COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

ALLSTATE INDEMNITY COMPANY
NORTHBROOK, IL

As of: November 8, 2018
Issued: January 4, 2019

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).

Paul E Towsen III

(Examiner Name), Examiner-in-Charge

Sworn to and Subscribed Before me

This 23rd Day of October, 2018

Glenda J Ebersole

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Glenda J. Ebersole. Notary Public
City of Harrisburg. Dauphin County
My Commission Expires Feb. 13. 2019

ALLSTATE INDEMNITY COMPANY

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 18th day of March, 2018, 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, 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.

Jessica K. Altman
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
ALLSTATE INDEMNITY COMPANY 2775 Sanders Rd., Suite A2W Northbrook, IL 60062	:	40 P.S. §323.3(a) and 323.4(b)
	:	40 P.S. §§310.41(a) and 310.71
	:	40 P.S. §§991.2006, 991.2006(6) and 991.2008(b)
	:	40 P.S. §§1171.5(a)(4), 1171.5(a)(8) 1171.5(a)(11) and 1171.5(a)(12)
	:	40 P.S. §1184(a)&(h)
	:	40 P.S. §1224(a)&(i)
	:	18 Pa. Code §4117(k)(1)
	:	31 Pa. Code §§62.3(a)(1), 62.3(a)(2) 62.3(b)(2), 62.3(b)(3), 62.3(b)(4), 62.3(b)(5), 62.3(b)(9), 69.22(c), 69.43(d) 69.52(a), 69.52(b), 69.52(e), 146.3 146.5(a), 146.6 and 146.7(a)(1)
	:	75 Pa. C.S. §§1705(a)(4), 1731(b)&(c) 1738(d)(1)&(2)(e) 1786(e)(3), 1791, 1791.1(a), 1793(b) and 1799.3(f)
Respondent.	:	Docket No. MC18-11-006

CONSENT ORDER

AND NOW, this 4th day of January, 2019, 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 Allstate Indemnity Company, and maintains its address at 2775 Sanders Rd., Suite A2W, Northbrook, IL 60062.

(b) A market conduct examination of Respondent was conducted by the Insurance

Department covering the experience period from January 1, 2016 through December 31, 2016.

(c) On November 8, 2018, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on December 7, 2018.

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

(i) 40 P.S. §323.3(a), requires every company subject to examination to keep all books, records, accounts, papers, documents and any computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the Department may require in order that its representatives may readily ascertain whether the company has complied with the laws of this Commonwealth;

(ii) 40 P.S. §323.4(b), requires every company or person from whom information is sought, its officers, directors and agents must provide to the examiners timely, convenient and free access at all reasonable hours at its offices 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;

(iii) 40 P.S. §310.41(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;

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

(v) 40 P.S. §991.2006, requires that cancellation by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the insured a written notice of the cancellation;

(vi) 40 P.S. §991.2006(6), requires that a cancellation notice or refusal to renew advise the insured that he must obtain compulsory automobile insurance coverage if he operates or registers a motor vehicle in this Commonwealth and that the insurer is notifying the Department of Transportation that the insurance is being cancelled and the insured must notify the Department of Transportation that he has replaced said coverage;

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

(viii) 40 P.S. §1171.5(a)(4), prohibits unfair methods of competition and unfair or deceptive acts or practices by entering into any agreement to commit, or by any concerted action committing, any act or boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(ix) 40 P.S. §1171.5(a)(8), states that "Unfair Methods of Competition" and "Unfair or Deceptive Act or Practices" prohibits unfairly discriminating by means except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow or give as inducement to such insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration, inducement or anything of value whatsoever which is not specified in the contract;

(x) 40 P.S. §1171.5(a)(11), requires a company to maintain a complete record of all the complaints it has received during the preceding four years;

(xi) 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;

(xii) 40 P.S. §1184(a)&(h), 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;

(xiii) 40 P.S. §1224(a)&(i), 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, except as to inland marine risks, 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.

(xiv) 18 Pa. C.S. §4117(k)(l), states 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;

(xv) 31 Pa. Code §62.3(a)(1), states an appraisal shall be signed by the appraiser before submitting the information to an insurer, consumer, or other party involved. An electronic signature is acceptable to remain compliant with appraisal requirements;

(xvi) 31 Pa. Code §62.3(a)(2), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements listed, the appraisal shall explain any abbreviations or symbols used in the description of work to be done or parts to be repaired or replaced;

(xvii) 31 Pa. Code §62.3(b)(2), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements listed, the appraisal shall also contain a written disclosure that

states costs above the appraised amount may be the responsibility of the vehicle owner;

(xviii) 31 Pa. Code §62.3(b)(3), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements listed, an appraisal shall also contain a written disclosure informing the policyholder that there is no requirement to use any specified repair shop;

(xix) 31 Pa. Code §62.3(b)(4), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements listed, an appraisal shall also contain a written disclosure informing the consumer of repair facilities that are able to repair the vehicle for the appraised amount;

(xx) 31 Pa. Code §62.3(b)(5), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in

question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements listed, an appraisal shall also contain a written disclosure informing the consumer of repair facilities that are able to repair the vehicle for the appraised amount;

(xxi) 31 Pa. Code §62.3(b)(9), requires that an appraisal shall contain a written disclosure which includes the following: The location where the listed parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident;

(xxii) 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;

(xxiii) 31 Pa. Code §69.43(d), requires an insurer to provide a complete explanation of the calculations made in computing its determination of the repriced bill;

(xxiv) 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;

(xxv) 31 Pa. Code §69.52(b), 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;

(xxvi) 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;

(xxvii) 31 Pa. Code §146.3, requires the claim files of the insurer shall be subject to examination by the Commissioner or by his/her 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;

(xxviii) 31 Pa. Code §146.5(a), 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;

(xxix) 31 Pa. Code §146.6, states that if an investigation cannot be completed within thirty (30) days, and every forty-five (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;

(xxx) 31 Pa. Code §146.7(a)(1), 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;

(xxxi) 75 Pa. C.S. §1705(a)(4), requires every insurer, prior to the first issuance of a private passenger motor vehicle liability insurance policy to provide each applicant with the notice required by paragraph (1). A policy may not be issued until the applicant has been provided an opportunity to elect a tort option. The notice shall be standardized form as adopted by the Commissioner;

(xxxii) 75 Pa. C.S. §1731(b) & (c), requires that the named insured shall be informed that uninsured and underinsured motorist coverage may be rejected by signing a written rejection form;

(xxxiii) 75 Pa. C.S. §1738(d)(1)&(2)(e), requires the named insured shall be informed that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms;

(xxxiv) 75 Pa. C.S. §1786(e)(3), states an insurer who has issued a contract of motor vehicle liability insurance and knows or has reason to believe that the contract is only for the purpose of providing proof of financial responsibility shall notify the Department if the insurance has been canceled or terminated by the insured or by the insurer. The insurer shall notify the Department not later than ten days following the effective date of the cancellation or termination;

(xxxv) 75 Pa. C.S. §1791, states it shall be presumed that the insured has been advised of the benefits available under this chapter provided the notice in bold print of at least ten-point type is given to the insured at time of application;

(xxxvi) 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 coverages 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;

(xxxvii) 75 Pa. C.S. §1793(b), requires the insurer to provide to the insured a copy of their 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;

(xxxviii) 75 Pa. C.S. §1799.3(f), 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. An applicant receiving a notice of reasons under this subsection may obtain review by the Commissioner pursuant to the Automobile Insurance Policy Act. If either the applicant or insurer is aggrieved by the Commissioner's review, the Commissioner may, in his discretion and for cause shown, hold a

hearing pursuant to the Automobile Insurance Policy Act. No insurer shall take any action, overt or otherwise, against any agent or broker for complying with this subsection;

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. §§310.41(a) and 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) Violations of 40 P.S.§§991.2006, 991.2006(6) and 991.2008(b) (relating to motor vehicles) of 40 P.S. are punishable by the following, under Section 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).

