1, 2010, the Company's name was changed to 21st Century Indemnity Insurance Company.

LICENSING

21st Century Indemnity Insurance Company's Certificate of Authority to write business in the Commonwealth was issued on October 23, 1996. The Company is licensed in Arizona, Arkansas, California, Delaware, Florida, Georgia, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maryland, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Utah and Wisconsin. The Company's 2010 annual statement

reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as \$57,710,326. Premium volume related to the areas of this review were: Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (personal injury protection) \$5,734,293; Other Private Passenger Auto Liability \$30,906,359 and Private Passenger Auto Physical Damage \$21,069,674.

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

From the universe of 976 private passenger automobile files identified as being cancelled in the first 60 days of new business, 75 files were selected for review. All 75 files were received and reviewed. No violations were noted.

2. 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 8,953 private passenger automobile files identified as midterm cancellations, 75 files were selected for review. All 75 files were received and reviewed. The violation resulted in an error ratio of 1%.

The following finding was made:

1 Violation Act 68, Section 2004 [40 P.S. §991.2004]

Requires that no insurer shall cancel a policy of automobile insurance except for nonpayment of premium, suspension or revocation of the named insured's driver license or motor vehicle registration or a determination that the insured has concealed a material fact or has made a material allegation contrary to fact or has made a misrepresentation of material fact and that such concealment, allegation or misrepresentation was material to the acceptance of the risk by the insurer. The Company cancelled the policy due to the suspension of someone other than the named insured.

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.

From the universe of 141 private passenger automobile files identified as nonrenewals, 50 files were selected for review. All 50 files were received and reviewed. The violation resulted in an error ratio of 2%.

The following finding was made:

1 Violation Act 205, Section 5(a)(4) [40 P.S. §1171.5(a)(4)]

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance. The Company nonrenewed a policy insuring a motor home indicating their underwriting guide prohibited a motor home from being the sole vehicle on the policy.

Requiring other vehicles to be insured is not permitted under the Act.

4. Declinations

From the universe of 375 private passenger automobile policies reported as declined during the experience period, 100 files were selected for review. All 100 files were received and reviewed. The 12 violations noted were based on 12 files, resulting in an error ratio of 12%.

The following findings were made:

12 Violations Act 68, Section 2008(b) [40 P.S. §991.2008(b)]

Any applicant for a policy who is refused such policy by an insurer shall be given a written notice of refusal to write by

the insurer. Such notice shall state the specific reason or reasons of the insurer for refusal to write a policy for the applicant. Within 30 days of the receipt of such reasons, the applicant may request in writing to the Insurance Commissioner that he review the action of the insurer in refusing to write a policy for the applicant. The Company failed to provide a specific reason for the declination of the 12 files noted.

B. Private Passenger Automobile – Assigned Risk

The Company is an excused carrier under the assigned risk Limited Assignment Distribution procedure. Under this procedure groups of companies not under common ownership or management may form a Limited Assignment Distribution (LAD) arrangement. Each LAD arrangement has one servicing company, which writes assigned risk business on behalf of those members, which choose to buy out from their private passenger quota. As part of this arrangement the Company wrote no assigned risk business during the experience period.

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.

Private Passenger Automobile – New Business Without Surcharges

From the universe of 3,961 private passenger automobile policies identified as new business without surcharges, 50 files were selected for review. All 50 files were received and reviewed. The 11,901 violations noted were based on the universe of 3,961 files, resulting in an error ratio of 100%.

The following findings were made:

3,961 Violations Title 75, Pa. C.S. §1791.1(a)

Requires that at the time of application for original coverage and every renewal thereafter, an insurer must provide to an insured an itemized invoice listing the minimum motor vehicle insurance coverage levels mandated by the Commonwealth and the premium charge for the insured to purchase the minimum mandated coverages. The invoice must contain the following notice in print of no less than ten-point type: “The laws of the Commonwealth of Pennsylvania, as enacted by the General Assembly, only require you to purchase liability and first-party medical benefit coverages. Any additional coverage or coverages in excess of the limits required by law are provided only at your request as enhancements to basic coverages.” The insurer shall provide the itemized invoice to the insured in conjunction with the declaration of coverage limits and premiums for the insured’s existing coverages. The Company failed to provide the itemized invoice listing the minimum mandated coverages and the premium charge to purchase the minimum coverages at the time of application.

