REPORT OF
MARKET CONDUCT EXAMINATION
OF

UNITRIN AUTO AND HOME INSURANCE COMPANY

New York, New York

AS OF
July 13, 2006

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: September 6, 2006

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, CPCU, Examiner-In-Charge

Sworn to and Subscribed Before me

This 30 Day of May , 2006

Theresa M. Seneca
Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
THERESA M. SENECA, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires Aug. 15, 2006

UNITRIN AUTO AND HOME INSURANCE COMPANY

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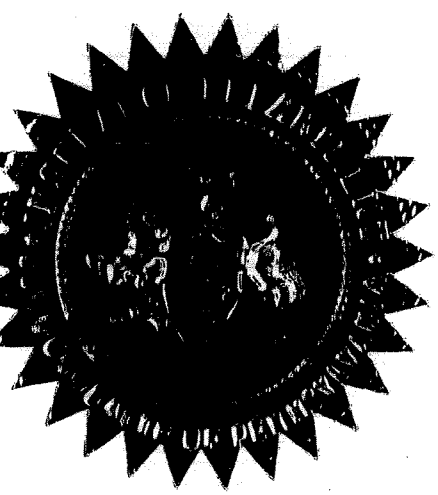
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 29 day of April, 2002, 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 Randolph L. Rohrbaugh, 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.



M. Diane Koken
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
UNITRIN AUTO AND HOME INSURANCE COMPANY 5210 Belfort Road Jacksonville, FL 32256	:	Sections 641-A and 671-A of Act 147 of 2002 (40 P.S. §§ 310.41 and 310.71)
	:	Sections 4(a) and 4(h) of the Act of June 11, 1947, P.L. 538, No. 246 (40 P.S. §§ 1184)
	:	Act 1990-6, Sections 1705(a)(1) & (4), 1791.1(a) and (b), 1793(b) and 1797(b)(1) (Title 75, Pa.C.S. §§ 1705, 1791, 1793 and 1797)
	:	Sections 5(a)(4), 5(a)(7)(iii), 5(a)(9), 5(a)(9)(ii) and 5(a)(9)(v) of the Unfair Insurance Practices Act, Act of July 22, 1974, P.L. 589, No. 205 (40 P.S. §§ 1171.5)
	:	Sections 2003(a)(1), 2003(b), 2003(a)(10), 2003(a)(11), 2004, 2006(2) and (3), and 2008(b) of Act 68 of 1998 (40 P.S. §§991.2003, 991.2004, 991.2006 and 991.2008)
	:	Title 31, Pennsylvania Code, Sections 69.42, 69.43, 69.53(a), 146.4, 146.6 and 146.7(a)(1)
	:	Title 18, Pennsylvania Consolidated Statutes, Section 4117(k)
	:	Title 75, Pennsylvania Consolidated Statutes, Section 1161(a) and (b) and 1822
Respondent.	:	Docket No. MC06-08-020

CONSENT ORDER

AND NOW, this 6th day of September, 2006, this Order is hereby issued by the Deputy Insurance Commissioner 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. Respondent neither admits nor contests the findings herein.

FINDINGS OF FACT

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

(a) Respondent is Unitrin Auto and Home Insurance Company, and maintains its address at 5210 Belfort Road, Jacksonville, Florida 32256.

(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 July 13, 2006, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on August 14, 2006.

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

(i) Section 641.1-A of Act 147 of 2002 prohibits any entity or the appointed agent of any entity from transacting the business of insurance through anyone acting without an insurance producer license (40 P.S. § 310.41a);

(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) 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;

(v) 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;

(vi) Section 1791.1(b) of Act 1990-6, Title 75, Pa.C.S. § 1791, which requires an insurer to provide an insured with a notice of the availability of two alternatives of full tort insurance and limited tort insurance;

(vii) Section 1793(b) of Act 1990-6, Title 75, Pa. C.S. § 1793, which requires the insurer to provide to the insured a surcharge disclosure plan. The insurer providing the surcharge disclosure plan shall detail the provisions of the plan and shall deliver the plan to each insured at least once annually. Additionally, the surcharge information plan shall be given to each prospective insured at the time application is made for motor vehicle insurance coverage;

(viii) Section 1797(b)(1) of Act 1990-6, Title 75, Pa.C.S. § 1797, which requires insurers to contract jointly or separately with any peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person. Such evaluation shall be for the purpose of confirming that such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary. An insurer's challenge must be made to a PRO within 90 days of the insurer's receipt of the provider's

bill for treatment or services or may be made at any time for continuing treatment or services;

(ix) Section 5(a)(4) of Act 205 (40 P.S. § 1171.5), which defines as an unfair method of competition or unfair or deceptive acts or practices as 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;

(x) Section 5(a)(7)(iii) of Act 205 (40 P.S. § 1171.5), which defines and prohibits unfair methods of competition as making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status;

(xi) 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;

(xii) Section 5(a)(9)(ii) of Act 205 (40 P.S. § 1171.5), which requires that a cancellation notice shall 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;