(d) Respondent's violations of 40 P.S. §§1171.5(a)(4), 1171.5(a)(8), 1171.5(a)(11) 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) Violations of Section 4 of the Casualty and Surety Rate Regulatory Act, No. 246 (40 P.S. §1184(a)&(h)) are punishable under Section 16 of the Act:

(i) imposition of a civil penalty not to exceed $50 for each violation or not more than $500 for each such willful violation;

(ii) suspension of the license of any insurer which fails to comply with an Order of the Commissioner within the time limited by such Order, or any extension thereof which the Commissioner may grant.

(g) Violations of 1224(a)&(i) are punishable by the following under the Fire and Marine Insurance Act (40 P.S. §1235):

(i) imposition of a civil penalty not to exceed $50 for each violation or not more than $500 for each such willful violation;

(ii) suspension of the license of any rating organization or 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.

(h) Respondent's violations of 31 Pa. Code §§146.3, 146.5(a), 146.6, and 146.7(a)(1) are punishable under Sections 1 through 5 and Section 9 of the Unfair Insurance Practices Act (40 P.S. §§1171.1 – 1171.5 and 1171.9):

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

(i) 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 One Hundred Fifty Thousand Dollars ($150,000.00) in settlement of all violations contained in the Report.

(c) Payment of this matter shall be made to the Commonwealth of Pennsylvania. 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 thirty (30) 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) After a period of 18 months from the date of this Order, Respondent shall be examined to verify corrective actions have been implemented. The experience period of the re-exam shall be one year and not begin any sooner than 6 months from the date of this Order.

(f) 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: ALLSTATE INDEMNITY COMPANY
Respondent

Tom Mathes, Product Vice President

CHRISTOPHER R. MONAHAN
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination was conducted at the claims office of Allstate Indemnity Company, hereinafter referred to as "Company", located in Malvern, Pennsylvania from March 12, 2018, through March 23, 2018. 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.

Kelly Krakowski, MCM
Market Conduct Division Chief
Pennsylvania Insurance Department

Paul Towsen
Market Conduct Examiner
Pennsylvania Insurance Department

Ryan Sellers
Market Conduct Examiner
Pennsylvania Insurance Department

Nanette Soliday
Market Conduct Examiner
Pennsylvania Insurance Department

Vern Schmidt
Market Conduct Examiner
Pennsylvania Insurance Department

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on Allstate Indemnity Company, at the claims office located in Malvern, 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, 2016, through December 31, 2016, 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, declinations, and rescissions.
    - Rating – Proper use of all classification and rating plans and procedures.

2. Personal 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. Producer Licensing
8. Data Integrity
9. MCAS Reporting
    - Private Passenger Automobile
    - Personal Property

III. COMPANY HISTORY

Allstate Indemnity Company is a wholly-owned subsidiary of Allstate Insurance Holdings, LLC, which is a Delaware limited liability company. Allstate Insurance Holdings, LLC is a wholly-owned subsidiary of The Allstate Corporation, which is a Delaware corporation. Allstate Indemnity Company was incorporated on July 7, 1960 under the laws of Illinois. Allstate Indemnity Company was authorized to commence business on December 12, 1960 as National Emblem Insurance Company. On January 21, 1974, the company name changed to Allstate Indemnity Company. The first date licensed in Pennsylvania was August 10, 1965.

LICENSING

Allstate Indemnity Company's last Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2018. The Company is licensed in all fifty states and the District of Columbia. The Company's 2016 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $77,532,285. Premium volume related to the areas of this review were: Homeowners Multiple Peril $12,500,207; Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (Personal Injury Protection) $31,630; Other Private Passenger Auto Liability $11,453,738; and Private Passenger Auto Physical Damage $3,783,997.

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, homeowners, renters, condominium, and manufactured homes. 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:

3 Violations *40 P.S. §1171.5(a)(4)*

States that "Unfair Methods of Competition" and "Unfair or Deceptive Act or Practices" prohibits unfairly discriminating by means of entering into any agreement to commit, or by any concerted action committing, any act or boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance. The Company's guidelines require supporting business as a condition to write a new business Tenant.Occupied Condo, a new business Seasonal/Secondary Condo, and a new business Manufactured Home.

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 368 private passenger automobile policies that were cancelled within the first 60 days of new business, 75 files were selected for review. All 75 files requested were received and reviewed. The 35 violations noted were based on 35 files, resulting in an error ratio of 47%.

The following findings were made:

35 Violations 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs

in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to have proof in the file to indicate the insured requested cancellation for the 35 files noted.

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 5,395 private passenger automobile policies which were cancelled midterm, 150 files were selected for review. All 150 files requested were received and reviewed. Of the 150 files reviewed, 15 files were identified as being 60-day cancellations. The 62 violations noted were based on 62 files, resulting in an error ratio of 41%.

The following findings were made:

62 Violations 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records,

accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to have proof in the file to indicate the insured requested cancellation for the 62 files noted.

The following concern was noted:

CONCERN: The Company is sending a Notice of Cancellation with no address and phone number to contact Assigned Risk. The Company should add the telephone number and address of Assigned Risk so the insured can contact if needed.

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 506 private passenger automobile policies which were nonrenewed during the experience period, 75 files were selected for review. All 75 files requested were received and reviewed. The entire universe of nonpay notices (178) was also reviewed and all were identified as midterm cancellations. The total number of files reviewed was 223. The 738 violations noted were based on 204 files, resulting in an error ratio of 91%.

The following findings were made:

204 Violations 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to have proof in the file to indicate the insured requested cancellation for 26 of the files noted and failed to keep records in a manner that the Department could determine compliance for the 178 non-pay nonrenewal files noted.

178 Violations 40 P.S. §1171.5(a)(8)

States that "Unfair Methods of Competition" and "Unfair or Deceptive Act or Practices" prohibits unfairly discriminating by means except as otherwise expressly provided by law,

knowingly permitting or offering to make or making any contract of insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow or give as inducement to such insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration, inducement or anything of value whatsoever which is not specified in the contract. The Company provided coverage past the termination date without receiving payment for the 178 files noted.

178 Violations 40 P.S. §1184(a)&(h)

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to issue policies in accordance with the Company's filed and approved rating plan. The Company provided coverage past the termination date without receiving payment for the 178 files noted.

178 Violations 40 P.S. §991.2006(6)

75 Pa. C.S. §1786(e)(3)

Requires that a cancellation notice advise the insured that he must obtain compulsory automobile insurance coverage if he

operates or registers a motor vehicle in this Commonwealth and that the insurer is notifying the Department of Transportation that the insurance is being cancelled and the insured must notify the Department of Transportation that he has replaced said coverage. In addition, an insurer who has issued a contract of motor vehicle liability insurance and knows or has reason to believe that the contract is only for the purpose of providing proof of financial responsibility shall notify the department if the insurance has been cancelled or terminated by the insured or by the insurer. The insurer shall notify the department not later than ten days following the effective date of the cancellation or termination. The Company failed to notify the Department of Transportation not later than ten days following the effective date of the cancellation or termination for the 178 files noted.

The following concerns were noted:

CONCERN: The Company is sending a Notice of Cancellation with no address and phone number to contact Assigned Risk. The Company should add the telephone number and address of Assigned Risk so the insured can contact if needed.

CONCERN: The Company is including the following language on nonpayment notices of cancellation following non-response to renewal offer: "You have been sent this cancellation notice because we haven't received the necessary payment for your insurance policy. If we do not receive payment, your policy will end on the cancellation date and time shown on this notice. If you send us a premium payment after your cancel

date, we may reinstate your policy as of the date we processed your payment provided your payment is honored by your financial institution. If your payment is not honored upon presentation to your financial institution, any notice we may issue that waives this cancellation notice or reinstates coverage is of no effect, and your policy will cancel on the date and time on this notice." The company should refrain from sending a notice of cancellation for nonpayment following the renewal offer.

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.

From the universe of 1,636 declinations for private passenger automobile insurance, 75 files were selected for review. All 75 files requested were received and reviewed. The 209 violations noted were based on 75 files, resulting in an error ratio of 100%.

