

**REPORT OF  
MARKET CONDUCT EXAMINATION  
OF**

**HANOVER FIRE AND CASUALTY  
INSURANCE COMPANY**  
Conshohocken, Pennsylvania

**AS OF  
February 16, 2007**

**COMMONWEALTH OF PENNSYLVANIA**



*Dept.  
Web Site*

**INSURANCE DEPARTMENT  
MARKET CONDUCT DIVISION**

**Issued: April 5, 2007**

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).

*M. Katherine Sutton*

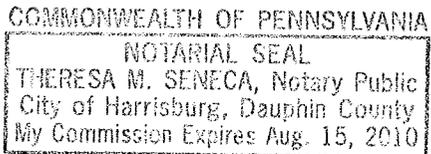
M. Katherine Sutton, AIC, Examiner-In-Charge

Sworn to and Subscribed Before me

This *30* Day of *January*, 2007

*Theresa M. Seneca*

Notary Public



# HANOVER FIRE AND CASUALTY INSURANCE COMPANY

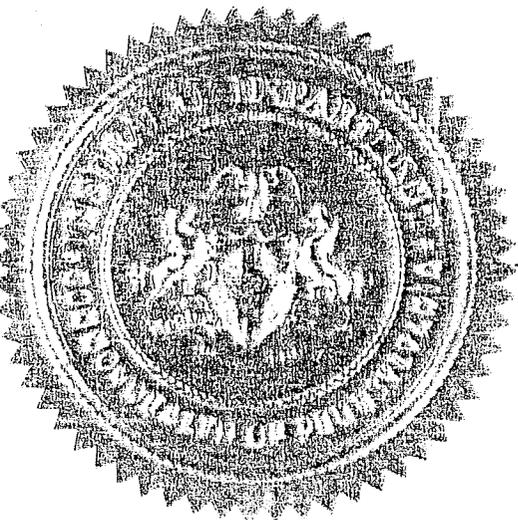
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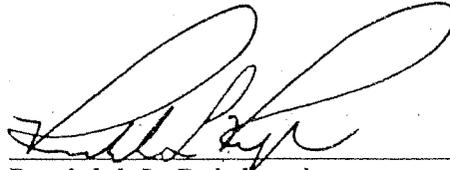
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BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

**ORDER**

AND NOW, this 20<sup>th</sup> day of February, 2007, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, 40 P.S. § 323.5, I hereby designate Terrance A. Keating, Deputy Chief Counsel, 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.



  
\_\_\_\_\_  
Randolph L. Rohrbaugh  
Acting Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

IN RE: : VIOLATIONS:  
: :  
HANOVER FIRE & CASUALTY : Section 903(a) of the Insurance  
INSURANCE COMPANY : Department Act, Act of May 17, 1921,  
100 West Elm Street : P.L. 789, No. 285 (40 P.S. § 323.3)  
Conshohocken, PA 19428 : :  
: Section 671-A of Act 147 of 2002  
: (40 P.S. § 310.71)  
: :  
: Sections 4(a) and 4(h) of the Act of  
: June 11, 1947, P.L. 538, No. 246  
: (40 P.S. §§ 1184)  
: :  
: Sections 5(a)(1)(i), 5(a)(9), 5(a)(9)(ii),  
: 5(a)(10)(xiii) and 5(a)(11) of the  
: Unfair Insurance Practices Act, Act  
: of July 22, 1974, P.L. 589, No. 205  
: (40 P.S. §§ 1171.5)  
: :  
: Title 31, Pennsylvania Code, Sections  
: 59.6(6), 146.3, 146.5(b), 146.6 and  
: 146.7(a)(1)  
: :  
: Title 18, Pennsylvania Consolidated  
: Statutes, Section 4117(k)  
: :  
Respondent. : Docket No. MC07-03-001

CONSENT ORDER

AND NOW, this 5<sup>th</sup> day of April, 2007, this Order is hereby  
issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant  
to the statutes cited above and in disposition of the matter captioned above.

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

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

#### FINDINGS OF FACT

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

- (a) Respondent is Hanover Fire & Casualty Insurance Company, and maintains its address at 100 West Elm Street, Conshohocken, Pennsylvania 19428.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2005 through December 31, 2005.
- (c) On February 16, 2007, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on March 15, 2007.