(xiii) Section 5(a)(9)(v) of Act 205 (40 P.S. § 1171.5), which requires that a cancellation notice advise the insured of his possible eligibility for insurance under the PA Fair Plan Act;

(xiv) Section 2003(a)(1) of Act 68 of 1998 (40 P.S. § 991.2006), which prohibits an insurer from canceling or refusing to write or renew a policy of automobile insurance for any of the following reasons: Age;

(xv) Section 2003(b) of Act 68 of 1998 (40 P.S. § 991.2003), which states that an insurer may not cancel or refuse to renew a policy of automobile insurance on the basis of one accident within the 36 month period prior to the upcoming anniversary date of the policy;

(xvi) Section 2003(a)(10) of Act 68 of 1998 (40 P.S. § 991.2003), which prohibits an insurer from canceling or refusing to write or renew a policy of automobile insurance for any of the following reasons: Occupation;

(xvii) Section 2003(a)(11) of Act 68 of 1998 (40 P.S. § 991.2003), which prohibits an insurer from canceling or refusing to write or renew a policy of automobile insurance for the following reason: The refusal of another insurer to write a policy or the cancellation or refusal to renew an existing policy by another insurer;

(xviii) 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;

(xix) Section 2006(2) of Act 68 of 1998 (40 P.S. § 991.2006), which requires an insurer to deliver or mail to the named insured a nonrenewal notice and state the date, not less than 60 days after the date of the mailing or delivery, on which cancellation shall become effective. When the policy is being cancelled for nonpayment of premium, the effective date may be 15 days from the date of mailing or delivery;

(xx) Section 2006(3) of Act 68 of 1998 (40 P.S. § 991.2006), which requires an insurer to deliver or mail to the named insured a nonrenewal notice and state the specific reason or reasons of the insurer for cancellation;

(xxi) 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;

(xxii) 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;

(xxiii) Title 31, Pennsylvania Code, Section 69.43, Insurer Payment Requirements, which states: (a) For Part A providers, the payment shall be 110% of the Medicare reimbursement allowance plus, when applicable, the estimated pass-through costs and applicable cost or day outliers which are facility specific as calculated by the intermediaries. An insurer is not required to maintain an open claim file until final settlement of the pass-through costs and outliers. A claim file may be closed upon payment of the estimated pass-through costs and outliers. The estimated pass-through costs should be submitted by the provider at the time of billing. Neither a provider not an insurer may seek to reopen closed claims or bill upon final settlement of the pass-through costs and outliers. A provider may seek payment for these amounts if an insurer has not paid for the estimated pass-through costs and outliers. (b) If a Medicare fee schedule exists for outpatient, rehabilitation and physician services, insurers shall pay Part A and B providers at 110%. If the Medicare reimbursement allowance is the Medicare aggregate payment, in areas such as outpatient services, rehabilitation services, and home health care services, payment shall be 110% of the actual cost based

upon the cost-to-charge ratios for each ancillary, out-patient, or other reimbursement cost center service utilized by the insured. When an ancillary cost center's services consist of a combined fee schedule and a blended payment, insurers shall pay at 110% of the fee schedule amount plus 110% of the actual cost based upon the cost-to-charge ratio payment for the ancillary cost center. Payment for in-patient rehabilitation services shall consist of the routine cost per diem (room and board) plus the actual cost based upon the cost-to-charge ratio of each ancillary cost center service times 110%. Payment for out-patient rehabilitation services shall be the actual cost based upon the cost-to-charge ratio for each ancillary cost center times 110%. The costs used to develop these payments shall be based upon the latest audited Medicare cost report for that facility; (c) 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 Section 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; (d) 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. 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;

(xxiv) Title 31, Pennsylvania Code, Section 146.4, which requires an insurer or agent to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented or when the benefits, coverages or other provisions are pertinent to a claim;

(xxv) 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;

(xxvi) 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

(xxvii) Title 18, Pennsylvania Consolidated Statutes, Section 4117(k)(1), 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."

(xxviii) 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; and

(xxix) 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

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

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

(b) Respondent's violations of Sections 641-A and 671-A of Act 147 of 2002 are punishable by the following, under Section 691-A of Act 147 of 2002 (40 P.S. § 310.91):

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

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

(iii) an order to cease and desist; and

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

(c) Respondent's violations of Sections 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)(4), 5(a)(7) and 5(a)(9) 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 Sections 2003, 2004, 2006 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).

(g) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.4, 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 Deputy Insurance Commissioner 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 Sixty Thousand Dollars ($60,000.00) 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. Harbert, Administrative Assistant, 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 Deputy Insurance Commissioner 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 Deputy Insurance Commissioner 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 Deputy Insurance Commissioner may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Deputy Commissioner finds that there has been a breach of any of the provisions of this Order, the Deputy Commissioner 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 Deputy Insurance Commissioner. Only the Insurance Commissioner or a duly authorized Deputy Insurance Commissioner 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 Deputy Insurance Commissioner.