The following findings were made:

142 Violations 40 P.S. §991.2008(b)

> Any applicant for a policy who is refused such policy by an insurer shall be given a written notice of refusal to write by the insurer. Such notice shall state the specific reason or reasons of the insurer for refusal to write a policy for the applicant. Within 30 days of the receipt of such reasons, the

applicant may request in writing to the Insurance Commissioner that he review the action of the insurer in refusing to write a policy for the applicant. The Company failed to provide a written notice of refusal to write for eight of the files noted, failed to provide a specific reason for the declination on 67 of the files noted, and sent a notice of cancellation which did not advise the insured of his right to request in writing a review by the Commissioner on 67 of the files noted.

67 Violations 75 Pa. C.S. §1799.3(f)

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 declination letter utilized by the Company is not a form approved by the Insurance Commissioner for the 67 files noted.

5. 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.

The universe of one private passenger automobile policy, which was rescinded during the experience period, was selected for review. The file requested was received and reviewed. The file reviewed was determined to be a nonrenewal. The violation noted was based on one file, resulting in an error ratio of 100%.

The following finding was made:

1 Violation 40 P.S. §991.2006

Requires that a cancellation by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the insured a written notice of the cancellation. The file noted did not contain any evidence that a cancellation notice was sent to the insured.

B. Personal 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.

From the universe of 225 property policies which were cancelled within the first 60 days of new business, 75 files were selected for review. The property files consisted of 25 condominiums and 50 manufactured homes. All 75 files requested were received and reviewed. The 37 violations noted were based on 35 files, resulting in an error ratio of 47%.

The following findings were made:

25 Violations 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to have proof in the file to indicate the insured requested cancellation for 22 of the files noted. The Company failed to document the file indicating why the cancellation date was backdated from the original cancellation date for the remaining three files noted.

10 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 10 files noted.

2 Violations 40 P.S. §1171.5(a)(4)

States that "Unfair Methods of Competition" and "Unfair or Deceptive Act or Practices" prohibits unfairly discriminating by means of entering into any agreement to commit, or by any concerted action committing, any act or boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance. The Company required supporting business to write a policy for the two files noted.

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 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 2,102 property policies which were cancelled midterm during the experience period, 317 files were selected for review. The property files consisted of 50 homeowners, 17 tenant homeowners, 100

condominiums, and 150 manufactured homeowners. All 317 files were received and reviewed. Of the 150 manufactured home files reviewed, 29 files were identified as a property 60-day cancellation. The 195 violations noted were based on 195 files, resulting in an error ratio of 62%.
The following findings were made:

195 Violations 40 P.S. §323.3(a)

> Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to have proof in the file to indicate the insured requested cancellation for the 195 files noted.

The following concern was noted:

CONCERN: The Company is sending a Notice of Cancellation with no address and phone number to contact The Fair Plan. The Company should add the telephone number and address of The Fair Plan so the insured can contact if needed.

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

From the universe of 793 property policies which were nonrenewed during the experience period, 173 files were selected for review. The property files consisted of 40 homeowners, eight tenant homeowners, 50 condominiums, and 75 manufactured homeowners. All 173 files were received and reviewed. The entire universe of property nonpay notices (287) was also reviewed and all were identified as midterm cancellations. The total number of files reviewed was 436. The 963 violations noted were based on 389 files, resulting in an error ratio of 89%.

The following findings were made:

389 Violations 40 P.S. §323.3(a)

> Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and

ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to have proof in the file to indicate the insured requested cancellation for 102 files noted and failed to keep records in a manner that the Department could determine compliance for the 287 non-pay nonrenewal files noted.

287 Violations 40 P.S. §1171.5(a)(8)

States that "Unfair Methods of Competition" and "Unfair or Deceptive Act or Practices" prohibits unfairly discriminating by means except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow or give as inducement to such insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration, inducement or anything or anything of value whatsoever which is not specified in the contract. The Company provided coverage past the termination date without

receiving payment for the 287 files noted.

287 Violations 40 P.S. §1224(a)&(i)

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating

plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to issue policies in accordance with the Company's filed and approved rating plan. The Company provided coverage past the termination date without receiving payment for the 287 files noted.

The following concerns were noted:

CONCERN: The Company is sending a Notice of Cancellation with no address and phone number to contact The Fair Plan. The Company should add the telephone number and address of The Fair Plan so the insured can contact if needed.

CONCERN: The Company is including the following language on nonpayment notices of cancellation following non-response to renewal offer: "You have been sent this cancellation notice because we haven't received the necessary payment for your insurance policy. If we do not receive payment, your policy will end on the cancellation date and time shown on this notice. If you send us a premium payment after your cancel date, we may reinstate your policy as of the date we processed your payment provided your payment is honored by your financial institution. If your payment is not honored upon presentation to your financial institution, any notice we may issue that waives this cancellation notice or reinstates coverage is of no effect, and your policy will cancel on the date and time on this notice." The company should refrain from sending a notice of cancellation for nonpayment following the renewal offer.

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 205, Unfair Insurance Practices Act, Section 5 [40 P.S. §1171.5], which defines unfair methods of competition and unfair or deceptive acts or practices.

From the universe of 83 property declinations, 35 files were selected for review. All 35 files requested were received and reviewed. The 17 violations noted were based on 17 files, resulting in an error ratio of 49%.

The following finding was made:

17 Violations 40 P.S. §1171.5(a)(4)

> Prohibits unfair methods of competition and unfair or deceptive acts or practices by entering into any agreement to commit, or by any concerted action committing, any act or boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in the business of insurance. The Company required supporting business to write a policy for the 17 files 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 The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), 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 all provisions of the Motor Vehicle Financial Responsibility Law (75 Pa. C.S. §§1701 – 1799.7) 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 uses an automated system to process and issue personal automobile policies. 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 Rating – New Business without Surcharges

From the universe of 6,368 private passenger automobile policies identified as new business without surcharges by the Company, 75 files were selected for review. All 75 policy files requested were received and reviewed. Of the 75 files reviewed, eight files were determined to be Private Passenger Automobile New Business with Surcharges. The 19,129 violations noted were based on the universe of 6,368 files, resulting in an error ratio of 100%.

The following findings were made:

5 Violations 75 Pa. C.S. §1705(a)(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 a signed and dated limited tort form for the five files noted.

3 Violations *75 Pa. C.S. §1731(b)(c)(c.1)*

The named insured shall be informed that he may reject uninsured and underinsured motorist coverage by signing a written rejection form. The Company failed to have a signed rejection form for uninsured and underinsured motorists coverages for the three files noted.

17 Violations *75 Pa. C.S. §1738(d)(1)&(2)(e)*

The named insured shall be informed that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms. The Company failed to provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for the 17 files noted.

6,368 Violations 75 Pa. C.S. §1791

Requires the Company to advise the insured of the benefits and limits available under this Chapter in bold print of at least ten-point type at the time of application for original coverage. The Company failed to provide the required wording in bold print of at least ten-point type and the language was not verbatim for the 6,368 files noted.

6,368 Violations 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 to the insured at the time of application for the 6,368 files noted.

6,368 Violations 75 Pa. C.S. §1793(b)

Requires the insurer to provide to the insured a copy of their 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 Company failed to include the number of years that a surcharge will be in effect within the surcharge disclosure plan provided to the insured for the 6,368 files noted.

General Violation 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records,

accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person has complied with the laws of the Commonwealth. The Company failed to retain phone sales recordings which demonstrate and contain application and disclosure information. Compliance could not be determined for the violations noted.

Private Passenger Automobile Rating – New Business with Surcharges

From the universe of 96 private passenger automobile policies identified as new business with surcharges by the Company, 25 files were selected for review. All 25 policy files requested were received and reviewed. The 298 violations noted were based on the universe of 96 files, resulting in an error ratio of 100%.

The following findings were made:

1 Violation *75 Pa. C.S. §1705(a)(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 a signed and dated limited tort form for the file noted.

9 Violations *75 Pa. C.S. §1738(d)(1)&(2)(e)*

Requires the named insured shall be informed that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms. The Company failed to provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for the nine files noted.

96 Violations 75 Pa. C.S. §1791

Requires the Company to advise the insured of the benefits and limits available under this Chapter in bold print of at least ten-point type at the time of application for original coverage. The Company failed to provide the required wording in bold print of at least ten-point type and the language was not verbatim for the 96 files noted.

96 Violations 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 to the insured at the time of application for the 96 files noted.