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

- (i) Section 903(a) of the Insurance Department Act, No. 285 (40 P.S. § 323.3), which requires every company subject to examination keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time as may be required in order that the Department may verify whether the company has complied with the laws of this Commonwealth;
- (ii) Section 671-A of Act 147 of 2002 prohibits producers from transacting business within this Commonwealth without written appointment as required by the Act (40 P.S. § 310.71).
- (iii) 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;

(iv) Section 5(a)(1)(i) of the Unfair Insurance Practices Act, No. 205 (40 P.S. § 1171.5), which states any of the following acts, if committed or performed with such frequency as to indicate a business practice, shall constitute unfair claim settlement or compromise practices: making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission, comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy;

(v) Section 5(a)(9) of Act 205 (40 P.S. §1171.5), which defines an unfair act or practice as: (9) cancelling any policy of insurance covering owner-occupied private residential properties or personal property of individuals that has been in force for 60 days or more or refusing to renew any such policy unless the policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the company; or there has been a substantial change or increase in hazard in the risk assumed by the company subsequent to the date the policy was issued; or there is a substantial increase in hazards insured against by reason of willful or negligent acts or omissions by the insured; or the insured has failed to pay any premium whether such premium is payable directly to the company or its agent or indirectly under any premium finance plan or extension of credit; or for any other reasons approved by the Commissioner pursuant to rules and regulations promulgated by the Commissioner. No cancellation or

refusal to renew by any person shall be effective unless a written notice of the cancellation or refusal to renew is received by the insured whether at the address shown in the policy or at a forwarding address;

- (vi) Section 5(a)(9)(ii) of Act 205 (40 P. S. §1171.5), which requires that a cancellation notice state the date, not less than 30 days after the date of delivery or mailing on which such cancellation or refusal to renew shall become effective;
- (vii) Section 5(a)(10)(xiii) of Act 205 (40 P.S. §§ 1171.5), which states any of the following acts, if committed or performed with such frequency as to indicate a business practice, shall constitute unfair claim settlement or compromise practices: Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance;
- (viii) Section 5(a)(11) of the Unfair Insurance Practices Act, No. 205 (40 P.S. § 1171.5), which requires a company to maintain a complete record of all the complaints which it has received during the preceding four years. This record shall indicate the total number of complaints, their classifications by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint;

- (ix) Title 31, Pennsylvania Code, Section 59.6(6), which states if the reason is a substantial change or an increase in hazard, the insurer shall specify the changes or increased hazards it relied on for its actions. If the reason is the failure to pay a premium, the insurer shall specify the amount due, and the date when it is due;
  
- (x) Title 31, Pennsylvania Code, Section 146.3, which requires the claim files of an insurer shall be subject to examination by the Commissioner or by duly appointed designees;
  
- (xi) Title 31, Pennsylvania Code, Section 146.5(b), which requires every insurer, upon receipt of any inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry;
  
- (xii) 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;

(xiii) 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. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial; and

(xiv) 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.”

#### CONCLUSIONS OF LAW

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

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.
  
- (b) Respondent's violations of Section 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) issue an order to cease and desist.
  - (iv) impose such other conditions as the department may deem appropriate.
  
- (c) 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 wilful violation;
  - (ii) suspension of the license of any insurer which fails to comply with an Order of the Commissioner within the time limited by such Order, or any extension thereof which the Commissioner may grant.

(d) Respondent's violations of Sections 5(a)(1), 5(a)(9), 5(a)(10) and 5(a)(11) 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 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).

- (f) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.3, 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

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:
- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
  - (b) Respondent shall 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 Twenty-Two Thousand, Five Hundred Dollars (\$22,500.00) 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 Enforcement, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120.

Payment must be made no later than thirty (30) days after the date of this Order.

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

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

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

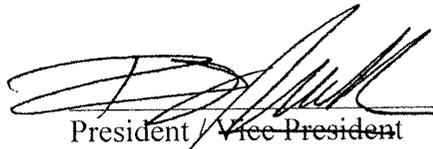
9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

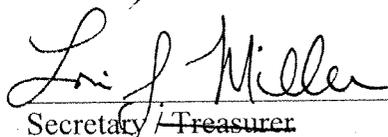
10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law

contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: HANOVER FIRE & CASUALTY  
INSURANCE COMPANY, Respondent

  
\_\_\_\_\_  
President / Vice President

  
\_\_\_\_\_  
Secretary / Treasurer

  
\_\_\_\_\_  
COMMONWEALTH OF PENNSYLVANIA  
By: Terrance A. Keating  
Deputy Chief Counsel

## I. INTRODUCTION

The market conduct examination was conducted at Hanover Fire and Casualty Insurance Company's office located in Conshohocken, Pennsylvania, from August 8, 2006, through August 23, 2006. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

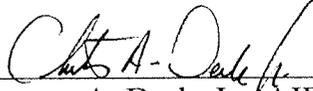
Pennsylvania Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was 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%.