3,961 Violations Title 75, Pa. C.S. §1791.1(c)

Requires an insurer to provide an insured a notice stating that discounts are available for drivers who meet the requirements of Sections 1799, 1799.1 and 1799.2. The Company failed to provide the required notice at the time of application.

17 Violations Title 75, Pa. C.S. §1738(d)(1)&(2)

The named insured shall be informed that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms. The Company did not provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for the 17 files noted.

1 Violation Title 75, Pa. C.S. §1792(b)(1)

Requires every private passenger automobile insurance policy providing collision coverage to provide a deductible in the amount of \$500.00 for collision coverage, unless the named insured signs a statement indicating the insured is aware that the purchase of a lower deductible is permissible and that there is an additional cost of purchasing a lower deductible and the insured agrees to accept it. The Company failed to provide a signed statement from the insured requesting a deductible of less than \$500 for the file noted.

3,961 Violations Title 75, Pa. C.S. §1705(a)(4)

Requires every insurer, prior to the first issuance of a private passenger motor vehicle liability insurance policy to provide each applicant with the notice required by paragraph (1). A

policy may not be issued until the applicant has been provided an opportunity to elect a tort option. The Company failed to provide the notice required prior to policy issuance.

The following concern was made:

Concern: The surcharge disclosure plan provided by the Company at the time of application does not include the estimated increase of the surcharge per policy period per policyholder and does not indicate the number of years any surcharge will be in effect. The Company must include this information within their Plan going forward.

Private Passenger Automobile - New Business With Surcharges

From the universe of 78 private passenger automobile policies identified as new business with surcharges by the Company, 25 files were selected for review. All 25 files were received and reviewed. The 240 violations noted were based on the universe of 78 files, resulting in an error ratio of 100%.

The following findings were made:

1 Violation Title 75, Pa. C.S. §1705(a)(1)&(4)

Requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option. The policy was issued with limited tort, but no signed election form was contained in the file.

5 Violations Title 75, Pa. C.S. §1738(d)(1)&(2)

The named insured shall be informed that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms. The Company did not provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for the 5 files noted.

78 Violations Title 75, Pa. C.S. §1791.1(a)

Requires that at the time of application for original coverage and every renewal thereafter, an insurer must provide to an insured an itemized invoice listing the minimum motor vehicle insurance coverage levels mandated by the Commonwealth and the premium charge for the insured to purchase the minimum mandated coverages. The invoice must contain the following notice in print of no less than ten-point type: “The laws of the Commonwealth of Pennsylvania, as enacted by the General Assembly, only require you to purchase liability and first-party medical benefit coverages. Any additional coverage or coverages in excess of the limits required by law are provided only at your request as enhancements to basic coverages.” The insurer shall provide the itemized invoice to the insured in conjunction with the declaration of coverage limits and premiums for the insured’s existing coverages. The Company failed to provide the itemized invoice listing the minimum mandated coverages and the premium charge to purchase the minimum coverages at the time of application.

78 Violations Title 75, Pa. C.S. §1791.1(c)

Requires an insurer to provide an insured a notice stating that discounts are available for drivers who meet the requirements of Sections 1799, 1799.1 and 1799.2. The Company failed to provide the required notice at the time of application.

78 Violations Title 75, Pa. C.S. §1705(a)(4)

Requires every insurer, prior to the first issuance of a private passenger motor vehicle liability insurance policy to provide each applicant with the notice required by paragraph (1). A policy may not be issued until the applicant has been provided an opportunity to elect a tort option. The Company failed to provide the notice required prior to policy issuance.

The following concern was made:

Concern: The surcharge disclosure plan provided by the Company at the time of application does not include the estimated increase of the surcharge per policy period per policyholder and does not indicate the number of years any surcharge will be in effect. The Company must include this information within their Plan going forward.

