pennsylvania
INSURANCE DEPARTMENT

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

CAPITOL INSURANCE COMPANY
NORTH WALES, PA

As of: April 20, 2015
Issued: June 10, 2015

BUREAU OF MARKET ACTIONS
PROPERTY AND CASUALTY DIVISION

VERIFICATION

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

Kelly A. Krakowski, Examiner-In-Charge

Sworn to and Subscribed Before me

This 20 Day of April , 2015

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Bryan Proper, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires Jan. 28, 2018

CAPITOL INSURANCE COMPANY

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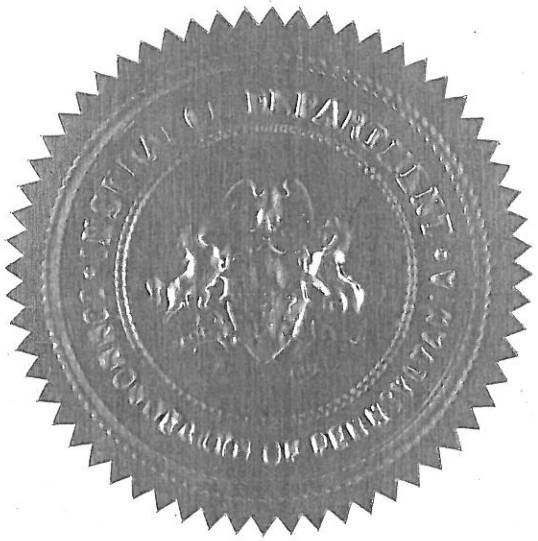
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 31st day of June, 2015, 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 Christopher R. Monahan, Acting 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.



Teresa D. Miller
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
CAPITOL INSURANCE COMPANY 1180 Welsh Road, Suite 100 North Wales, PA 19454	:	40 P.S. §323.4(b)
	:	40 P.S. §§310.41a(a) and 310.71
	:	40 P.S. §§991.2003(a)(1), 991.2003(a)(12) and 991.2004
	:	40 P.S. §§1171.5(a)(10)(iii) and 1171.5(a)(12)
	:	31 Pa. Code §§62.3(e)(4), 62.3(e)(7) 69.22(c), 69.52(a), 69.52(b), 69.52(e) 146.3, 146.5(a), 146.5(b), 146.5(d), 146.6 and 146.7(a)(1)
	:	75 Pa. C.S. §§1716, 1793(c) and 1799.3(f)
Respondent.	:	Docket No. MC15-04-017

CONSENT ORDER

AND NOW, this 10th day of June, 2015, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

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

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

FINDINGS OF FACT

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

(a) Respondent is Capitol Insurance Company, and maintains its address at 1180 Welsh Road, Suite 100, North Wales, PA 19454.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the experience period from January 1, 2013 through December 31, 2013.

(c) On April 20, 2015, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on May 20, 2015.

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

(i) 40 P.S. §323.4(b), requires every company or person from whom information is sought must provide to the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined;

(ii) 40 P.S. §310.41a(a) prohibits any entity or the appointed agent of any entity from transacting the business of insurance through anyone acting without an insurance producer license.

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

(iv) 40 P.S. §991.2003(a)(1), which states an insurer may not cancel or refuse to renew a policy of automobile insurance on the basis of age;

(v) 40 P.S. §991.2003(a)(l2), states that an insurer may not cancel or refuse to renew a policy of automobile insurance for the following reason: illness or permanent disability where the insured can medically document that such illness or disability will not impair his ability to operate a motor vehicle.