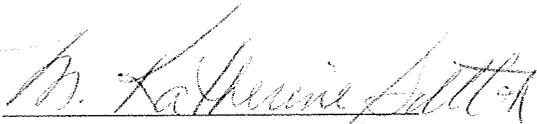
Throughout the course of the examination, Company officials were provided with status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company personnel 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.

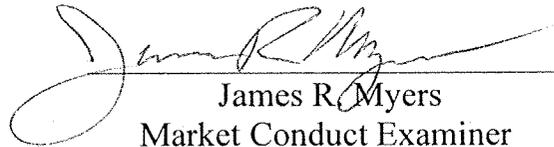
The undersigned participated in this examination and in preparation of this Report.



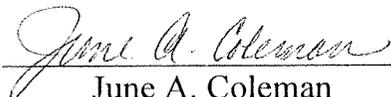
Chester A. Derk, Jr., AIE, HIA  
Market Conduct Division Chief



M. Katherine Sutton, AIC  
Market Conduct Examiner



James R. Myers  
Market Conduct Examiner



June A. Coleman  
Market Conduct Examiner

## II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on Hanover Fire and Casualty Insurance Company, hereinafter referred to as “Company,” at their office located in Conshohocken, Pennsylvania. 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 January 1, 2005, through December 31, 2005, 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. Property
  - Underwriting – Appropriate and timely notices of midterm cancellations and declinations.
  - Rating – Proper use of all classification and rating plans and procedures.
2. Claims
3. Forms
4. Advertising
5. Complaints
6. Licensing

### III. COMPANY HISTORY AND LICENSING

Hanover Fire and Casualty Insurance Company was originally chartered as Fire and Casualty Insurance Company of America. In 1998, the Company merged with its sister company Hanover Mutual Fire Insurance Company and was renamed Hanover Fire and Casualty Insurance Company. The Company is a 100% wholly owned subsidiary of Hanover Fire Holdings, Inc.

#### LICENSING

Hanover Fire and Casualty Insurance Company's Certificate of Authority to write business in the Commonwealth was issued on February 2, 1987. The Company is licensed in the District of Columbia, Illinois, New Jersey and Pennsylvania. The Company's 2005 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as \$2,184,765. Premium volume related to the areas of this review were: Fire \$1,688,715 and Homeowner's Multiple Peril \$68,406.

#### **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. The Company advised there were no written underwriting guidelines and manuals; however, a 10 point General Information & Field Underwriting sheet was provided for review. 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. 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 458 property policies which were cancelled midterm during the experience period, 170 files were selected for review. The property policies consisted of homeowners, tenant homeowners and owner occupied dwelling fire. Of the 170 files requested, 18 files were received and reviewed. The universe of midterm cancellations originally provided by the Company was not an accurate representation of its actual universe. The Company reported that its estimated number of mailings of midterm cancellations were 250 to 300 notices per month for the experience period. In addition, the Company did not retain copies of the original tenant homeowner and owner occupied dwelling fire midterm cancellation notices that were issued to insureds. The Company did provide a sample of a midterm cancellation notice that it issued during the experience period. The 1,337 violations was based on 457 files, resulting in an error ratio of 99.8%.

The following findings were made:

*440 Violations Insurance Department Act, Section 903(a) [40 P.S. §323.3]*

Requires every company subject to examination to keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its business in such manner and for such time as may be required in order that the Department may readily verify whether the Company has complied with the laws of this Commonwealth. The Company did not provide any records of midterm cancellation notices being sent or retained for all tenant homeowner and owner occupied dwelling fire policies.

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

Prohibits canceling any policy of insurance covering owner-occupied private residential properties or personal property of individuals that has been in force for sixty days or more or refusing to renew any such policy unless the policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the company; or there has been a substantial change or increase in hazard in the risk assumed by the company subsequent to the date the policy was issued; or there is a substantial increase in hazards insured against by reason of willful or negligent acts or omissions by the insured; or the insured has failed to pay any premium when due or for any other reasons approved by the Commissioner. The Company could not provide documentation for the entire universe of tenant

homeowner and owner occupied dwelling fire policies to support cancellation for reason of nonpayment. In addition 2 homeowner policies were cancelled for an improper reason.