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 10,338 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.

The following concern was made:

Concern: The surcharge disclosure plan provided by the Company at the time of renewal does not indicate the number of years any surcharge will be

in effect. The Company must include this information within their Plan going forward.

Private Passenger Automobile – Renewals With Surcharges

From the universe of 1,224 private passenger automobile policies renewed with surcharges during the experience period, 50 files were selected for review. All 50 files were received and reviewed. No violations were noted.

The following concern was made:

Concern: The surcharge disclosure plan provided by the Company at the time of renewal does not indicate the number of years any surcharge will be in effect. The Company must include this information within their Plan going forward.

B. Private Passenger Automobile – Assigned Risk

The Company is an excused carrier under the assigned risk Limited Assignment Distribution procedure. Under this procedure groups of companies not under common ownership or management may form a Limited Assignment Distribution (LAD) arrangement. Each LAD arrangement has one servicing company, which writes assigned risk business on behalf of those members, which choose to buy out from their private passenger quota. As part of this arrangement the Company wrote no assigned risk business during the experience period.

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

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 522 private passenger automobile property damage claims reported during the experience period, 25 files were selected for review. All 25 files were received and reviewed. The 3 violations noted were based on 3 files, resulting in an error ratio of 12%.

The following findings were made:

2 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 2 claims noted.

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 send a written denial letter to the claimant.

B. Automobile Comprehensive Claims

From the universe of 1,603 private passenger automobile comprehensive claims reported during the experience period, 25 files were selected for review. All 25 files were received and reviewed. No violations were noted.

C. Automobile Collision Claims

From the universe of 3,309 private passenger automobile collision 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 send a written denial letter to the claimant.

D. Automobile Total Loss Claims

From the universe of 1,023 private passenger automobile total loss claims reported during the experience period, 75 files were selected for review. All 75 files were received and reviewed. The 8 violations noted were based on 7 files, resulting in an error ratio of 9%.

The following findings were made:

7 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 7 claims noted.

1 Violation Title 75, Pa. C.S. §1161(a)&(b) – Certificate of Salvage Required.

(a) General rule – Except as provided in Sections 1162 and 1163, a person, including an insurer or self-insurer as defined in Section 1702 (relating to definitions), who owns, possesses or transfers a vehicle located or registered in the Commonwealth which qualifies as a salvage vehicle shall make application to the Department for a certificate of salvage for that vehicle.

(b) Application for certificate of salvage. – An owner who transfers a vehicle to be destroyed or dismantled, salvaged or recycled shall assign the certificate of title to the person to whom the vehicle is transferred. Except as provided in Section 1163, the transferee shall immediately present the assigned certificate of title to the Department or an authorized agent of the Department with an application for a certificate of salvage upon a form furnished and prescribed by the Department. An insurer as defined in Section 1702 to which title to a vehicle is assigned upon payment to the insured or claimant of the replacement value of a vehicle shall be regarded as a transferee under this subsection. The Company failed to provide a Pennsylvania certificate of salvage for the claim file noted.

E. Automobile First Party Medical Claims

From the universe of 969 private passenger automobile first party medical claims reported during the experience period, 75 files were selected for review. All 75 files were received and reviewed. The 28 violations noted were based on 9 files, resulting in an error ratio of 12%.

The following findings were made:

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 claims noted.

2 Violations 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 2 claims that were not paid within 30 days.

12 Violations Title 31, Pa. Code, Section 69.42

An insurer shall make payments to providers in accordance with the Medicare Program as applied in this Commonwealth by the carrier and intermediaries. Care covered under the Medicare Program shall be reimbursed at 110% of the

Medicare payment or a different allowance as may be determined under §69.12(b). Medicare co-insurance and deductibles may not be excluded in payments made by the insurer.

AND

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.

10 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 failed to send written denial letters for 10 separate medical bills for one claim.

2 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 application for benefits to the claimant within 10 working days of notification of claim for the 2 claims noted.