96 Violations 75 Pa. C.S. §1793(b)

Requires the insurer to provide to the insured a copy of their 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 Company failed to include the number of years that a surcharge will be in effect within the surcharge disclosure plan provided to the insured for the 96 files noted.

General Violation 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person has complied with the laws of the Commonwealth. The Company failed to retain phone sales recordings which demonstrate and contain application and

disclosure information. Compliance could not be determined for the violation 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 measure compliance with The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), 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 of 1998, 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 7,007 private passenger automobile policies identified as renewals without surcharges, 75 files were selected for review. All 75 policy files requested were received and reviewed. The 14,015 violations noted were based on the universe of 7,007 files, resulting in an error ratio of 100%.

The following findings were made:

1 Violation *40 P.S. §1184*

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company issued the policy with an improper territory. The amount of the undercharge was $.25.

7,007 Violations 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 to the insured at the time of renewal for the 7,007 files noted.

7,007 Violations 75 Pa. C.S. §1793(b)

Requires the insurer to provide to the insured a copy of their 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 Company failed to include the number of years that a surcharge will be in effect within the surcharge disclosure plan provided to the insured for the 7,007 files noted.

Private Passenger Automobile – Renewals with Surcharges

From the universe of 1,307 private passenger automobile policies identified as renewals with surcharges, 50 files were selected for review. All 50 policy files requested were received and reviewed. The 2,614 violations noted were based on the universe of 1,307 files, resulting in an error ratio of 100%.

The following findings were made:

1,307 Violations 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 to the insured at the time of renewal for the 1,307 files noted.

1,307 Violations 75 Pa. C.S. §1793(b)

Requires the insurer to provide to the insured a copy of their 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 Company failed to include the number of years that a surcharge will be in effect within the surcharge disclosure plan provided to the insured for the 1,307 files noted.

B. Personal Property

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 purpose of the review was to measure compliance with Act 247, the Fire, Marine, and Inland Marine Rate Regulatory Act, Sections 4(a) and (i) (40 P.S. §1224(a), (i)), which require every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time.

Condominium Rating – New Business without Surcharges

From the universe of 1,776 condominium policies identified as new business without surcharges by the Company, 40 files were selected for review. All 40 policy files requested were received and reviewed. The universe of policies that had the additional coverage of increased building property (964) was also reviewed. The total number of files reviewed was 977. The 968 violations noted were based on 964 files, resulting in an error ratio of 99%.

The following findings were made:

3 Violations *40 P.S. §323.3(a)*

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to retain the new business application and accurate rating could not be determined for the three files noted.

General Violation *40 P.S. §323.3(a)*

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person has complied with the laws of the Commonwealth. The Company failed to retain phone sales

recordings which demonstrate and contain application and disclosure information. Compliance could not be determined.

965 Violations 40 P.S. §1224(a)&(i)

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to apply the correct deductible factor resulting in an undercharge of $.25 for one of the files noted. The Company failed to apply the correct deductible factor for remaining 964 files that had the additional coverage of increased building property.

The following concern was noted:

CONCERN: Condo homeowner policies are subject to a surcharge for losses. Therefore, it is a concern that no surcharge disclosure plan is provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided in the Company's rate filing and how long the surcharge will last. Notification of the surcharge disclosure requirement was provided to all companies in

an Important Notice dated 9/18/1998.

Condominium Rating – New Business with Surcharges

From the universe of 106 condominium policies identified as new business with surcharges by the Company, 35 files were selected for review. All 35 policy files requested were received and reviewed. The universe of policies that had the additional coverage of increased building property (55) was also reviewed. The total number of files reviewed was 77. The 59 violations noted were based on 57 files, resulting in an error ratio of 74%.

The following findings were made:

3 Violations *40 P.S. §323.3(a)*

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to retain the new business application and accurate rating could not be determined for the three files noted.

General Violation *40 P.S. §323.3(a)*

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person has complied with the laws of the Commonwealth. The Company failed to retain phone sales recordings which demonstrate and contain application and disclosure information. Compliance could not be determined for the violations noted.

56 Violations *40 P.S. §1224(a)&(i)*

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to apply the correct deductible factor resulting in an undercharge of $.45 for the one file noted. The Company failed to apply the correct deductible factor for the remaining 55 files that had the additional coverage of increased building property.

The following concern was noted:

CONCERN: Condo homeowner policies are subject to a surcharge for losses. Therefore, it is a concern that no surcharge disclosure plan is provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided in the Company's rate filing and how long the surcharge will last. Notification of the surcharge disclosure requirement was provided to all companies in an Important Notice dated 9/18/1998.

Manufactured Home Rating – New Business without Surcharges

From the universe of 1,266 manufactured home policies identified as new business without surcharges by the Company, 35 files were selected for review. All 35 policy files requested were received and reviewed. The seven violations noted were based on seven files, resulting in an error ratio of 20%.

The following findings were made:

7 Violations *40 P.S. §323.3(a)*

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of

any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to retain the new business application and accurate rating could not be determined for the seven files noted.

General Violation 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person has complied with the laws of the Commonwealth. The Company failed to retain phone sales recordings which demonstrate and contain application and disclosure information. Compliance could not be determined for the violations noted.

The following concern was noted:

CONCERN: In some of the files reviewed, the surcharge disclosure plan was not issued to the insured. Manufactured homeowner policies are subject to a surcharge for losses. Therefore, it is a concern that no surcharge disclosure plan is provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided in the

Company's rate filing and how long the surcharge will last. Notification of the surcharge disclosure requirement was provided to all companies in an Important Notice dated 9/18/1998.

Manufactured Home Rating – New Business with Surcharges

From the universe of 28 manufactured home policies identified as new business with surcharges by the Company, 20 files were selected for review. All 20 policy files requested were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 10%.

The following findings were made:

2 Violations *40 P.S. §323.3(a)*

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed

to retain the new business application and accurate rating could not be determined for the two files noted.

General Violation 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person has complied with the laws of the Commonwealth. The Company failed to retain phone sales recordings which demonstrate and contain application and disclosure information. Compliance could not be determined for the violations noted.

The following concern was noted:

CONCERN: The surcharge disclosure plan provided to the policyholders does note state what surcharge percentage applies for paid losses.

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 247, the Fire, Marine, and Inland Marine Rate Regulatory Act, Sections 4(a) and (i) (40 P.S. §1224(a), (i)), 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 4,039 homeowner policies identified as renewal without surcharges by the Company, 50 files were selected for review. All 50 policy files requested were received and reviewed. The 49 violations noted were based on 49 files, resulting in an error ratio of 98%.

The following findings were made:

49 Violations 40 P.S. §323.3(a)

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed

to retain the new business application and accurate rating could not be determined for the 49 files noted.

The following concern was noted:

CONCERN: Homeowner policies are subject to a surcharge for losses. Therefore, it is a concern that no surcharge disclosure plan is provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided in the Company's rate filing and how long the surcharge will last. Notification of the surcharge disclosure requirement was provided to all companies in an Important Notice dated 9/18/1998.

Homeowner Rating – Renewals with Surcharges

From the universe of 90 homeowner policies identified as renewal with surcharges by the Company, 35 files were selected for review. All 35 policy files requested were received and reviewed. The 35 violations noted were based on 35 files, resulting in an error ratio of 100%.

The following findings were made:

35 Violations 40 P.S. §323.3(a)

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to retain the new business application and accurate rating could not be determined for the 35 files noted.

The following concern was noted:

CONCERN: Homeowner policies are subject to a surcharge for losses. Therefore, it is a concern that no surcharge disclosure plan is provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided in the Company's rate filing and how long the surcharge will last. Notification of the surcharge disclosure requirement was provided to all companies in an Important Notice dated 9/18/1998.

Condominium Rating – Renewals without Surcharges

From the universe of 9,112 condominium policies identified as renewal without surcharges by the Company, 75 files were selected for review. All 75 policy files requested were received and reviewed. The universe of policies that had the additional coverage of increased building property (5,380) was also reviewed. The total number of files reviewed was 5,409.

The 5,458 violations noted were based on 5,412 files, resulting in an error ratio of 100%.

The following findings were made:

75 Violations 40 P.S. §323.3(a)

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to retain the new business application and accurate rating could not be determined for the 75 files noted.