BY: UNITRIN AUTO AND HOME INSURANCE COMPANY, Respondent

V.P. Underwriting

President / Vice President

Secretary / ~~Treasurer~~

RANDOLPH L. ROHRBAUGH
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The market conduct examination was conducted at Unitrin Auto and Home Insurance Company's offices located in Syracuse, New York and Jacksonville, Florida, from March 14, 2006, through April 19, 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

Jerry L. Houston
Market Conduct Examiner

Joseph S. Meizen
Market Conduct Examiner

Diane B. Freed
Market Conduct Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on Unitrin Auto and Home Insurance Company, hereinafter referred to as "Company," at their offices located in Syracuse, New York and Jacksonville, Florida. 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. Private Passenger Automobile

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

2. Property

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

3. Claims

4. Forms

5. Advertising

6. Complaints

7. Licensing

III. COMPANY HISTORY AND LICENSING

Unitrin Auto and Home Insurance Company was incorporated on October 15, 1996, under the name General Security Insurance Company of New York under the laws of New York to serve as the vehicle for the redomestication of the Company from Maryland to New York. Effective December 31, 1996, this Company merged with its operational predecessor, General Security Insurance Company, Rockville, Maryland. Concurrent with the 1996 merger, the surviving entity became known as General Security Insurance Company. The predecessor Company was incorporated on April 22, 1936, under the laws of Maryland and began business on the same date as The International Insurance Company of Takoma Park, Maryland (IIC). On December 4, 1992, IIC was purchased by SCOR Reinsurance Company and changed its name to "General Security Insurance Company" on January 12, 1993. The current title was adopted on February 18, 2003.

LICENSING

Unitrin Auto and Home Insurance Company's Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2006. The Company is licensed in District of Columbia, Guam, U.S. Virgin Islands and all states except Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont. The Company's 2005 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $20,690,213. Premium volume related to the areas of this review were: Fire $105,480; Homeowners multiple peril $6,160,745; Ocean Marine $30,520; Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault

(personal injury protection) $1,458,361; Other Private Passenger Auto Liability $6,803,887 and Private Passenger Auto Physical Damage $5,661,662.

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. Underwriting guides were furnished for private passenger automobile and personal lines property. 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.

The following findings were made:

2 Violations *Act 205, Section 5(a)(7)(iii) [40 P.S. §1171.5(a)(7)(iii)]*

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined. "Unfair Methods of Competition" and "Unfair or Deceptive Practices" in the business of insurance means: Unfairly discriminating by means of: Making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethic group, age, sex, family size, occupation, place of residence or marital status. The Company's homeowner guidelines stated individuals subject to high public exposure are not eligible for coverage. The Company's homeowner manual indicated boats operated by principal operators under the age of 21 or occasional operators under the age of 16 who have not completed the appropriate safety course are not eligible.

2 Violations *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's homeowner and dwelling manuals indicated that the Company must insure the primary dwelling in order to write a seasonal or secondary home.

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's homeowner manual and underwriting guidelines indicate the following: "The Companies will not take action on existing business solely due to the existence of EIFS construction. However, if EIFS contributed to a loss on an individual risk identified through the Claim Review process, the risk

may be nonrenewed. The Company cannot nonrenew a homeowner's policy based on a loss.

1 Violation *Act 68, Section 2003(a)(1) [40 P.S. §991.2003(a)(1)]*
Discrimination Prohibited – (a) An insurer may not cancel or refuse to write or renew a policy of automobile insurance for any of the following reasons: Age. The Company's automobile underwriting guidelines indicated that applicants with less than 5 years driving experience, if not part of a family account is an unacceptable risk.

1 Violation *Act 68, Section 2003(a)(10) [40 P.S. §991.2003(a)(1)]*
Discrimination Prohibited – (a) An insurer may not cancel or refuse to write or renew a policy of automobile insurance for any of the following reasons: Occupation. The Company's automobile underwriting guidelines indicated that applicants subject to high public exposure is an unacceptable risk.

1 Violation *Act 68, Section 2003(a)(11) [40 P.S. §991.2003(a)(11)]*
Discrimination Prohibited – (a) An insurer may not cancel or refuse to write or renew a policy of automobile insurance for the following reason: The refusal of another insurer to write a policy or the cancellation or refusal to renew an existing policy by another insurer. The Company's automobile underwriting guidelines indicated that applicants who have not been insured with a standard carrier or who have had a lapse in coverage, prior declination, cancellation or nonrenewal for underwriting reasons by any other carrier is an unacceptable risk.

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.

The universe of 27 private passenger automobile files identified as being cancelled in the first 60 days of new business was selected for review. All 27 files selected 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 504 private passenger automobile files identified as midterm cancellations by the Company, 100 files were selected for review. All 100 files selected were received and reviewed. The 21 violations noted were based on 21 files, resulting in an error ratio of 21%.

The following findings were made:

6 Violations *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 6 files noted were cancelled for other than permitted reasons.

15 Violations *Act 68, Section 2006(3) [40 P.S. §991.2006(3)]*

Requires an insurer to deliver or mail to the named insured a cancellation notice and state the specific reason or reasons of the insurer for cancellation. The 15 violations noted resulted in cancellation notices being issued without a reason for cancellation.