F. Automobile First Party Medical Claims Referred to a PRO

From the universe of 45 automobile first party medical claims that were referred to a peer review organization by the Company, 15 claim files were selected for review. All 15 claim 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 7%.

The following finding was made:

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

Requires an insurer to provide copies of the Peer Review Organization's written analysis to the provider and the insured within 5 days of receipt. The Company failed to provide a copy of the PRO report to the provider and the insured within 5 days.

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:

Automobile Rating – New Business Without Surcharges

3,235 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." The Company failed to provide the required fraud warning at the time of application for phone sales.

Automobile Rating – New Business With Surcharges

67 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." The Company failed to provide the required fraud warning at the time of application for phone sales.

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 54 pieces of advertising which included mail solicitation, broadcast media and print media. 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 132 consumer complaints received during the experience period and provided all consumer complaint logs requested. Of the 132 complaint files reported, 50 files 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.

No violations were noted.

The following synopsis reflects the nature of the 50 complaints that were reviewed.

• 21	Cancellation/Nonrenewal	42%
• 10	Claims	20%
• 7	Pricing	14%
• 3	Payment	6%
• 9	Miscellaneous	18%
<hr/>		<hr/>
50		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. No violations were noted.

The following concern was made:

Concern: The Company does not identify the producer's name on the declarations page or the application. They identify them by internal computerized records. The identity of the licensed producer shown on these two documents will make it readily apparent who sold the business for which they are accountable. Licensure and appointment with the Company when the account is written and/or renewed is necessary; therefore, it is recommended the Company add the producer's name to the aforementioned documents.

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 and revise internal control procedures to ensure compliance with cancellation and nonrenewal notice requirements of Act 68, Sections 2004 and 2008 [40 P.S. §991.2004 and 2008], so that the violations noted in the Report do not occur in the future.
2. The Company must review Act 205, Section 5(a)(4) [40 P.S. §1171.5(a)(4)] to ensure that the violation relative to supporting coverage noted in the Report does not occur in the future.
3. The Company must review Title 75, Pa. C.S. §1791.1(a) violations to ensure that an itemized invoice listing minimum coverages are provided at the time of application, as noted in the Report, and do not occur in the future.
4. The Company must review Title 75, Pa. C.S. §1791.1(c) to ensure that violations regarding the requirement to provide notice to insureds stating that discounts are available for drivers, as noted in the Report, do not occur in the future.
5. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to elect a tort option prior to policy issuance

and that signed tort option selection forms are obtained and retained with the underwriting file. This is to ensure that violations noted under Title 75, Pa. C.S. §1705(a)(1)(4) do not occur in the future.

6. The Company must revise underwriting procedures to ensure that the insured is aware that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms. This is to ensure that violations noted under Title 75, Pa. C.S. §1738(d)(1) and (2) do not occur in the future.
7. The Company must revise underwriting procedures to ensure that the insured is aware that there is an additional cost for purchasing a lower deductible for collision coverage. This is to ensure the violation noted under Title 75, Pa. C.S. §1792(b)(1) does not occur in the future.
8. 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 necessary claim forms, status letters and written denials, as noted in the Report, does not occur in the future.
9. The Company must review Title 31, Pa. Code, Section 69.52(e) with its claim staff to ensure that the insured is provided a copy of a PRO evaluation in a timely manner.
10. The Company must review Title 75, Pa. C.S. §1161(a)&(b) with its claim staff to ensure that salvage certificates are obtained and are retained with the claim file.

11. 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.

12. 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.

13. The Company must review Title 31, Pa. Code, Sections 69.42 and 69.43 with its claim staff to ensure that provider bills are repriced for cost containment as required.