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

(vii) 40 P.S. §1171.5(a)(10)(iii), which prohibits failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(viii) 40 P.S. §1171.5(a)(12), states that "Unfair methods of competition" and "unfair or deceptive acts or practices in the business of insurance means making false statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurers, agent, broker or individual;

(ix) 31 Pa. Code §62.3(e)(4), which requires that applicable sales tax on the replacement cost of a motor vehicle shall be included as part of the replacement value;

(x) 31 Pa. Code §62.3(e)(7), which states the appraiser is responsible for ensuring that a copy of the total loss evaluation report be sent within 5 working days to the consumer by the appraiser after the appraisal is completed. If a settlement offer is extended before the consumer receives the total loss evaluation report, the consumer shall be advised of the total loss evaluation report's contents and of the consumer's right to be sent a copy within 5 days after its completion;

(xi) 31 Pa. Code §69.22(c), requires the insurer, when an insured's first-party limits have been exhausted, to provide notice to the provider and the insured within 30 days of the receipt of the provider's bill;

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

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

(xiv) 31 Pa. Code §69.52(e), requires an insurer to provide copies of the Peer Review Organization's written analysis to the provider and the insured within 5 days of receipt;

(xv) 31 Pa. Code §146.3, which requires the claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed;

(xvi) 31 Pa. Code §146.5(a), which states every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice, unless payment is made within such period. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated;

(xvii) 31 Pa. Code §146.5(b), which states every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of

receipt of such inquiry, furnish the Department with an adequate response to the inquiry;

(xviii) 31 Pa. Code §146.5(d) states that an insurer, upon receiving notification of a claim, shall provide within ten working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable requirements of the insurer;

(xix) 31 Pa. Code §146.6, states that if an investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected;

(xx) 31 Pa. Code §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;

(xxi) 75 Pa. C.S. §1716, states that benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of benefits. If reasonable proof is not supplied as to all benefits, the portion supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Overdue benefits shall bear interest at the rate of 12% per annum from the date the benefits become due. In the event the insurer is

found to have acted in an unreasonable manner in refusing to pay the benefits when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended;

(xxii) 75 Pa. C.S. §1799.3(f), which states if requested by the applicant, an agent for an insurer shall submit an application for automobile insurance to the insurer or provide the applicant written notice of the reasons for refusal to write on a form supplied by the insurer and approved by the Commissioner.

CONCLUSIONS OF LAW

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

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

(b) Respondent's violations of 40 P.S. §§310.41a(a), 310.71 are punishable by the following, under (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 40 P.S. §§991.2003(a)(1), 991.2003(a)(12) and 991.2004 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).

(d) Respondent's violations of 40 P.S. §§1171.5(a)(10)(iii) and 1171.5(a)(12) 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 40 P.S. §§1171.1 – 1171.5, the Commissioner may, under (40 P.S. §§1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

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

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

(f) Respondent's violations of 31 Pa. Code §§146.3, 146.5(a), 146.5(b), 146.5(d), 146.6 and 146.7(a)(1) are punishable 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.

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

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

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

ORDER

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

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

(b) Respondent shall pay Ten Thousand Dollars ($10,000.00) in settlement of all violations contained in the Report.

(c) Payment of this matter shall be made to the Pennsylvania Insurance Department. Payment should be directed to April Phelps, Insurance Department, Bureau of Market Actions, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than fourteen (14) days after the date of this Order.

(d) 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.

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

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

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

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

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

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

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

BY: CAPITOL INSURANCE COMPANY
Respondent

President / Vice President

Secretary / Treasurer

CHRISTOPHER R. MONAHAN
Acting Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The market conduct examination was conducted at the office of Capitol Insurance Company, hereinafter referred to as "Company," located in North Wales, Pennsylvania, from October 13, 2014, through October 17, 2014. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

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

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

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

written summaries provided on the violations found. The courtesy and cooperation extended by the officers and employees of the Company during the course of the examination is hereby acknowledged.