5,383 Violations 40 P.S. §1224(a)&(i)

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also,

no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to apply the correct deductible factor resulting in an undercharge of $1.46 for three of the files noted. The Company failed to apply the correct deductible factor for the remaining 5,380 files that had the additional coverage of increased building property.

The following concern was noted:

CONCERN: Condo homeowner policies are subject to a surcharge for losses. Therefore, it is a concern that no surcharge disclosure plan is provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided in the Company's rate filing and how long the surcharge will last. Notification of the surcharge disclosure requirement was provided to all companies in an Important Notice dated 9/18/1998.

Condominium Rating – Renewals with Surcharges

From the universe of 112 condominium policies identified as renewal with surcharges by the Company, 35 files were selected for review. All 35 policy files requested were received and reviewed. The universe of policies that had the additional coverage of increased building property (62) was also reviewed. The total number of files reviewed was 75. The 77 violations noted were based on 67 files, resulting in an error ratio of 89%.

The following findings were made:

11 Violations 40 P.S. §323.3(a)

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to retain the new business application and accurate rating could not be determined for the 11 files noted.

66 Violations 40 P.S. §1224(a)&(i)

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to apply the correct deductible factor resulting in an undercharge of $3.66 for four of the files noted. The Company failed to apply the correct deductible factor for the remaining 62 files that that had the additional coverage of increased building property.

The following concern was noted:

CONCERN: Condo homeowner policies are subject to a surcharge for losses. Therefore, it is a concern that no surcharge disclosure plan is provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided in the Company's rate filing and how long the surcharge will last. Notification of the surcharge disclosure requirement was provided to all companies in an Important Notice dated 9/18/1998.

Tenant Homeowner Rating – Renewals without Surcharges

From the universe of 159 tenant homeowner policies identified as renewal without surcharges by the Company, 25 files were selected for review. All 25 policy files requested were received and reviewed. The 25 violations noted were based on 25 files, resulting in an error ratio of 100%.

The following findings were made:

25 Violations 40 P.S. §323.3(a)

40 P.S. §1224(a)&(i)

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, every insurer shall file with the

Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to retain the new business application and accurate rating could not be determined for the 25 files noted.

The following concern was noted:

CONCERN: Tenant homeowner policies are subject to a surcharge for losses. Therefore, it is a concern that no surcharge disclosure plan is provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided in the Company's rate filing and how long the surcharge will last. Notification of the surcharge disclosure requirement was provided to all companies in an Important Notice dated 9/18/1998.

Manufactured Home Rating – Renewals without Surcharges

From the universe of 5,880 manufactured homeowner policies identified as renewal without surcharges by the Company, 75 files were selected for review. All 75 policy files requested were received and reviewed. The 52 violations noted were based on 52 files, resulting in an error ratio of 69%.

The following findings were made:

52 Violations 40 P.S. §323.3(a)

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to retain the new business application and accurate rating could not be determined for the 52 files noted.

The following concern was noted:

CONCERN: Manufactured homeowner policies are subject to a surcharge for losses. Therefore, it is a concern that no surcharge disclosure plan is provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided to these policyholders. The disclosure plan should state what surcharge percentage applies for paid losses as provided in the Company's rate filing and how long the surcharge will last. Notification of the surcharge disclosure requirement was provided to all companies in an Important Notice dated 9/18/1998.

Manufactured Home Rating – Renewals with Surcharges

The universe of six manufactured homeowner policies identified as renewal with surcharges by the Company was selected for review. All six policy files requested were received and reviewed. The three violations noted were based on three files, resulting in an error ratio of 50%.

The following findings were made:

3 Violations *40 P.S. §323.3(a)*

40 P.S. §1224(a)&(i)

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, every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to retain the new business application and accurate rating could not be determined for the three files noted.

The following concern was noted:

CONCERN: The surcharge disclosure plan provided to the policyholders does not state what surcharge percentage applies for paid losses.

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.

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 Claims
H. Tenant Homeowner Claims
I. Manufactured Homeowner Claims

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 1,378 private passenger automobile property damage liability claims reported during the experience period, 150 files were selected for review. All 150 files selected were received and reviewed. The 25 violations noted were based on 23 files, resulting in an error ratio of 15%.

The following findings were made:

4 Violations *31 Pa. Code §62.3*

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards per statute for the four claims noted.

1 Violation *31 Pa. Code §146.3*

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. The Company failed to provide a complete file for the claim noted.

3 Violations *31 Pa. Code §146.5(a)*

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice

unless payment is made within the period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement 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 failed to acknowledge the claim within 10 working days for the three files noted.

7 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 be 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 seven claims noted.

11 Violation 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: 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. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall 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 issue a denial letter to the claimant within 15 working days for the 11 files noted.

The following concerns were noted:

CONCERN: When the Company closes a claim file with no payment, it is not providing the policyholder/clamant with written notice indicating its action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

CONCERN: The Company did not provide a specific address for a local dealership where OEM parts are available on the vehicle appraisal. The Company should provide a specific address for a local dealership on the vehicle appraisal.

B. Automobile Comprehensive Claims

From the universe of 248 private passenger automobile comprehensive claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The eight violations noted were based on five files, resulting in an error ratio of 10%.

The following findings were made:

1 Violation *31 Pa. Code §146.5(a)*

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice

unless payment is made within the period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement 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 failed to acknowledge the claim within 10 working days for the file noted.

5 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 be 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 five claims noted.

2 Violations 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: 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. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall 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 accept or deny the claim within 15 working days for the two files noted.

The following concern was noted:

CONCERN: When the Company closes a claim file with no payment, it is not providing the policyholder/clamant with written notice indicating its action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

C. Automobile Collision Claims

From the universe of 362 private passenger automobile collision claims reported during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 3%.

The following findings were made:

1 Violation *31 Pa. Code §62.3*

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards for the claim noted.

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 be 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 concerns were noted:

CONCERN: In some of the files reviewed, the Company closes a claim file with no payment and is not providing the policyholder/clamant with written notice indicating its action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

CONCERN: The Company did not provide a specific address for a local dealership where OEM parts are available on the vehicle appraisal. The Company should provide a specific address for a local dealership on the vehicle appraisal.

D. Automobile Total Loss Claims

From the universe of 176 private passenger automobile collision claims reported during the experience period, 40 files were selected for review. All 40 files selected were received and reviewed. The seven violations noted were based on seven files, resulting in an error ratio of 18%.

The following findings were made:

1 Violation 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards for the claim noted.

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 be 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: The Company did not provide a specific address for a local dealership where OEM parts are available on the vehicle appraisal. The Company should provide a specific address for a local dealership on the vehicle appraisal.

E. Automobile First Party Medical Claims

From the universe of 494 private passenger automobile first party medical claims reported during the experience period, 40 files were selected for review. All 40 files selected were received and reviewed. The five violations noted were based on five files, resulting in an error ratio of 13%.

The following findings were made:

1 Violation *31 Pa. Code §69.22(c)*

States if an insured's first-party limits have been exhausted, the insurer shall, within 30 days of the receipt of the provider's bill, provide notice to the provider and the insured that the first-party limits have been exhausted. The Company failed to provide notice to the provider and/or insured that the first-party benefits have been exhausted for the claim noted.

1 Violation *31 Pa. Code §69.43(d)*

Requires an insurer to provide a complete explanation of the calculations made in computing its determination of the repriced bill. The Company failed to provide a complete explanation of how the repriced bill was calculated for the claim noted.

3 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 be 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 three claims noted.

The following concern was noted:

CONCERN: When the Company closes a claim file with no payment,

it is not providing the policyholder/clamant with written notice indicating its action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

F. Automobile First Party Medical Claims Referred to a PRO

The universe of 16 private passenger automobile first party medical claims referred to a PRO reported during the experience period was selected for review. All 16 files were received and reviewed. The three violations noted were based on one file, resulting in an error ratio of 6%.

The following findings were made:

1 Violation *31 Pa. Code §69.52(a)*

A provider's bill shall be referred to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided caused 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. An insurer shall notify a provider, in writing, when referring bills for PRO review at the time of the referral. The Company failed to notify the provider in writing, when referring bills to a Peer Review Organization for the claim noted.