14. The Company must ensure that all applications contain the required fraud warning notice.

X. COMPANY RESPONSE



MAURA C. POPP
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November 22, 2011

**VIA FAX (717) 772-4334 AND
FEDERAL EXPRESS**

Constance Arnold
Property & Casualty Division Chief
Bureau of Market Actions
Office of Market Regulation
Pennsylvania Insurance Department
1227 Strawberry Square
Harrisburg, PA 17120

RE: EXAMINATION WARRANT NUMBER: 10-M19-062

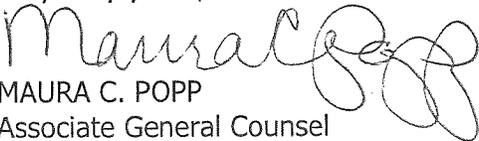
Dear Constance:

We are in receipt of the Report of Examination of 21st Century Indemnity Company covering the period May 1, 2009 through April 30, 2010.

The Company's Response is enclosed to be included as a part of the Final Report.

Thank you for your time and cooperation as we worked through the issues raised during this exam.

Very truly yours,


MAURA C. POPP
Associate General Counsel

Enclosures

MCP:tlo

COMPANY RESPONSE

IV. Underwriting Practices and Procedures:

No response is necessary as no violations were noted.

V. Underwriting:

A. Private Passenger Automobile:

1. 60-Day Cancellations:

No response is necessary as no violations were noted.

2. Midterm Cancellations:

The one violation noted was due to human error. The department in question has been notified and the error discussed with employees.

3. Nonrenewals:

The one violation noted was due to human error. The department in question has been notified and the error discussed with employees.

4. Declinations:

The 12 violations were due to a combination of human error and system limitations. However, a change was made to the system effective 06/18/11 that should prevent these types of errors from occurring in the future.

VI. Rating:

A. Private Passenger Auto:

1. New Business:

New Business without Surcharges:

The violations noted for the disclosure required at the time of application concerning the itemized invoice were solely due to the failure to include the notice. The itemized invoices were provided. A change was implemented to include the notice while the examiner was still on-site on February 3, 2011.

The violations concerning the availability of discounts concerned only the driver improvement course. The passive restraint and anti-theft device discounts were regularly discussed by the representative with the customer. Therefore, the Company will change its processes to include

notification to customers of the driver improvement course either through its website or via email or through its call centers.

The violations concerning the lack of a signed rejection of stacking form were due to human error. The Company has a robust process in place to make sure coverage selection forms are received.

The one violation concerning the collision deductible was due to human error. The Company has a robust process in place to make sure coverage selection forms are received.

The violations concerning the selection of a tort option are technical in nature. Customers are notified of the differences and selections are made. However, the Company will agree to review its processes to ensure compliance either through its website or via email or through its call centers.

The Concern regarding the Surcharge Disclosure Plan has been noted and the estimated increase of the surcharge per policy period per policyholder and the number of years will be added to the notice.

New Business with Surcharges:

The one violation concerning the tort option selection form was due to human error. The Company has a robust process in place to make sure coverage selection forms are received.

The violations noted for the disclosure required at the time of application concerning the itemized invoice were solely due to the failure to include the notice. The itemized invoices were provided. A change was implemented to include the notice while the examiner was still on-site on February 3, 2011.

The violations concerning the availability of discounts concerned only the driver improvement course. The passive restraint and anti-theft device discounts were regularly discussed by representatives with the customer. Therefore, the Company will change its processes to include notification to customers of the driver improvement course either through its website or via email or through its call centers.

As noted above, the violations concerning the selection of a tort option are only technical. The Company will agree to review its processes and make changes to ensure compliance either through its website or via email or through its call centers.

The Concern regarding the Surcharge Disclosure Plan has been noted and the estimated increase of the surcharge per policy period per policyholder and the number of years will be added to the notice.

2. Renewals:

Renewals Without Surcharges:

No response is necessary as no violations were noted.

The Concern regarding the Surcharge Disclosure Plan has been noted and the number of years will be added to the notice.

Renewals With Surcharges:

No response is necessary as no violations were noted.

The Concern regarding the Surcharge Disclosure Plan has been noted and the number of years will be added.

VI. Claims:

Automobile Property Damage Claims

The three violations noted were due to human error. The errors have been discussed with employees.

Automobile Comprehensive Claims

No response is necessary as no violations were noted.