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

Constance L. Arnold, MCM
Market Conduct Division Chief
Pennsylvania Insurance Department

Kelly Krakowski
Market Conduct Examiner
Pennsylvania Insurance Department

Karen Veronikis
Market Conduct Examiner
Pennsylvania Insurance Department

Mark Plesha
Market Conduct Examiner
INS Regulatory Insurance Services

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on Capitol Insurance Company, at its office located in North Wales, Pennsylvania. The examination was conducted pursuant to Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act of 1921 and covered the experience period of January 1, 2013, through December 31, 2013, unless otherwise noted. The purpose of the examination was to determine the Company's compliance with Pennsylvania insurance laws and regulations.

The examination focused on Company operations in the following areas:

1. Private Passenger Automobile
   - Underwriting - Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, and rescissions.

2. Claims

3. Complaints

4. Producer Licensing

5. Data Integrity

6. MCAS Reporting

III. COMPANY HISTORY

Capitol Guaranty Holding Corporation ("Capitol Guaranty") was incorporated in the State of Florida on April 1, 1988. Capitol Guaranty purchased Capitol Insurance Company ("Capitol Insurance") a Pennsylvania based private passenger automobile insurance company. Capitol Insurance Company was established in 1968 and focused its business in Philadelphia and the surrounding counties. Since Capitol Guaranty's purchase of Capitol Insurance it was successful in expanding the insurance company's premium base throughout the Commonwealth of Pennsylvania. Capitol Insurance currently writes private passenger personal automobile and motorcycle insurance through a network of approximately 300 independent local agents throughout the Commonwealth of Pennsylvania. Capitol Insurance has focused its efforts exclusively on servicing the market created by the $15,000/$30,000/$5,000 minimum insurance policy limits required by state law throughout Pennsylvania.

LICENSING

Capitol Insurance Company's Certificate of Authority to write business in the Commonwealth was issued on November 15, 1968. The Company is only licensed in the Commonwealth of Pennsylvania. The Company's 2013 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $21,384,637. Premium volume related to the Private Passenger Automobile Direct Written Premium was reported as Other Private Passenger Auto Liability $14,629,679 and Private Passenger Auto Physical Damage $6,754,958.

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 and supplements were furnished for private passenger automobile. The purpose of this review was to identify any inconsistencies which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature.

The following findings were made:

1 Violation *40 P.S. §991.2003(a)(1)*

States that an insurer may not cancel or refuse to renew a policy of automobile insurance for the following reason: age. The Company's Underwriting & Procedures Manual – (Effective 4/15/2012) requires a medical report be submitted with applications where the resident household member who operates the vehicle is over seventy (70) years of age.

1 Violation *40 P.S. §991.2003(a)(12)*

States that an insurer may not cancel or refuse to renew a policy of automobile insurance for the following reason: illness or permanent disability where the insured can medically document that such illness or disability will not impair his ability to operate a motor vehicle. The Company's Underwriting & Procedures Manual – (Effective 4/15/2012) requires a medical report be submitted with applications involving any handicapped risk.

14 Violations 40 P.S. §1171.5(a)(12)

States that "Unfair methods of competition" and "unfair or deceptive acts or practices in the business of insurance means making false statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurers, agent, broker or individual. The Company wrote risks it knew to be ineligible according to its published underwriting guidelines for the 14 files noted.

General Violation 40 P.S. §323.4

75 Pa. C.S. §1799.3(f)

Requires every company or person from whom information is sought must provide to the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. In addition, if requested by the applicant, an agent for an insurer shall submit an application for automobile insurance to the insurer or provide the applicant written notice of the reasons for refusal to write on a form supplied by the insurer and approved by the Commissioner. The Company failed to maintain records of refusal to write.

The following concern was noted:

CONCERN: When the Company writes a new policy it is not communicating clearly to insureds that their first invoice will be due 15 days after the inception date of the policy, as evidenced by numerous consumer complaints to the Company. The Company's Rates and Rules Manual (Eff. 3/1/2008 – pg. 13)

indicates "The first installment is due 30 (thirty) days from the policy effective date. Additional installments will be due at thirty day intervals." The Company must file the change to its invoice practice and update its Rates and Rules Manual pages. The Company will also need to document to the Department its plan for educating its Agency force on this issue.