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

Prohibits canceling any policy of insurance covering owner-occupied private residential properties or personal property of individuals that has been in force for sixty days or more or refusing to renew any such policy unless the policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the company; or there has been a substantial change or increase in hazard in the risk assumed by the company subsequent to the date the policy was issued; or there is a substantial increase in hazards insured against by reason of willful or negligent acts or omissions by the insured; or the insured has failed to pay any premium when due or for any other reasons approved by the Commissioner.

*AND*

*Adjudication: Mohanal/Lebanon Mutual, P95-08-048 (1998).* When the insurer notifies its agent of an allegedly hazardous condition on the insureds' property together with recommendations to correct the condition but does not notify the insureds, a cancellation based upon failure to comply with the recommendations violates Act 205. The Company did not directly notify the insured of the required corrections or recommendations.

*440 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 did not provide 30 days notice of cancellation for the entire universe of tenant homeowner and owner occupied dwelling fire policies.

*14 Violations Title 31, Pa. Code, Section 59.6(6)*

If the reason is a substantial change or an increase in hazard, the insurer shall specify the changes or increased hazards it relied on for its actions. If the reason is the failure to pay a premium, the insurer shall specify the amount due, and the date when it is due. The Company cancelled the policies for nonpayment of premium and did not identify the date when the premium was due.

**Concern:** The Company should include a statement within the “reason section” of its notice of cancellation that an addendum page is attached for further details of the cancellation.

## 2. 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, Unfair Insurance Practices Act, Section 5(a)(7)(iii) [40 P.S. §1171.5(a)(7)(iii)], discriminatory reasons.

The universe of 16 owner occupied dwelling fire declinations reported during the experience period was selected for review. All 16 files were received and reviewed. No violations were noted.

## VI. RATING

### **A. 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.

#### Homeowner Rating – New Business Without Surcharges

The universe of 19 homeowner policies written as new business without surcharges during the experience period was selected for review. All 19 files were received and reviewed. No violations were noted.

#### 2. Renewals

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

The purpose of the review was to 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 110 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.

### **B. 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.

#### Tenant Homeowner Rating – New Business Without Surcharges

From the universe of 2,248 tenant homeowner policies written as new business without surcharges, 100 files were selected for review. All 100 files were received and reviewed. The 4 violations noted were based on 4 files, resulting in an error ratio of 4%.

The following findings were made:

*4 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 utilized special promotional rates which were not approved. This resulted in undercharges of \$4.20.

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 5,675 homeowner policies renewed without surcharges during the experience period, 100 files were selected for review. All 100 files were received and reviewed. The 2 violations noted were based on 2 files, resulting in an error ratio of 2%.

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 utilized rates other than those that were filed and approved, which resulted in an overcharge of \$10.68 and an undercharge of \$28.80.

**C. Dwelling Fire**

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.

### Dwelling Fire Rating – New Business Without Surcharges

From the universe of 808 dwelling fire policies written as new business without surcharges, 50 files were selected for review. All 50 files were received and reviewed. No violations were noted.

### 2. Renewals

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

The purpose of the review was to 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.

### Dwelling Fire Rating – Renewals Without Surcharges

From the universe of 476 dwelling fire policies renewed without surcharges during the experience period, 50 files were selected for review. All 50 files were received and reviewed. The 22 violations noted were based on 22 files, resulting in an error ratio of 44%.

The following findings were made:

*22 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 utilized rates other than those that were filed and approved, which resulted in overcharges of \$16.51 and an undercharge of \$.14.

## 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. Homeowner Claims
- B. Tenant Homeowner Claims
- C. Dwelling Fire 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. Homeowner Claims**

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

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.

## **B. Tenant Homeowner Claims**

The universe of 73 tenant homeowner claims reported during the experience period was selected for review. All 73 files requested were received and reviewed. The 94 violations noted were based on the universe of 73 files, resulting in an error ratio of 100%.

The following findings were made:

### *11 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 11 claims noted.

### *9 Violations 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 did not reference policy provisions, conditions or exclusions in their denial letters to the claimants for the 9 claims noted.