Automobile Collision Claims

The violation noted was due to human error. The error has been discussed with those involved.

Automobile Total Loss Claims

The eight noted violations were discussed with employees as well as implementing an internal review process of this area.

Automobile First Party Medical Claims

The nine noted violations were discussed with employees as well as follow up training and internal review of the area going forward.

Automobile First Party Medical Claims Referred to a PRO

The violation noted was due to human error and discussed with those involved.

VII. Forms:

New Business Without Surcharges:

In reviewing Section 1822 pertaining to the fraud warning, it appears that the notice must be "on the application" and the Company complies with this requirement as the statement appears on the application.

New Business With Surcharges:

In reviewing Section 1822 pertaining to the fraud warning, it appears that the notice must be "on the application" and the Company complies with this requirement as the statement appears on the application.

IX. Advertising:

No response is necessary as no violations were noted.

X. Complaints:

No response is necessary as no violations were noted.

XI. Licensing:

No response is necessary as no violations were noted.

A Concern was raised with regard to identifying the producing agent on the declarations page or the application. While the Company understands the Department's concern, the Company is not aware of any legal or regulatory requirement that would necessitate the listing of the producing agent on the declarations page or the application. In addition, as a direct writer of auto insurance in the Commonwealth of Pennsylvania, traditional or independent agents are not used. The producing agents are employees. In a call center environment, while the producing agent is "accountable" for the business they write, the next time the policyholder calls, that policyholder will not necessarily speak to the same person. Listing a specific name on a declarations page may set that expectation with the policyholder and it could lead to an unsatisfactory policyholder experience. Therefore, the Company respectfully requests that this concern be removed from the Report.

XII. Recommendations:

1. The Company has reviewed the statutory requirements with the responsible department and this was discussed with employees. In addition, a system change has been implemented for the declinations on June 18, 2011.
2. The Company has reviewed the statutory requirements with the responsible department and this was discussed with employees.
3. The change to correct this error was implemented on February 3, 2011.
4. The Company will change its process to comply with Title 75, Pa. C.S. §1791.1(c) regarding the discount notice.
5. The Company will revise its process to ensure that each applicant is provided an opportunity to elect a tort option prior to policy issuance in accordance with Title 75, Pa. C.S. §1705 (a)(1)(4).
6. The Company will reinforce its existing procedures to ensure that the insured is aware of the ability to waive stacked limits for uninsured and underinsured motorist coverage under Title 75, Pa. C.S. §1738(d)(1) and (2).

7. The Company will reinforce its existing procedures to ensure the insured is aware that there is an additional cost for purchasing a lower deductible for collision coverage in accordance with Title 75, Pa. C.S. §1792 (b)(l).
8. The Company has implemented additional internal reviews of these areas of concern during the monthly file review process 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 necessary claim forms, status letters and written denials.
9. The Company has reviewed Title 31, Pa. Code, Section 69.52(e) with its claim staff to ensure that the insured is provided a copy of a PRO evaluation in a timely manner. We have implemented additional internal reviews of this area of concern during the monthly file review process.
10. The Company reviewed Title 75, Pa. C.S. §1161(a)&(b) with its claim staff to ensure that salvage certificates are obtained and are retained with the claim file. A review was conducted during the month of December 2010 to test the area for compliance. 100% of the salvage certificates were available.
11. The Company has reviewed Title 31, Pa. Code, Section 69.52(b) with its claim staff to ensure that first party medical bills are paid within 30 days. Training meetings were held with entire staff to confirm understanding of the requirements and process. A follow up file review for compliance will be conducted. For employees found not in 100% compliance as a result of internal review, supervisor to complete additional reviews on those employees. Those who are not in 100% compliance placed on Performance Management for 90 days.
12. Interest payment was issued on two claims. A copy of the interest payment for the 2 claims noted has been provided.
13. Title 31, Pa. Code, Sections 69.42 and 69.43 has been discussed with the claim staff to ensure that provider bills are repriced for cost containment as required.
14. The Company's application currently includes the fraud warning notice.