V. UNDERWRITING

A. Private Passenger Automobile

1. 60-Day Cancellations

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

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

From the universe of 8,228 private passenger automobile policies that were cancelled within the first 60 days of new business, 135 files were selected for review. All 135 files requested were received and reviewed. Of the 135 files reviewed, 110 files were identified as 60-day cancellations, 24 files were identified as rescissions and one file was identified as a midterm cancellation. The two violations noted were based on two files, resulting in an error ratio of 1%.

The following findings were made:

1 Violation *40 P.S. §1171.5(a)(12)*

States that "Unfair methods of competition" and "unfair or deceptive acts or practices in the business of insurance means

making false statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurers, agent, broker or individual. The Company failed to disclose that premium collected for a new application was being applied to bad debt from a previous policy in the file noted.

1 Violation *75 Pa. C.S. §1793(c)*

When an insurer cancels a motor vehicle insurance policy within the first 60-days of new business, the insurer shall within 30 days of canceling the policy return to the insured all premiums paid under the policy less any proration for the period the policy was in effect. Premiums are overdue if not paid to the insured within 30 days after canceling the policy. Overdue return premiums shall bear interest at the rate of 12% per annum from the date the return premium because due. The Company failed to return unearned premium within 30 days of canceling the policy and include the 12% interest from the date the return premium became due for the file noted. The amount of interest refunded was $14.25.

2. Mid-term Cancellations

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

The primary purpose of the review was to determine 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 7,629 private passenger automobile policies which were cancelled midterm, 50 files were selected for review. All 50 files requested were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 4%.

The following findings were made:

2 Violations 40 P.S. §991.2004

Requires that no insurer shall cancel a policy of automobile insurance except for nonpayment of premium, suspension or revocation of the named insured's driver license or motor vehicle registration or a determination that the insured has concealed a material fact or has made a material allegation contrary to fact or has made a misrepresentation of material fact and that such concealment, allegation or misrepresentation was material to the acceptance of the risk by the insurer. The Company cancelled the policy for reasons that were not permissible in the two files noted.

3. Nonrenewals

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

The 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 873 private passenger automobile policies which were nonrenewed, 50 files were selected for review. All 50 files requested were received and reviewed. No violations were noted.

4. Rescissions

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

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

From the universe of 108 private passenger automobile policies that were identified by the Company as rescissions, 50 files were selected for review. All 50 files requested were received and reviewed. The five violations noted were based on five files, resulting in an error ratio of 10%.

The following findings were made:

5 Violations 40 P.S. §1171.5(a)(12)

States that "Unfair methods of competition" and "unfair or deceptive acts or practices in the business of insurance means making false statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other

benefit from any insurers, agent, broker or individual. The Company failed to disclose that premium collected for a new application was being applied to bad debt from a previous policy in the five files noted.

VI. CLAIMS

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

The Claims review consisted of the following areas of review:

A. Automobile Property Damage Claims
B. Automobile Comprehensive Claims
C. Automobile Collision Claims
D. Automobile Total Loss Claims
E. Automobile First Party Medical Claims
F. Automobile First Party Medical Claims Referred to a PRO

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

A. Automobile Property Damage Claims

From the universe of 1,609 private passenger automobile property damage liability claims reported, 50 files were selected for review. All 50 files selected were received and reviewed. The seven violations noted were based on seven files, resulting in an error ratio of 14%.

The following findings were made:

1 Violation *31 Pa. Code §146.5(a)*

Every insurer, upon receiving notification of a claim, shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company did not acknowledge the claim within 10 working days.

6 Violations *31 Pa. Code §146.6*

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

The following concern was noted:

CONCERN: When the Company closes a claim file with no payment for "lack of interest" they are not providing the policyholder/claimant with written notice indicating their action. The Company should provide policyholders/claimants with written notice when a claim file is being closed due to lack of interest.