1 Violation *31 Pa. Code §69.52(b)*

Requires an insurer to pay bills 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 claim noted.

1 Violation *31 Pa. Code §69.52(e)*

A PRO shall provide a written analysis, including specific reasons for its decision, to insurers, which shall within 5 days of receipt, provide copies to providers and insureds. The Company failed to provide copies of the PRO report to providers and insureds within 5 days of receipt for the claim noted.

G. Homeowner Claims

From the universe of 834 homeowner claims reported during the experience period, 100 files were selected for review. All 100 files were received and reviewed. The three violations noted were based on three files, resulting in an error ratio of 3%.

The following findings were 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 be 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.

2 Violations 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: 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. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall 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 accept or deny the claim for one file noted. The Company failed to deny the claim in writing for the other file noted.

The following concern was noted:

CONCERN: In some of the files reviewed, the Company closes a claim file with no payment and is not providing the policyholder/clamant with written notice indicating its action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

H. Tenant Homeowner Claims

The universe of one tenant homeowner claim reported during the experience period was selected for review. No violations were noted.

I. Manufactured Homeowner Claims

From the universe of 318 tenant homeowner claims reported during the experience period, 75 files were selected for review. All 75 files were received and reviewed. The two violations noted were based on two files, resulting in an error ratio of 3%.

The following findings were made:

1 Violation 31 Pa. Code §146.3

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. The Company failed to provide a complete file for the claim noted.

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 be 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: In some of the files reviewed, the Company closes a claim file with no payment and is not providing the policyholder/clamant with written notice indicating its action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

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 the 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 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 and 18 Pa. C.S. §4117(k)(1), which requires all insurers to provide an insurance fraud notice on all applications for insurance and all claim forms.

The following findings were made:

8 Violations 18 Pa. C.S. §4117(k)(1)

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. For seven of the violations noted, the Company failed to provide the required fraud warning on claims forms. The Company used a fraud warning that was not verbatim per statute on a claims form for the remaining violation noted.

IX. ADVERTISING

The Company was requested to provide copies of all advertising, sales material and internet advertisements in use during the experience period. The Company provided 353 pieces of advertising which included brochures, direct mailers, postcards, and emails. Of the 353 pieces of advertising, 50 pieces were reviewed. The Company website 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 412 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the universe of 412 complaint files, 100 files were selected for review. All 100 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:

4 Violations 40 P.S. §1171.5(a)(11)

Failure of any person to maintain a complete record of all the complaints which it has received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

The complaint log for 2013 does not have the disposition logged for all complaints. The complaint logs for 2013, 2014, 2015 and 2016 do not indicate the total number of complaints and the time it took to process each complaint.

The following concern was noted:

CONCERN: The Company is including the following language on nonpayment notices of cancellation following non-response to renewal offer: "You have been sent this cancellation notice because we haven't received the necessary payment for your insurance policy. If we do not receive payment, your policy will end on the cancellation date and time shown on this notice. If you send us a premium payment after your cancel date, we may reinstate your policy as of the date we processed your payment provided your payment is honored by your financial institution. If your payment is not honored upon presentation to your financial institution, any notice we may issue that waives this cancellation notice or reinstates coverage is of no effect, and your policy will cancel on the date and time on this notice." The company should refrain from sending a notice of cancellation for nonpayment following the renewal offer.

The following synopsis reflects the nature of the 20 complaints that were received.

61	Cancellation/Nonrenewal	61%
6	Other	6%
25	Claims Related	25%
4	Billing	4%
4	Service/Handling	4%
100		100%

XI. PRODUCER LICENSING

In order to determine compliance by the Company and its agency force with 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. §§310.41(a)a, 310.71), 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 and rating files were checked to verify proper licensing and appointment.

The following findings were noted:

1 Violation *40 P.S. §310.41(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 a civil penalty of no more than $5000.00 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 producer was found to be writing policies but was not found in Insurance Department records as being licensed.

The Rising Sun Agency

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 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.

Myers Insurance Agency

XII. 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 exam.

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

Automobile Midterm Cancellations

Situation: As the examiners reviewed the automobile midterm cancellation files of the automobile underwriting section of the exam, it was noted that not all of the 150 files selected for review were automobile midterm cancellation files.

Finding: Of the 150 automobile midterm cancellation files reviewed, 15 files were identified as automobile 60-day cancellation files.

Automobile Rescissions

Situation: As the examiners reviewed the one automobile rescission file of the automobile underwriting section of the exam, it was noted that the file selected for review was not an automobile rescission file.

Finding: The one automobile rescission file reviewed was identified as an automobile nonrenewal file.

Automobile Nonrenewals

Situation: As the examiners reviewed the automobile nonrenewal files of the automobile underwriting section of the exam, it was noted that not all files selected for review were automobile nonrenewals.

Finding: The entire universe (178) of automobile non-pay nonrenewals was identified as being an automobile midterm cancellations.

Automobile Rating NB without Surcharges

Situation: As the examiners reviewed the automobile new business without surcharges files of the automobile rating section of the exam, it was noted that not all of the 75 files selected for review were automobile new business without surcharges files.

Finding: Of the 75 automobile new business without surcharges files reviewed, eight files were identified as automobile new business with surcharges files.

Property Nonrenewals

Situation: As the examiners reviewed the property nonrenewal files of the property underwriting sections of the exam, it was noted that not all files selected for review were property nonrenewals.

Finding: The entire universe (287) of automobile non-pay nonrenewals was identified as being automobile midterm cancellations.

Manufactured Homeowner Midterm Cancellations

Situation: As the examiners reviewed the manufactured home midterm cancellation files of the property underwriting section of the exam, it was noted that not all of the 75 files selected for review were manufactured home midterm cancellation files.

Finding: Of the 75 manufactured home midterm cancellation files reviewed, 29 files were identified as manufactured home 60-day cancellation files.

Manufactured Homeowner Rating Renewals with Surcharges

Situation: As the examiners reviewed the manufactured homeowner renewals with surcharges files of the property rating section of the exam, it was noted that not all of the six files selected for review were manufactured homeowner renewals with surcharges files.

Finding: Of the six manufactured home renewals with surcharges files reviewed, one file was identified as a manufactured home new business with surcharge file.

Complaints

Situation: As the examiners reviewed the files of the complaints section of the exam, it was noted that not all of the 100 files selected for review were complaints for the state of Pennsylvania.

Finding: Of the 100 complaints reviewed, one file was identified as a state of New York complaint.

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 was the result of a failure to exercise sufficient due diligence to ensure compliance with Insurance Department Act of 1921.

XIII. PRIVATE PASSENGER AUTOMOBILE 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 2016.

The examination team reviewed the Company's 2016 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 claims open at the beginning of the period.
B.	Number of claims open at the beginning of the period.

C.	Number of claims opened during the period.
D.	Number of claims closed during the period, with payment.
E.	Number of claims closed during the period, without payment.
F.	Number of claims remaining open at the end of the period.
G.	Number of claims closed with payment within 0-60 days.
H.	Number of claims closed with payment > 60 days.
I.	Number of suits open at the beginning of the period.
J.	Number of suits open during the period.
K.	Number of suits closed during the period.
L.	Number of suits open at the end of the 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 2016 MCAS filing. Each list contained the claim and policy numbers for each category. The 2016 data submitted was validated to ensure the information was accurate and consistent with the information provided to the NAIC. No violations were noted.

Phase 2

The Company was asked to provide a record of all claims and policy data listings which supported the 2016 MCAS filings. From each universe list of 2016 data, a random sample of five claims or underwriting 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:

14 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 14 files in four claim categories and two underwriting categories.

Phase 3

A review was performed on various claims and underwriting files 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:

3 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 files in two underwriting categories.

XIV. PROPERTY 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 2016.

The examination team reviewed the Company's 2016 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 property sections that were reviewed.

A.	Number of claims open at the beginning of the period.
B.	Number of claims open at the beginning of the period.

C.	Number of claims opened during the period.
D.	Number of claims closed during the period, with payment.
E.	Number of claims closed during the period, without payment.
F.	Number of claims remaining open at the end of the period.
G.	Number of claims closed with payment within 0-60 days.
H.	Number of claims closed with payment > 60 days.
I.	Number of suits open at the beginning of the period.
J.	Number of suits open during the period.
K.	Number of suits closed during the period.
L.	Number of suits open at the end of the 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 2016 MCAS filing. Each list contained the claim and policy numbers for each category. The 2016 data submitted was validated to ensure the information was accurate and consistent with the information provided to the NAIC. No violations were noted.