3. Nonrenewals

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

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

The universe of 92 private passenger automobile files identified as nonrenewals by the Company was selected for review. All 92 files selected were received and reviewed. The 5 violations noted were based on 4 files, resulting in an error ratio of 4%.

The following findings were made:

4 Violations *Act 68, Section 2003(b) [40 P.S. §991.2003(b)]*

An insurer may not cancel or refuse to renew a policy of automobile insurance on the basis of one accident within the 36 month period prior to the upcoming anniversary date of the policy. The Company nonrenewed the 4 files noted based on one accident within the 36 month period.

1 Violation *Act 68, Section 2006(2) [40 P.S. §991.2006(2)]*

Requires an insurer to deliver or mail to the named insured a cancellation notice and state the date, not less than sixty (60) days after the date of the mailing or delivery, on which cancellation shall become effective. When the policy is being cancelled for the nonpayment of premium, the effective date may be fifteen (15) days from the date of mailing or delivery. The Company failed to provide 60 days notice of nonrenewal for the file noted.

4. Declinations

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

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

The universe of 174 private passenger automobile files identified as declinations by the Company was selected for review. All 174 files requested was received and reviewed. The 174 violations noted were based on 174 files, resulting in an error ratio of 100%.

The following findings were made:

174 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 written notice stating the specific reason for refusal and provide 30 days to request review by the Insurance Commissioner.

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.

C. Property

1. 60-Day Cancellations

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

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

The universe of 24 homeowner policies, which were cancelled within the first 60 days of new business was selected for review. All 24 files selected were received and reviewed. No violations were noted.

2. Midterm Cancellations

A midterm cancellation is any policy termination that occurs at any time other than the twelve-month 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, 135 files were selected for review. The property policies consisted of homeowners, tenant homeowners and owner occupied dwelling fire. All 135 files requested were received and reviewed. The 27 violations noted were based on 27 files, resulting in an error ratio of 20%.

The following findings were made:

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 cancelled the policy for a hazard that existed when the Company wrote the policy.

1 Violation *Act 205, Section 5(a)(9)(ii) [40 P.S. §1171.5(a)(9)(ii)]*
Requires that a cancellation notice shall state the date, not less than thirty days after the date of delivery or mailing on which such cancellation or refusal to renew shall become effective. The Company failed to provide 30 days notice of cancellation.

25 Violations *Act 205, Section 5(a)(9)(v) [40 P.S. §1171.5(a)(9)(v)]*
Requires that a cancellation notice shall advise the insured of his possible eligibility for insurance under the act of July 31, 1968 (P.L. 738, No. 233), known as "The PA Fair Plan Act". The Company did not advise the insured of his possible eligibility under the Fair Plan for the 25 files noted.

3. Nonrenewals

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

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

The universe of 80 property policies which were nonrenewed during the experience period was selected for review. The property policies consisted of homeowners, tenant homeowners, boat and owner occupied dwelling fire. All 80 files requested were received and reviewed. The 68 violations noted were based on 68 files, resulting in an error ratio of 85%.

The following findings were made:

65 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 nonrenewed the 65 files noted for improper reasons. The improper reasons were: Agency termination, protection class, auto claims, lack of a PA driver's license and increase in hazard, which was not supported.

3 Violations *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 3 files were nonrenewed due to lack of supporting business.

4. 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 39 homeowner declinations identified by the Company was selected for review. All 39 files selected were received and reviewed. No violations were noted.

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 942 private passenger automobile policies identified as new business without surcharges by the Company, 50 files were selected for review. All 50 files requested were received and reviewed. The 3,769 violations noted were based on the universe of 942 files, resulting in an error ratio of 100%.

The following findings were noted:

942 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 indicating the minimum coverages and premiums at the time of application.

942 Violations Title 75, Pa. C.S. §1793(b)

Requires the insurer to provide to the insured a surcharge disclosure plan. The insurer providing the surcharge disclosure plan shall detail the provisions of the plan and the plan shall be delivered to each insured by the insurer at least once annually. Additionally, the surcharge information plan shall be given to each prospective insured at the time application is made for motor vehicle insurance coverage. The 942 violations were the result of the Company not providing the insured with a copy of a surcharge disclosure plan at the time of application.

942 Violations Title 75, Pa. C.S §1791.1(b)

Requires an insurer to provide an insured a notice of the availability of two alternatives of full tort insurance and limited tort insurance. The Company did not provide the notice of tort options to the insured at the time of application.

942 Violations 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 Company failed to provide the proper language for the election of tort options required at the time of application.

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

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The policy was rated with an incorrect territory factor, resulting in an overcharge of $12.

Private Passenger Automobile – New Business With Surcharges

The universe of 45 private passenger automobile policies identified as new business with surcharges was selected for review. All 45 files requested were received and reviewed. The 181 violations noted were based on 45 files, resulting in an error ratio of 100%.

The following findings were made:

45 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 indicating the minimum coverages and premiums at the time of application.