B. Automobile Comprehensive Claims

From the universe of 245 private passenger automobile comprehensive claims reported, 50 files were selected for review. All 50 files selected were received and reviewed. The violation noted was based on one file, resulting in an error ratio of 2%.

The following finding was made:

1 Violation *31 Pa. Code §146.6*

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

The following concern was noted:

CONCERN: When the Company closes a claim file with no payment for "lack of interest" they are not providing the policyholder/claimant with written notice indicating their action. The Company should provide policyholders/claimants with written notice when a claim file is being closed due to lack of interest.

C. Automobile Collision Claims

From the universe of 1,104 private passenger automobile collision claims reported, 50 files were selected for review. All 50 files selected were received and reviewed. The violation noted was based on one file, resulting in an error ratio of 2%.

The following finding was made:

1 Violation *31 Pa. Code §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 accept or deny the claim within 15 working days after proof of loss was received.

The following concern was noted:

CONCERN: When the Company closes a claim file with no payment for "lack of interest" they are not providing the policyholder/claimant with written notice indicating their action. The Company should provide policyholders/claimants with written notice when a claim file is being closed due to lack of interest.

D. Automobile Total Loss Claims

From the universe of 397 private passenger automobile total loss claims reported, 50 files were selected for review. All 50 files were received and reviewed. The 55 violations noted were based on 48 files, resulting in an error ratio of 96%.

The following findings were made:

2 Violations *31 Pa. Code §62.3(e)(4)*

Requires that applicable sales tax on the replacement cost of a motor vehicle shall be included as part of the replacement value. The two claims noted did not have sales tax included in the replacement value of the vehicle. The amount of sales tax refunded was $854.99.

1 Violation *31 Pa. Code §146.5(a)*

Every insurer, upon receiving notification of a claim, shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company did not acknowledge the claim within 10 working days.

9 Violations *31 Pa. Code §146.6*

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

Company did not provide timely status letters for the nine claims noted.

43 Violations 31 Pa. Code §62.3(e)(7)

The appraiser is responsible for ensuring that a copy of the total loss evaluation report be sent within 5 working days to the consumer by the appraiser after the appraisal is completed. If a settlement offer is extended before the consumer receives the total loss evaluation report, the consumer shall be advised of the total loss evaluation report's contents and of the consumer's right to be sent a copy within 5 days after its completion. The Company did not provide a copy of the total loss evaluation to the insured for the 43 claims noted.

E. Automobile First Party Medical Claims

From the universe of 1,010 private passenger automobile first party medical claims reported, 50 claim files were selected for review. All 50 files requested were received and reviewed. The 79 violations noted were based on 39 files, resulting in an error ratio of 78%.

The following findings were made:

1 Violation 31 Pa. Code §69.22(c)

Requires the insurer when an insured's first-party limits have been exhausted, to provide notice to the provider and the insured within 30 days of the receipt of the provider's bill. The Company did not provide evidence that a notice of

exhausted limits was sent to the insured and provider in the claim noted.

24 Violations 31 Pa. Code §69.52(b)

Requires an insurer to pay bills for care that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill. The Company failed to pay medical bills within 30 days for the 24 claims noted.

3 Violations 31 Pa. Code §146.5(a)

Every insurer, upon receiving notification of a claim, shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company did not acknowledge the claim within 10 working days for the three claims noted.

19 Violations 31 Pa. Code §146.5(d)

Requires an insurer, upon receiving notification of a claim, shall provide within ten working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable requirements of the insurer. The Company did not provide

the necessary claim forms to the claimant within 10 working days for the 19 claims noted.

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

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide a written denial to the insured for the two claims noted.