Phase 2

The Company was asked to provide a record of all claims and policy data listings which supported the 2016 MCAS filings. From each universe list of 2016 data, a random sample of five claims 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:

11 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 11 files in three claim categories and two underwriting categories.

Phase 3

A review was performed on various claims and underwriting files 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:

2 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 two underwriting categories.

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

2. The Company must reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.3(a), so that violations noted in the Report do not occur in the future.

3. 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, status letters and acceptance and denials, as noted in the Report do not occur in the future.

4. Company must review 31 Pa. Code §62.3 with its claim staff to ensure all appraisal requirements are met so the violations noted in the Report do not occur in the future.

5. The Company must review 18 Pa. C.S.§4117(k)(1) to ensure that violations regarding the requirement of a fraud warning on all claim forms, as noted in the Report, do not occur in the future.
6. 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.

7. The Company must review 31 Pa. Code §69.52(a) with its claim staff to ensure that a written notification is sent to the provider when referring a bill for PRO review.

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 31 Pa. Code §69.43(d) with its claim staff to ensure a complete explanation of how a repriced bill was calculated is sent to the provider.

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

11. The Company shall comply with guidance regarding phone sales retention to be provided by the Department at a further date.

12. The Company must review 31 Pa Code §146.3 with its claim staff to ensure the claims department maintains complete claim files.

13. The Company must review 40 P.S. §1171.5(a)(11) to ensure that a complete complaint log is maintained.

14. The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notice requirements of 40 P.S. §§991.2006 and 991.2008, so that the violations noted in the Report do not occur in the future.

15. The Company must review 75 Pa. C.S. §1799.3(f) to ensure that the Company is using a form approved by the Commissioner when issuing auto declination letters to the insured.

16. The Company must review 40 P.S. §1184 and take appropriate measures to ensure the automobile rating violation listed in the report does not occur in the future.

17. The Company must review 40 P.S. §1224 and take appropriate measures to ensure the homeowner rating violations listed in the report do not occur in the future.

18. The Company must review 40 P.S. §1171.5(a)(8) and take appropriate

measures to make sure coverage is not provided past the termination date without receiving payment.

19. The Company must review 40 P.S. §1786(e)(3) to ensure proper notification to the Department of Transportation when a policy has been cancelled or terminated by the insured or insurer.

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

21. The Company must review 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.

22. The Company must review 40 P.S. §1171.5(a)(12) and take appropriate actions to ensure that policies are not issued that are known to be ineligible at the time of application.

23. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to elect a tort option and that signed tort option selection forms are obtained and retained with the underwriting file. This is to ensure that violations noted under 75 Pa. C.S. §1705(a)(4) do not occur in the future.

24. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to exercise the waiver for uninsured and underinsured motorist coverage forms are obtained and retained with the underwriting file. This is

to ensure that violations noted under 75 Pa. C.S. §1731(b) & (c) do not occur in the future.

25. The Company must revise underwriting procedures to ensure that the insured is aware that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms. This is to ensure that violations noted under 75 Pa. C.S. §1738(d)(1) and (2)(e) do not occur in the future.

26. The Company must review 75 Pa. C.S. §1791 violations to ensure that the notice of available benefits is given to the insured at the time of application as noted in the Report.

27. The Company must review 75 Pa. C.S. §1791.1(a) to ensure that violations regarding the requirement to provide an itemized invoice listing minimum coverages at the time of application and every renewal thereafter, as noted in the Report, do not occur in the future.

28. The Company must review 75 Pa. C.S. 1793(b) to ensure that violations regarding the requirement to provide the insured with a surcharge disclosure plan at the time of application, as noted in the Report, do not occur in the future.

XVI. COMPANY RESPONSE

Benjamin E. Lumicao
Senior Counsel
Law & Regulation

December 7, 2018

Commonwealth of Pennsylvania
Insurance Department
Bureau of Market Actions
1321 Strawberry Square
Harrisburg, PA 17120

ATTN: Kelly Krakowski, Chief, Property & Casualty Division

RE: Examination Warrant Number 17-M36-021

Dear Ms. Krakowski:

This is the response of Allstate Indemnity Company (the "Company") to the Department's Report of Examination of Allstate Indemnity Company dated November 8, 2018 (the "Report"). Allstate appreciates the courtesy and professionalism extended by the examiners and Department personnel involved in this process. This letter will address each of the Recommendations raised by the Department individually as expressed within the Report.

1. 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(b), so that violations noted in the Report do not occur in the future.

Company Response:
The Company acknowledges the exceptions noted by the Department. The Company submits it has processes, procedures and internal data controls in place to help ensure records and documents are maintained in accordance with 40 P.S. §323.4(b). The exceptions noted were inconsistent with our established practices. To help prevent further instances of such error, the Company will recommunicate its established processes, procedures and internal data controls to the appropriate personnel.

2. The Company must reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.3(a), so that violations noted in the Report do not occur in the future.

Company Response:
The Company believes it has complied with this section but was unable to produce satisfactory verification for purposes of the examination, and acknowledges the exceptions noted by the Department. The Company submits it has processes, procedures and internal data controls in place to help ensure records and documents are maintained in accordance with 40 P.S. §323.3(a). The exceptions noted were inconsistent with our established practices. To help prevent further instances of such error, the Company will review and update its processes and procedures as necessary, and will recommunicate its established processes, procedures and internal data controls to the appropriate personnel.

3. 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, status letters and acceptance and denials, as noted in the Report do not occur in the future.

Company Response:
The Company acknowledges the exceptions noted by the Department. The Company submits it has processes and procedures in place to help ensure that acknowledgement, status letters, acceptance and denials follow the claims handling requirements of 31 Pa. Code, Chapter 146, Unfair Claims Settlement Practices. The exceptions noted were inconsistent with our established practices and likely the result of oversight by the handling adjuster. To help prevent further instances of such error, the Company will recommunicate its established processes and procedures to all Pennsylvania claims handling adjusters.

4. Company must review 31 Pa. Code §62.3 with its claim staff to ensure all appraisal requirements are met so the violations noted in the Report do not occur in the future.

Company Response:
The Company acknowledges the exceptions noted by the Department. The Company submits it has processes and procedures in place to help ensure that all appraisals meet the requirements of 31 Pa. Code §62.3. The exceptions noted were inconsistent with our established practices and likely the result of oversight by the handling adjuster. To help prevent further instances of such error, the Company will recommunicate its established processes and procedures to all Pennsylvania licensed appraisers.

5. The Company must review 18 Pa. C.S.§4117(k)(1) to ensure that violations regarding the requirement of a fraud warning on all claim forms, as noted in the Report, do not occur in the future.

Company Response:
The Company acknowledges the exceptions noted by the Department. The Company submits it has processes and procedures in place to help ensure that the required fraud warning on all claim forms meet the requirements of 18 Pa. C.S.§4117(k)(1). The exceptions noted were inconsistent with our established practices. To help prevent further instances of such error, the Company will revise its forms.

6. 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.

Company Response:
The Company acknowledges the single exception noted by the Department. The Company submits it has processes and procedures in place to help ensure that the insured and provider are properly notified when first-party medical benefits have been exhausted in accordance with the requirements of 31 Pa. Code §69.22(c). The exception noted was inconsistent with our established practices and likely the result of oversight by the handling adjuster. To help prevent further instances of such error, the Company will recommunicate its established processes and procedures to all Pennsylvania claims handling adjusters.

7. The Company must review 31 Pa. Code §69.52(a) with its claim staff to ensure that a written notification is sent to the provider when referring a bill for PRO review.

Company Response:
The Company acknowledges the single exception noted by the Department. The Company submits it has processes and procedures in place to help ensure that a written notification is sent to the provider when referring a bill for PRO review in accordance with the requirements of 31 Pa. Code §69.22(c). The exception noted is inconsistent with our established practices and likely the result of oversight by the handling adjuster. To help prevent further instances of such error, the Company will recommunicate its established processes and procedures to all Pennsylvania claims handling adjusters.