45 Violations Title 75, Pa. C.S. §1793(b)

Requires the insurer to provide to the insured a surcharge disclosure plan. The insurer providing the surcharge disclosure plan shall detail the provisions of the plan and the plan shall be delivered to each insured by the insurer at least once annually. Additionally, the surcharge information plan shall be given to each prospective insured at the time application is made for motor vehicle insurance coverage. The 45 violations were the result of the Company not providing the insured with a copy of a surcharge disclosure plan at the time of application.

45 Violations Title 75, Pa. C.S §1791.1(b)

Requires an insurer to provide an insured a notice of the availability of two alternatives of full tort insurance and limited tort insurance. The Company did not provide the notice of tort options to the insured at the time of application.

45 Violations 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 Company failed to provide the proper language for the election of tort options required at the time of application.

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

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The policy was incorrectly surcharged for a hit-and-run accident, which resulted in an overcharge of $394.

Concern: The surcharge disclosure statement required by Title 75, Pa. C.S. §1799.3(d), should indicate the nature of violations, i.e., speeding, reckless driving, etc.

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 9,990 private passenger automobile policies renewed without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 9,999 violations noted were based on the universe of 9,990, resulting in an error ratio of 100%.

The following findings were made:

9,990 Violations Title 75, Pa. C.S §1791.1(b)

Requires an insurer to provide an insured a notice of the availability of two alternatives of full tort insurance and limited tort insurance. The Company did not provide the required language of notice of tort options to the insured at the time of renewal.

9 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 9 policies noted were rated with an incorrect territory factor, which resulted in overcharges of $453 and undercharges of $262.

Private Passenger Automobile – Renewals With Surcharges

From the universe of 365 private passenger automobile policies renewed with surcharges during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. The 377 violations noted were based on the universe of 365 files, resulting in an error ratio of 100%.

The following findings were made:

365 Violations Title 75, Pa. C.S §1791.1(b)

Requires an insurer to provide an insured a notice of the availability of two alternatives of full tort insurance and limited tort insurance. The Company did not provide the required language of notice of tort options to the insured at the time of renewal.

12 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. Of the 12 violations noted, 11 policies were rated with an incorrect territory factor and one policy was incorrectly surcharged, resulting in overcharges of $673 and undercharges of $130.

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.

C. Homeowners

1. New Business

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

The purpose of the review was to measure compliance with Act 246, Sections 4(a) and (h) (40 P.S. §1184), which require every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time.

Homeowner Rating – New Business Without Surcharges

From the universe of 612 homeowner policies written as new business without surcharges during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. 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 9,138 homeowner policies renewed without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The violation noted resulted in an error ratio of 1%.

The following finding was made:

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

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The policy was rated with an incorrect territory factor, which resulted in an undercharge of $112.

Homeowner Rating – Renewals With Surcharges

The universe of 41 homeowner policies renewed with surcharges during the experience period was selected for review. All 41 files selected were received and reviewed. The violation noted resulted in an error ratio of 2%.

The following finding was made:

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

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The policy was not rated according to the Company's filed and approved rating plan which resulted in an undercharge of $204.

Concern: In accordance with a Department notice dated September 18, 1998, to all companies doing business in the Commonwealth of Pennsylvania, when surcharging a homeowner policy, the Company should include a surcharge disclosure statement indicating the manner in which loss surcharges are applied. The statement can be provided at the time of new business or at renewal. The Company is currently not providing this notice to their insureds.

D. Tenant Homeowners

1. New Business

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

The purpose of the review was to measure compliance with Act 246, Sections 4(a) and (h) (40 P.S. §1184), which require every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time.

From the universe of 358 tenant homeowner policies written as new business, 50 files were selected for review. All 50 files selected 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 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.

From the universe of 876 tenant homeowner policies renewed during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. No violations were noted.

E. 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.

The universe of 5 dwelling fire policies written as new business was selected for review. All 5 files selected 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 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.

The universe of 41 dwelling fire policies renewed during the experience period was selected for review. All 41 files selected were received and reviewed. No violations were noted.

VII. CLAIMS

The Company was requested to provide copies of all established written claim handling procedures utilized during the experience period. Written claim handling procedures were received and reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The Claims review consisted of the following areas of review:

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

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 753 private passenger automobile property damage claims reported during the experience period, 100 files were selected for

review. All 100 files requested were received and reviewed. No violations were noted.

B. Automobile Comprehensive Claims

From the universe of 955 private passenger automobile comprehensive claims reported during the experience period, 100 files were selected for review. All 100 files requested were received and reviewed. The violation noted resulted in an error ratio of 1%.

The following finding was made:

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

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

C. Automobile Collision Claims

From the universe of 874 private passenger automobile collision claims reported during the experience period, 100 files were selected for review. All 100 files requested 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:

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

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

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. 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. The Company failed to deny the claim in writing.

D. Automobile Total Loss Claims

From the universe of 261 private passenger automobile total loss claims reported during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. The 4 violations noted were based on the universe of 4 files, resulting in an error ratio of 5%.

The following findings were made:

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 file noted did not reflect a salvage title was obtained.

3 Violations *Title 31, Pa. Code, Section 146.4*

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented or when the benefits, coverages or other provisions are pertinent to a claim. The Company improperly

deducted storage charges from the replacement value of vehicles subject to total loss.