24 Violations *75 Pa. C.S. §1716*

Payment of Benefits. Benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of benefits. If reasonable proof is not supplied as to all benefits, the portion supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Overdue benefits shall bear interest at the rate of 12% per annum from the date the benefits become due. In the event the insurer is found to have acted in an unreasonable manner in refusing to pay the benefits when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended. The Company failed to pay interest on the 24 claims that were not paid within 30 days. The amount of interest refunded was $1,202.72.

6 Violations *40 P.S. §1171.5(a)(10)(iii)*

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means any of

the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The Company failed to close or deny the six claims noted in a timely manner.

G. Automobile First Party Medical Claims Referred to a PRO

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

The following findings were made:

1 Violation *31 Pa. Code §146.3*

31 Pa. Code §69.52(a)

The claim files of an insurer shall be subject to examination by the Commissioner or by duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. Also, an insurer is required to refer a provider's bill to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with PRO procedures, standards and practices, to believe it necessary

that a PRO determine the reasonableness and necessity of care, the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care. The insurer shall notify a provider, in writing, when referring bills for PRO review at the time of referral. The Company failed to provide documentation to determine the date the provider was notified of the PRO referral and compliance could not be determined for the claim noted.

1 Violation *31 Pa. Code §69.52(a)*

Requires an insurer to refer a provider's bill to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with PRO procedures, standards and practices, to believe it necessary that a PRO determine the reasonableness and necessity of care, the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care. The insurer shall notify a provider, in writing, when referring bills for PRO review at the time of referral. The violation noted was the result of the Company not notifying the provider, in writing, upon referring bills to a PRO.

1 Violation *31 Pa. Code §69.52(b)*

Requires an insurer to pay bills for care that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill. The Company failed to pay a bill that was referred to a PRO after 90 days for the claim noted.

3 Violations *31 Pa. Code §69.52(e)*

Requires an insurer to provide copies of the Peer Review Organization's written analysis to the provider and the insured within 5 days of receipt. The Company did not provide a copy of the PRO report to the provider and insured within 5 days of receipt for the three claims noted.

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

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to accept or deny the claim within 15 working days after proof of loss was received for the two claims noted.

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of their consumer complaint logs for the preceding four years. The Company identified 157 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the universe of 157 complaint files, 75 files were selected for review. All 75 files requested were received and reviewed.

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

The following findings were made:

7 Violations 31 Pa. Code §146.5(b)

Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry. The Company failed to respond to a Department inquiry in a timely manner for the seven complaints noted.

The following concern was noted:

CONCERN: The Company has not maintained complete files for Complaints that are received directly from its Insureds. The Company must maintain a complete file (either paper or electronic) which contains all correspondence and documentation related to the Complaint. Each file should allow the Department, upon review, to re-create the events associated with the Complaint.

The following synopsis reflects the nature of the 75 complaints that were reviewed.

• 43	Cancellation	57%
• 14	Billing	19%
• 11	Claims Related	15%
• 7	Agent	9%
75		100%

VIII. PRODUCER LICENSING

As a result of a review of consumer complaints reported directly to the Company, the examiners reviewed the licensing requirements applicable to Section 641.1-A(a) and Section 671-A of the Insurance Department Act No. of 1921, (40 P.S. §§310.41a(a), 310.71).

The following findings were made:

2 Violations 40 P.S. §310.41a

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

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

Wayne's Auto Tags & Insurance
Best Insurance of Delaware Valley

1 Violation *40 P.S. §310.71*

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

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

(1) Delineates the services to be provided; and

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

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

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

(e) Appointment fee – An appointment fee of $15 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 producer was found to be writing the Company's policies but was 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.

T&A Insurance Agency LLC

IX. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary examination packet in accordance with NAIC uniformity standards and provided specific information relative to the exam. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure its accuracy and completeness to determine compliance with Insurance Department Act of 1921, Section 904(b) (40 P.S. §323.4(b)). Several data integrity issues were found during the on-site portion of the exam.