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.

Company Response:
The Company acknowledges the single exception noted by the Department. The Company submits it has processes and procedures in place to help ensure that first party medical bills are paid within 30 days in accordance with the requirements of 31 Pa. Code §69.52(b). The exception noted is inconsistent with our established practices and likely the result of oversight by the handling adjuster. To help prevent further instances of such error, the Company will recommunicate its established processes and procedures to all Pennsylvania claims handling adjusters.

9. The Company must review 31 Pa. Code §69.43(d) with its claim staff to ensure a complete explanation of how a repriced bill was calculated is sent to the provider.

Company Response:
The Company acknowledges the single exception noted by the Department. The Company submits it has processes and procedures in place to help ensure that a complete explanation of how a repriced bill was calculated is sent to the provider in accordance with the requirements of 31 Pa. Code §69.43(d). The exception noted is inconsistent with our established practices and likely the result of oversight by the handling

adjuster. To help prevent further instances of such error, the Company will recommunicate its established processes and procedures to all Pennsylvania claims handling adjusters.

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

Company Response:
The Company acknowledges the single exception noted by the Department. The Company submits it has processes and procedures in place to help ensure that the insured is provided a copy of a PRO evaluation in a timely manner in accordance with the requirements of 31 Pa. Code §69.52 (e). The exception noted is inconsistent with our established practices and likely the result of oversight by the handling adjuster. To help prevent further instances of such error, the Company will recommunicate its established processes and procedures to all Pennsylvania claims handling adjusters.

11. The Company shall comply with guidance regarding phone sales retention to be provided by the Department at a further date.

Company Response:
The Company will adopt processes and procedures designed to comply with guidance from the Department regarding phone sales retention in a timely manner once the Department provides such guidance.

12. The Company must review 31 Pa Code §146.3 with its claim staff to ensure the claims department maintains complete claim files.

Company Response:

The Company acknowledges both exceptions noted by the Department. The Company submits it has processes and procedures in place to help ensure that that complete claim files are maintained in accordance with the requirements of 31 Pa. Code §146.3. The exceptions noted are inconsistent with our established practices and likely the result of oversight by the handling adjuster. To help prevent further instances of such error, the Company will recommunicate its established processes and procedures to all Pennsylvania claims handling adjusters.

13. The Company must review 40 P.S. §1171.5(a)(11) to ensure that a complete complaint log is maintained.

Company Response:
The Company will review and revise its processes and procedures to ensure that a complete complaint log is maintained, including the total numbers of complaints, the disposition of complaints, and the time it took to process each complaint as indicated within 40 P.S. §1171.5(a)(11).

14. The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notice requirements of 40 P.S. §§991.2006 and 991.2008, so that the violations noted in the Report do not occur in the future.

Company Response:
The Company will review and revise its processes and procedures to ensure that notices of refusal to write be provided and shall comply with the requirements 40 P.S. §991.2008, and that rescission notices comply with the requirements of 40 P.S. §991.2006.

15. The Company must review 75 Pa. C.S. §1799.3(f) to ensure that the Company is using a form approved by the Commissioner when issuing auto declination letters to the insured.

Company Response:
The Company will review and revise its processes, procedures and forms to ensure that it is using a form approved by the Commissioner when issuing auto declinations to applicants for insurance.

16. The Company must review 40 P.S. §1184 and take appropriate measures to ensure the automobile rating violation listed in the report does not occur in the future.

Company Response:
The Company will review its processes and procedures and revise them as necessary to ensure that coverage is not provided past the termination date of a policy without receiving payment.

17. The Company must review 40 P.S. §1224 and take appropriate measures to ensure the homeowner rating violations listed in the report do not occur in the future.

    Company Response:
    The Company will review its processes and procedures and revise them as necessary to ensure that coverage is not provided past the termination date of a policy without receiving payment.

18. The Company must review 40 P.S. §1171.5(a)(8) and take appropriate measures to make sure coverage is not provided past the termination date without receiving payment.

    Company Response:
    The Company will review its processes and procedures and revise them as necessary to ensure that coverage is not provided past the termination date of a policy without receiving payment.

19. The Company must review 40 P.S. §1786(e)(3) to ensure proper notification to the Department of Transportation when a policy has been cancelled or terminated by the insured or insurer.

    Company Response:
    The Company will review its processes and procedures and revise them as necessary to ensure that it notifies the Department of Transportation not later than ten days following the effective date of a cancellation or termination.

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

    Company Response:
    The Company acknowledges the two exceptions noted by the Department. The Company submits it has processes and procedures in place to help ensure that all producers are properly licensed and appointed prior to accepting any business from such producer. The exceptions noted are inconsistent with our established practices and likely the result of an inadvertent oversight. To help prevent further instances of such error, the

Company will recommunicate its established processes and procedures to the involved personnel.

21. The Company must review 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.

Company Response:
The Company will review and revise its processes and procedures to ensure that the violations relating to requiring supporting coverage noted in the Report do not recur.

22. The Company must review 40 P.S. §1171.5(a)(12) and take appropriate actions to ensure that policies are not issued that are known to be ineligible at the time of application.

Company Response:
The Company will review and revise its processes and procedures to ensure that policies are not issued that are known to be ineligible at the time of application.

23. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to elect a tort option and that signed tort option selection forms are obtained and retained with the underwriting file. This is to ensure that violations noted under 75 Pa. C.S. §1705(a)(4) do not occur in the future.

Company Response:
The Company believes it has been in compliance with this requirement but was unable to produce satisfactory verification for the purposes of the examination. The Company is reviewing its processes and procedures to assure that the selection forms are obtained and retained.

24. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to exercise the waiver for uninsured and underinsured motorist coverage forms are obtained and retained with the underwriting file. This is to ensure that violations noted under 75 Pa. C.S. §1731(b) & (c) do not occur in the future.

Company Response:
The Company believes it has been in compliance with these requirements but was unable to produce satisfactory verification for the purposes of the examination. The Company is reviewing its processes and procedures to assure that the selection forms for uninsured and underinsured motorists coverage forms are obtained and retained when necessary.

25. The Company must revise underwriting procedures to ensure that the insured is aware that he may exercise the waiver of stacked limits for uninsured and underinsured motorist coverage by signing written rejection forms. This is to ensure that violations noted under 75 Pa. C.S. §1738(d)(1) and (2)(e) do not occur in the future.

Company Response:
The Company believes it has been in compliance with these requirements but was unable to produce satisfactory verification for the purposes of the examination. The Company is reviewing its processes and procedures to assure that the waiver of stacked limits forms for uninsured and underinsured motorists coverage forms are obtained and retained when necessary.

26. The Company must review 75 Pa. C.S. §1791 violations to ensure that the notice of available benefits is given to the insured at the time of application as noted in the Report.

Company Response:
The Company will review and revise its notice forms as necessary to ensure that the required wording will be provided in bold print of at least ten-point type and the language is verbatim as required in the section.

27. The Company must review 75 Pa. C.S. §1791.1(a) to ensure that violations regarding the requirement to provide an itemized invoice listing minimum coverages at the time of application and every renewal thereafter, as noted in the Report, do not occur in the future.

Company Response:
The Company will review and revise its processes, procedures, forms and systems as necessary to assure that it meets the requirement to provide an itemized invoice listing

minimum coverages at the time of application and every renewal thereafter.

28. The Company must review 75 Pa. C.S. 1793(b) to ensure that violations regarding the requirement to provide the insured with a surcharge disclosure plan at the time of application, as noted in the Report, do not occur in the future.

Company Response:
The Company will review and revise its forms and systems as necessary to assure that its surcharge disclosure plan information provided to insureds includes the number of years that a surcharge may be in effect.

The Company acknowledges the Concerns noted by the Department within the Report, and will take them under advisement.

In conclusion, the Company looks forward to the opportunity to work with the Department to conclude the issues raised in this examination, and thanks you for the courtesy and professionalism extended to the Company's representatives throughout the course of the examination.

Sincerely,

Ben Lumicao

Benjamin Lumicao
Senior Counsel
Law & Regulation
Allstate Insurance Company

Copies to:

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