E. Automobile First Party Medical Claims

From the universe of 450 private passenger automobile first party medical claims reported during the experience period, 100 files were selected for review. All 100 files requested were received and reviewed. The violation noted resulted in an error ratio of 1%.

The following finding was made:

1 Violation *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).

AND

Title 31, Pa. Code, Section 69.43-Insurer Payment Requirements

(a) For Part A providers, the payment shall be 110% of the Medicare reimbursement allowance plus, when applicable, the estimated pass-through costs and applicable cost or day outliers which are facility specific as calculated by the intermediaries. An insurer is not required to maintain an open claim file until final settlement of the pass-through costs and outliers. A claim file may be closed upon payment of the estimated pass-through costs and outliers.

The estimated pass-through costs should be submitted by the provider at the time of billing. Neither a provider nor an insurer may seek to reopen closed claims or bill upon final settlement of the pass-through costs and outliers. A provider may seek payment for these amounts if an insurer has not paid for the estimated pass-through costs and outliers.

(b) If a Medicare fee schedule exits for out-patient, rehabilitation and physician services, insurers shall pay Part A and B providers at 110%. If the Medicare reimbursement allowance is the Medicare aggregate payment, in areas such as out-patient services, rehabilitation services, and home health care services, payment shall be 110% of the actual cost based upon the cost-to-charge ratios for each ancillary, out-patient, or other reimbursement cost center service utilized by the insured. When an ancillary cost center's services consist of a combined fee schedule and a blended payment, insurers shall pay at 110% of the fee schedule amount plus 110% of the actual cost based upon the cost-to charge ratio payment for the ancillary cost center. Payment for in-patient rehabilitation services shall consist of the routine cost per diem (room and board) plus the actual cost based upon the cost-to charge ratio of each ancillary cost center service times 110%. Payment for out-patient rehabilitation services shall be the actual cost based upon the cost-to-charge ratio for each ancillary cost center times 110%. The costs used to develop these payments shall be

based upon the latest audited Medicare cost report for that facility.

(c) 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) (relating to exemption from payment limitations). 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.

(d) 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.

F. Automobile First Party Medical Claims Referred to a PRO

The universe of 5 private passenger automobile first party medical claims referred to a peer review organization was selected for review. All 5 claim files requested were received and reviewed. The Company was requested to provide copies of any contracts with the peer review organization it has contracted.

The following finding was made:

1 Violation *Title 31, Pa. Code, Section 69.53(a)*

A Peer Review Organization shall contract, in writing, jointly or separately with an insurer for the provision of peer review services as authorized by Act 1990-6 and this chapter.

AND

Title 75, Pa. C.S. §1797(b)(1)

Peer review plan for challengers to reasonableness and necessity of treatment. Peer review plan. Insurers shall contract jointly or separately with any peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person. Such evaluation shall be for the purpose of confirming that such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary. An insurer's challenge must be made to a PRO within 90 days of the insurer's receipt of the provider's bill for treatment or services or may be made at any time for continuing treatment or services. The Company utilized a peer review organization without having a contract in place.

G. Homeowner Claims

From the universe of 467 homeowner claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The violation noted resulted in an error ratio of 2%.

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 violation noted resulted from failure to send a written denial letter to the claimant.

H. Tenant Homeowner Claims

The universe of 23 tenant homeowner claims reported during the experience period was selected for review. All 23 files selected were received and reviewed. The violation noted resulted in an error ratio of 4%.

The following finding was made:

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

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

Company did not provide a timely status letter for the claim noted.

I. Dwelling Fire Claims

The one dwelling fire claim reported during the experience period was selected for review. The file selected was received and reviewed. No violations were noted.

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:

1 Violation *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 did not provide the fraud warning on an automobile claim form entitled, "Release of all claims".

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 tenant homeowner claim form entitled, "Lightning/Power Surge Damage Affidavit".

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 13 pieces of advertising which included agency mailers, newspaper advertisements, wearing apparel and brochures. 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 41 consumer complaints received during the experience period and provided consumer complaint logs for the years 2003, 2004 and 2005. The Company did not report any complaints for 2001 and 2002. The 41 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:

4 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 nonrenewed the 4 policies for improper reasons.

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

Requires that a cancellation notice shall state the date, not less than thirty days after the date of delivery or mailing on which such cancellation or refusal to renew shall become effective. The Company did not provide 30 days notice of nonrenewal.

1 Violation *Act 68, Section 2003(b) [40 P.S. [40 P.S. §991.2003(b)]*

States that an insurer may not cancel or refuse to renew a policy of automobile insurance on the basis of one accident within the thirty-six (36) month period prior to the upcoming anniversary date of the policy. The Company canceled the policy based on one accident that occurred within the 36 month period.

The following synopsis reflects the nature of the 41 complaints that were reviewed.