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

60-Day Cancellations

Situation: As the examiners reviewed the 60-day cancellation files of the underwriting section of the exam, it was noted that not all 135 files selected for review were 60-day cancellation files.

Finding: Of the 135 60-day cancellation files reviewed, 24 files were identified as rescissions and one file was identified as a midterm cancellation.

The following finding was made:

General Violation *40 P.S. §323.4(b)*

Requires every company or person from whom information is sought must provide to the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings

relating to the property, assets, business and affairs of the company being examined. The violation resulted in the failure to exercise sufficient due diligence to ensure compliance with Insurance Department Act of 1921.

X. MCAS REPORTING

In Pennsylvania, insurers are required annually to submit a Market Conduct Annual Statement (MCAS) to the National Association of Insurance Commissioners (NAIC). The review of MCAS data was conducted pursuant to the authority granted by Section 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the Market Conduct Annual Statement (MCAS) reporting for 2013.

The examination team reviewed the Company's 2013 MCAS Submissions. All companies that submit an MCAS filing must attest to the completeness and accuracy of their submission. The attestation is required once per filing period and applies to all submissions for a specific company code. No submissions will be accepted until an attestation is completed for the company. Below are the private passenger automobile sections that were reviewed.

A.	Number of autos which have policies in-force at the end of the period.
B.	Number of Policies in-force at the end of the period.
C.	Number of new business policies written during the period.
D.	Number of Company-Initiated nonrenewals during the period.
E.	Dollar amount of direct written premium during the period.
F.	Number of cancellations for non-pay, non-sufficient funds or insured's request.
G.	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated Company.
H.	Number of Company-Initiated cancellations that occur 60 or more days after effective date, excluding rewrites to an affiliated Company.
I.	Number of Complaints received directly from the consumer.
J.	Number of Claims open at the beginning of the Period

K.	Number of Claims opened during the period.
L.	Number of Claims closed during the period, with payment.
M.	Number of Claims closed during the period, without payment.
N.	Number of Claims remaining open at the end of the period.
O.	Number of Claims closed with payment within 0-60 days.
P.	Number of Claims closed with payment >60 days.
Q.	Number of Suits open at beginning of the period.
R.	Number of Suits opened during the period.
S.	Number of Suits closed during the period.
T.	Number of Suits open at end of period.

The review consisted of three phases, as noted below.

Phase 1

The Company was asked to provide the claims and policy data listings that support the 2013 MCAS filing. Each list contained the claim and policy numbers for each category. The 2013 data submitted was validated to ensure the information was accurate and consistent with the information provided to the NAIC.

The following findings were made:

9 Violations 40 P.S. §323.4(b)

Requires every company or person from whom information is sought must provide to the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The Company failed to provide 2013 data that was consistent with the information

provided to the NAIC for one claim category and eight underwriting categories.

Phase 2

The Company was asked to provide a record of all claims and policy data listings which supported the 2013 MCAS filings. From each universe list of 2013 data, a random sample of five (5) claims or policy files was requested, received and reviewed. The files were reviewed to ensure compliance with the Commonwealth of Pennsylvania's Statutes and Regulations.

The following findings were made:

15 Violations 40 P.S. §323.4(b)

Requires every company or person from whom information is sought must provide to the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The Company failed to provide accurate data for one underwriting category and 14 claim categories.

Phase 3

A review was performed on various policies and claims provided in the Market Conduct portion of the exam to ensure the MCAS data was inclusive of all the policies applicable to each line item. The files were reviewed to ensure compliance with the Commonwealth of Pennsylvania's Statutes and Regulations.

The following findings were made:

4 Violations 40 P.S. §323.4(b)

Requires every company or person from whom information is sought must provide to the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The Company failed to provide accurate data for three underwriting categories and one claim category.

XI. RECOMMENDATIONS

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

1. The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notices requirements of 40 P.S. §§991.2003 and 991.2004, so that the violations noted in the Report do not occur in the future.