*1 Violation Title 31, Pa. Code, Section 146.3*

The claim files of an insurer shall be subject to examination by the Commissioner or by duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The Company did not provide a complete claim file so that compliance could be determined.

*73 Violations Title 31, Pa. Code, Section 146.3*

The claim files of an insurer shall be subject to examination by the Commissioner or by duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The 73 claim files did not show evidence that date stamping of incoming loss documentation was being done.

**Concern:** The Company uses a two-part Proof of Loss settlement process. In most cases, the actual Proof of Loss document does not contain the proper fraud notice; however, the accompanying statement of loss, which also requires a signature does contain the fraud notice. Where both forms are utilized, each must contain the fraud notice.

### C. Dwelling Fire

The universe of 10 dwelling fire claims reported during the experience period was selected for review. All 10 files were received and reviewed. The 6 violations noted were based on 4 files, resulting in an error ratio of 40%.

The following findings were made:

*4 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 4 claims noted.

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy. The Company applied a deductible that was not applicable to the claim loss.

*1 Violation Act 205, Section 5(a)(10)(xiii) [40 P.S. §1171.5(a)(10)(xiii)]*

Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:  
Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance. The Company offset the amount of a claim because the policyholder owed money to the Company.

## 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)], which requires all insurers to provide an insurance fraud notice on all applications for insurance and all claims forms.

The following findings were made:

### *3,078 Violations 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 did not provide the fraud warning on all homeowner and apartment resident policy applications as well as the General Release Claim Form, Release and Subrogation Receipt Claim Form and a Proof of Loss Claim Form.

Dwelling Fire Rating – New Business

*21 Violations 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 did not provide the fraud warning on the application for the 21 files noted.

Advertising

*1 Violation 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 did not provide the fraud warning on a mail solicitation that is issued for advertising purposes.

## *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 1 piece of advertising which was a mail solicitation. Internet advertising was 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 9 consumer complaints received during the experience period and provided all consumer complaint logs requested. All 9 complaint 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.

The following findings were made:

### *5 Violations Act 205, Section 5(a)(11) [40 P.S. §1171.5(a)(11)]*

Requires an insurer to maintain a complete record of all the complaints, which it has 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 time it took to process each complaint. The 5 violations noted was the result of the Company not maintaining required complaint records for the experience period and the preceding four years. The records did not indicate the classification by line of insurance, the nature of the complaint or the disposition of the complaint.

*1 Violation Insurance Department Act, Section 903(a) [40 P.S. §323.3]*

Requires every company subject to examination to keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its business in such manner and for such time as may be required in order that the Department may readily verify whether the Company has complied with the laws of this Commonwealth. The file noted was incomplete. The original complaint file was not presented for examination.

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

Prohibits canceling any policy of insurance covering owner-occupied private residential properties or personal property of individuals that has been in force for sixty days or more or refusing to renew any such policy unless the policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the company; or there has been a substantial change or increase in hazard in the risk assumed by the company subsequent to the date the policy was issued; or there is a substantial increase in hazards insured against by reason of willful or negligent acts or omissions by the insured; or the insured has failed to pay any premium when due or for any other reasons approved by the Commissioner. The Company nonrenewed the policy for an improper reason.

*1 Violation Title 31, Pa. Code, Section 146.5(b)*

Requires every insurer, upon receipt of any inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate

response to the inquiry. The Company failed to respond within 15 working days.

The following synopsis reflects the nature of the 9 complaints that were reviewed.

• 4	Cancellation/Nonrenewal	45%
• 3	Premiums	33%
• 2	Claims	22%
<hr/>		<hr/>
9		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:

### *11 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.

Baron, Serina  
Franklin Agency  
Glen Center Insurance Associates, Inc.  
Jaico Financial Group, Inc.  
Kaminski, Ed  
Kravitz, Michael  
Reinard Agency  
Tretina, Andrew  
Tri-Arc Financial Services, Inc.  
Weber Insurance Corp.  
Joseph Joyce Associates

## *XII. 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 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 status letters and denials, as noted in the Report, do not occur in the future.
2. The Company must ensure that all applications and claim forms contain the required fraud warning notice.
3. 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.
4. The Company must review Title 31, Pa. Code, Section 59.6 to ensure that violations regarding cancellation or refusal to renew due to failure to pay a premium, as noted in the Report, do not occur in the future.
5. The Company must reinforce its internal underwriting controls to ensure that all records and documents are maintained in accordance with Insurance Department Act, Section 903(a) [40 P.S. §323.3], so that violations noted in the Report do not occur in the future.