• 14	Cancellation/Nonrenewal	34%
• 13	Claims Related	32%
• 7	Pricing/Increases	17%
• 3	Billing Issues	7%
• 4	Service/Marketing	10%
41		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:

10 Violations Act 147 of 2002, Section 641.1A [40 P.S. §310.41a]

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

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

A&A Insurance
Bartos Group, Inc.
Citizens Insurance Services
Gelvin, Jackson & Starr, Inc.

Giancola Associates, Inc.
Hott, George
Liberty Insurance Agency, Inc.
Mang, Brown & Fitzsimmons Insurance Agency
Peoples Insurance Agency
Waypoint Insurance Services

48 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 in 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.

AAA Mid Atlantic Insurance Agency
Advanced Insurance Solutions
Affiliated Insurance Service Corporation
Allegheny Insurance Agency, Inc.
Alltypes Insurance & Investments
Amerisc Corporation, The
Biddle & Company Insurance Brokers
Black, Russ Insurance, Inc.
Brumbaugh Insurance Group, Inc.
Burns & Burns Associates, Inc.
Byerly Insurance Agents
Carlisle Insurance Services
Cochran, J. Edward & Co. Inc.
Complete Ins. Services, Inc.
CSC Insurance Options
Culp, John
Deihl, Thomas S., Inc.
Engle, Hambright & Davies, Inc.
Florey, Amy
Frost & Conn, Inc.
Hamilton, J. B. Agency Inc.
Hartman Ins. Agency t/a Upper Bucks Ins. Services
Henderson Brothers, Inc.

Hilb Rogal & Hamilton Co. of Pittsburgh LLC
Hockley and O'Donnell Ins. Agency
Jacobs, Don Insurance Services, Inc.
Loesel-Schaaf Ins. Agency
McGrath Insurance Group, Inc.
McKeighan Ins. Agency, Inc.
Mid-Penn Insurance Associates, Inc.
Miller Insurance Agency
Miller Insurance Associates, Inc.
Moschetti Insurance Agency
PFCU Insurance Services
Rossi, Dominic
Rossi Group, The
Sausman Insurance Agency
Seltzer Insurance Agency
Sholley Agency, Inc.
Solution Coverage, Inc. DBA Affordable Insurance Service Center
Spectrum Insurance Services
Strickler Agency, Inc.
Teeter Insurance Agency, Inc.
Tracy, Bob Insurance Agency
Upper Bucks Insurance Services
Wagner Agency, Inc.
Wetzel- Lanzi, Inc.
Westmoreland Insurance Services

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 must review and revise internal control procedures to ensure compliance with cancellation notice requirements of Act 68, Section 2003 [40 P.S. §991.2003], so that the violations noted in the Report do not occur in the future.

2. The Company must review Act 205, Section 5(a)(9) [40 P.S. §1171.5(a)(9)] to ensure compliance with nonrenewal notice requirements so that the violations noted in the Report do not occur in the future.

3. The Company must review Act 246, Section 4 [40 P.S. §1184] and take appropriate measures to ensure the rating violation noted in the Report does not occur in the future.

4. The premium overcharges noted in the rating section of this report must be refunded to the insured and proof of such refunds must be provided to the Insurance Department within 30 days of the Report issue date.

5. 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.

6. 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.

7. The Company must ensure that all claim forms contain a required fraud warning notice.

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

9. The Company must revise and reissue their underwriting guidelines for use in Pennsylvania to ensure that the guidelines do not exclude applicants from being eligible to obtain insurance based on age, occupation and place of residence.

10. The Company must review Act 205, Section 5(a)(4) [40 P.S. §1171.5(a)(4)] to ensure that the violations relative to supporting coverage noted in the Report does not occur in the future and remove such requirements from all underwriting guidelines.

XIII. COMPANY RESPONSE

5210 Belfort Rd
Suite 120
Jacksonville, FL 32256

August 10, 2006

Chester A. Derk Jr.
Market Conduct Division Chief
Commonwealth of Pennsylvania
Insurance Department
Strawberry Square
Harrisburg, PA 17120

RE: Report of Examination of Unitrin Auto and Home Insurance Company
Examination Warrant Number: 05-M19-088

Dear Mr. Derk:

Please allow this letter to serve as our response to the Report of Examination (the "Report") of Unitrin Auto and Home Insurance Company ("UAH" or "We"). Let me begin by thanking the Department and its examiners for their professionalism and cooperation throughout the examination process. We appreciate your guidance and assistance, particularly since this is the first time We have been examined by your Department since our change of ownership and new name.

Per your request, We are providing a summary of specific corrective measures taken by UAH to address recommendations raised in the Report. In the Report, there were ten (10) individual items identified and We will address each one individually.