2. The Company must review 40 P.S. §1171.5(a)(12) to ensure that the violations noted in the Report do not occur in the future.

3. The Company must review policies with unearned premium not returned within 30 days of cancelling the policy. Those with unearned premium not returned within 30 days of cancellation of the policy shall bear interest at the rate of 12% per annum from the date the return premium became due as required by 75 Pa. C.S. §1793(c). The interest amount must be paid to the policyholder and proof of such payment must be provided to the Insurance Department within 30 days of the Report issue date.

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

5. The Company must review 31 Pa. Code §62.3(e)(4) with its claim staff to ensure that sales tax is included in the replacement value of a motor vehicle. The Company must review all claims where sales tax was not included in the replacement value of a motor vehicle. The sales tax must be paid to the claimant and proof of such payment must be provided to the Insurance Department within 30 days of the Report issue date.

6. The Company must review 31 Pa. Code §62.3(e)(7) with its claim staff to ensure that the consumer receives the total loss evaluation report within 5 working days after the appraisal is completed.

7. The Company must review 31 Pa. Code §69.22(c) with its claim staff to ensure that the insured and provider are properly notified when first-party medical benefits have been exhausted.

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

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

10. The Company must review practices and procedures that do not comply with the prompt investigation and payment of claim requirements of 40 P.S. §1171.5(a)(10)(iii) so that the violations noted in the Report do not occur in the future.

11. The Company must review 31 Pa. Code §§69.52(a) and 146.3 with its claim staff to ensure documentation is recorded to determine and ensure that providers are notified when referring bills for PRO review at the time of referral.

12. The Company must review 31 Pa. Code §69.52(e) with its claim staff to ensure that the insured and provider are provided a copy of a PRO evaluation in a timely manner.

13. The Company must review 31 Pa. Code §146.5(b) to ensure that all Department inquiries are responded to within 15 working days of receipt of such inquiry.

14. The Company must maintain records of refusal to write as required by 40 P.S. §323.4 and 75 Pa. C.S. §1799.3(f).

15. The Company must ensure all producers are properly licensed and appointed, as required by 40 P.S. §§310.41a(a) and 310.71, prior to accepting any business from any producer.

16. The Company must reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.4, so that violations noted in the Report do not occur in the future.

XII. COMPANY RESPONSE

CAPITOL INSURANCE COMPANY

1180 WELSH ROAD, SUITE 180

NORTH WALES, PA 19454

215-956-9399 Fax 215-956-9436

May 20, 2015

Constance Arnold
Property & Casualty Division Chief
Department of Insurance
1227 Strawberry Square
Harrisburg, PA 17120

RE: Examination Warranty Number: 14-M08-008

Dear Ms. Arnold

Please accept this correspondence in lieu of a more formal response to the Report of Examination of Capitol Insurance Company covering the period of January 1, 2013 through December 31, 2013 and dated April 20, 2015.

Capitol Insurance Company concurs with the Department's assessment that the market conduct examination serves as a useful procedure in identifying problem areas so that insurers may take appropriate remedial actions, if necessary. Capitol Insurance Company appreciated the Market Conduct Division's thorough review, level of professionalism and insight in the business practices and procedures at Capitol Insurance Company during the examination.

Capitol Insurance would like to assure the Department that the company has taken deliberate action to implement corrective steps that will improve the company's business practices to avoid any compliance issues in the future. It was Capitol Insurance's intent to provide you and the members of your Division timely, convenient and free access to all of the company's information and documents related to the property, assets, business and affairs of Capitol Insurance Company. It has always been the company's intent to operate its business in accordance with the letter and spirit of all applicable laws, orders, rules and regulations promulgated by the Commonwealth of Pennsylvania and its regulators that were intended to protect consumers.

Thank you for the opportunity to respond to the Examination Report and we look forward to the resolution of the issues raised during the examination.

Sincerely,

Lambros Economides
General Counsel/COO