6. The premium overcharges noted in the rating section of this report must be refunded to the insureds and proof of such refunds must be provided to the Insurance Department within 30 days of the Report issue date.
7. The Company must review Act 246, Section 4(a) and (h) [40 P.S. §1184] and take appropriate measures to ensure the rating violations listed in the report do not occur in the future.
8. The Company must review Act 205, Sections 5(a)(1)(i) and 5(a)(10)(xiii) [40 P.S. §1171.5(a)(1)(i) and 5(a)(10)(xiii)], to ensure compliance relative to the proper handling of claims, so that the violations noted in the Report do not happen in the future.
9. The Company must refund the deductible amount that was improperly applied on the dwelling fire claim noted in the Report and provide proof of such refund to the Insurance Department within 30 days of the Report issue date.
10. The Company must review Act 205, Section 5(a)(11) [40 P.S. §1171.5(a)(11)], to ensure that the violations relative to complaint records noted in the Report does not occur in the future.
11. The Company must ensure all producers are properly appointed, as required by Section 671-A [40 P.S. §310.71] of the Insurance Department Act No. 147, prior to accepting any business from any producer.

**XIII. COMPANY RESPONSE**



# Hanover

FIRE & CASUALTY INSURANCE COMPANY

100 W. ELM STREET • SUITE 100 • CONSHOHOCKEN, PA 19428

Phone:(610) 940 - 1165  
(800) 919 - FIRE  
Fax:(610) 940 - 1917

March 7, 2007

Mr. Chester A. Derk, Jr., AIE, HIA  
Market Conduct Division Chief  
Pennsylvania Insurance Department  
1227 Strawberry Square  
Harrisburg, PA 17120

Re: Examination Warrant Number: 05-M17-085

Dear Mr. Derk:

I am in receipt of the Report of Examination concerning the above captioned warrant. I have reviewed the Report and will set forth our comments, regarding the Report, below.

Page 9 of the Report sets forth a "Concern" with regard to the company's Notice of Cancellation. Specifically, the company's Notice of Cancellation consisted of two (2) pages. The Report suggests that the first page of the notice contain language advising the insured that a second page is attached. The company has reformatted its Notice of Cancellation. The result is that the entire notice is now contained within one (1) page. Thus, there is no longer any need for any supplemental language.

Page 19 of the report sets forth a "Concern" with regard to the company's Proof of Loss settlement process. Specifically the company sometimes uses two separate forms. One form contains a fraud notice and the other form does not. The Report notes that both forms must contain a fraud notice. The company has amending its Proof of Loss form to contain the fraud notice.

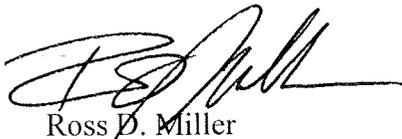
The Report of Examination contains eleven (11) recommendations to address the findings set forth in the Report. Below, please find the company response to each recommendation in the same order as presented in the Report.

1. The company has revised its' claim handling procedures to ensure that all mandated letters are sent in the proper time frame.
2. All applications and claim forms now contain the required fraud notice.
3. The company has revised its' cancellation notices to ensure that the notices adhere to all applicable laws and regulations.
4. The company has revised its' cancellation procedures adhere to all applicable laws and regulations.
5. The company has revised its document retention policies such that it now adheres to all applicable laws and regulations.
6. The company shall make all requested refunds to its' insureds and shall provide proof of the refunds, to the Department, in the time frame requested.
7. The company will revise its' rating algorithms to ensure that the rating violations noted in the report do not recur.
8. The company has revised its' claim procedures to ensure proper compliance relative to the proper handling of claims.
9. The company has refunded the deductible amount improperly deducted from the claim noted in the report. The company has provided proof of refund to the Department.
10. The company has revised its complaint procedures to ensure that it adheres to all applicable laws and regulations.
11. The company has revised its' appointment procedures to ensure that it adheres to all applicable laws and regulation.

Thus, the company has already taken the necessary steps to ensure that the violations noted in the Report of Examination do not recur. We would like to take this opportunity to thank the Insurance Department, and specifically the examiners on site, for their professionalism and efficiency in conducting this examination.

Please do not hesitate to contact me should you have any questions or require any additional information.

Very truly yours,



Ross D. Miller  
President