1. **The Company must review and revised internal control procedures to ensure compliance with cancellation notice requirements of Act 68, Section 2003 [40 P.S. S.991.2003] so that violations noted in the Report do not occur in the future.**
   UAH accepts this recommendation. We have reviewed Act 68, Section 2003 and have revised internal controls to ensure that we are in compliance with the Act. We have also changed our procedures so that if we cancel a "package" policy for a homeowners reason, we will only cancel the homeowners side of the "package" policy and we will automatically issue a monoline personal auto policy. Underwriting and Operations staff have been trained on the new procedures. Additionally, we have held training sessions with our Underwriters to review proper reasons for the cancellation of automobile policies and have instituted a monthly compliance review process to ensure Underwriters are not canceling personal automobile policies for inappropriate reasons.
2. **The Company must review Act 205, Section 5(a)(9) [40 P.S. S.1171.5(a)(9)] to ensure compliance with nonrenewal notice requirements so that violations noted in the Report do no occur in the future.**
   UAH accepts this recommendation. We have reviewed Act 2005, Section 5(a)(9) and have revised internal controls to ensure that we are in compliance with the Act. We have changed our procedures so that if we non-renew a "package" policy for an automobile reason, we will only non-renew the personal automobile side of the "package" policy and we will automatically issue a monoline homeowners policy. Underwriting and Operations staff have been trained on the new procedures. Additionally, we have held training sessions with our Underwriters to review the proper reasons for the non-renewal of a homeowners policy and have instituted a monthly

compliance review process to ensure Underwriters are not non-renewing homeowners policies for inappropriate reasons.

3. **The Company must review Act 246, Section 4 [40 P.S. S.1184] and take appropriate measures to ensure the rating violation noted in the Report does not occur in the future.**
UAH accepts this recommendation. We have reviewed Act 246, Section 4 and we have instituted a process to ensure proper rating of policies. We will review a random sample of policies on a regular basis to ensure the proper rates are being charged. Additionally we have initiated a process to check zip code and territory assignments to ensure the policy is rated in the correct territory. These processes are in addition to the rate sign off process already in place.

   While we accept the Department's view of the violations for the incorrect forms, UAH would like to point out that it was not willful or malicious in any way. Previously one package of forms was distributed with both the new business package and the renewal package. This form was seen by the applicant at the time of application in most cases as they did have to make selections for their coverage options and we did provide signed forms that included a date equal to the date of application. Additionally, there were minor language errors that did not substantially change the intent of the notice.

   UAH has made a number of changes to the forms. A new form has been created for the time of application. The form has been distributed to agents and they have been instructed to use that form at the time of application. We will soon have that form included in our on-line application. This form has been created to comply with proper language on the limited tort disclosure statement and has added the limited tort selection/rejection form. The form that previously went out at new business and renewal now only goes out at renewal. It has been updated to include the proper wording on the limited tort disclosure statement.

4. **The premium overcharges noted in the rating section of this report must be refunded to the insured and proof of such refunds must be provided to the Insurance Department within 30 days of the Report issue date.**
UAH accepts this recommendation. We have returned the premiums to the policies where an overcharge occurred. Proof of such refunds has been provided to the Insurance Department and is attached here. Refund amounts may differ slightly from those given in earlier reports due to changes made to the policies during the policy term that affected the premium. Original refunds were calculated based on the original DEC pages provided.

5. **The Company must 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.**
UAH accepts this recommendation. We have reviewed Title 31, Chapter 146 to ensure compliance with the requirements relating to status letters and denials. Training sessions have been held with the claims department to review these requirements and will be reviewed with the staff on a periodic basis.

6. **The Company must review Title 75, Pa. C.S. S.1161(a)&(b) with its claim staff to ensure that salvage certificates are obtained and are retained with the claim file.**
UAH accepts this recommendation. We have reviewed Title 75, Pa. C.S. S.1161 with the claim staff to ensure compliance with the requirements that salvage certificates are obtained and retained with the claim file. Training sessions have been held with the claims department to review these requirements and will be reviewed with the staff on a periodic basis.

7. **The Company must ensure that all claim forms contain a required fraud warning notice.**
UAH accepts this recommendation. We have held training sessions with the claims department to ensure that the proper fraud warning notice is included. Training sessions have been held with the claims department to review these requirements and will be reviewed with the staff on a periodic basis.

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

UAH accepts this recommendation. We have reviewed our list of producers so that any that did not have the proper license or appointments have been updated. A list of the appointment and producer license is provided and the appropriate appointment fees have been submitted to the Department.

9. **The Company must revise and reissue their underwriting guidelines for use in Pennsylvania to ensure that the guidelines do not exclude applicants from being eligible to obtain insurance based on age, occupation and place of residence.**
   UAH accepts this recommendation. We have reviewed and reissued underwriting guidelines. The new guidelines have removed any reference to age, occupation or place of residence.
10. **The Company must review Act 205, Section 5(a)(4) [40 P.S. S.1171.5(a)(4)] to ensure that the violations relative to supporting coverage noted in the Report does not occur in the future and remove such requirements from all underwriting.**
    While UAH does not believe that its activities violated Act 205, we accept the Department's recommendation. UAH will comply with the Department's position with respect to writing unsupported business. Consequently, UAH has removed any language from its homeowner and dwelling manuals acceptability standards that require supporting business in order to write a seasonal or secondary home.

If you have any questions regarding this data, please do not hesitate to call me at 904-245-5637 or e-mail me at jmitchell@kahg.com

Respectfully

J Lincoln Mitchell
Regional Product Manager
(904) 245-5637
(904) 245-5601 FAX