

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

CHUBB INDEMNITY INSURANCE COMPANY
New York, New York

**AS OF
June 12, 2006**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION**

Issued: July 31, 2006

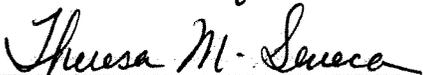
VERIFICATION

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


M. Katherine Sutton, Examiner-In-Charge

Sworn to and Subscribed Before me

This 15 Day of *May*, 2006



Notary Public

COMMONWEALTH OF PENNSYLVANIA

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

CHUBB INDEMNITY INSURANCE COMPANY

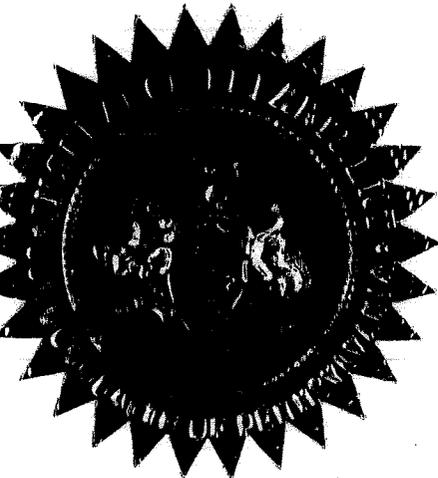
TABLE OF CONTENTS

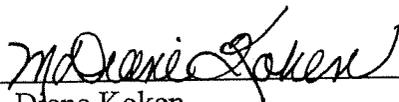
Order		
I.	Introduction.....	1
II.	Scope of Examination.....	3
III.	Company History/Licensing.....	5
IV.	Underwriting Practices and Procedures.....	6
V.	Underwriting	
	A. Private Passenger Automobile.....	8
	B. Assigned Risk.....	10
	C. Property.....	10
	D. Workers' Compensation.....	14
VI.	Rating	
	A. Private Passenger Automobile.....	16
	B. Assigned Risk.....	20
	C. Homeowners.....	20
VII.	Claims.....	23
VIII.	Forms.....	32
IX.	Advertising.....	33
X.	Consumer Complaints.....	34
XI.	Licensing.....	36
XII.	Recommendations.....	39
XIII.	Company Response.....	42

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 29 day of April, 2002, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Randolph L. Rohrbaugh, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.





M. Diane Koken
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE: : VIOLATIONS:
: :
CHUBB INDEMNITY INSURANCE : Sections 641-A and 671-A of Act 147
COMPANY : of 2002 (40 P.S. §§ 310.41 and 310.71)
15 Mountain View Road :
Warren, NJ 07061 : Sections 4(a) and 4(h) of the Act of
: June 11, 1947, P.L. 538, No. 246
: (40 P.S. §§ 1184)
: :
: Title 75, Pennsylvania Consolidated
: Statutes, Sections 1161(a) and (b)
: :
: Act 1990-6, Sections 1705(a)(1) & (4),
: 1716 and 1731 (Title 75, Pa.C.S. §§
: 1705, 1716 and 1731)
: :
: Sections 5(a)(4), 5(a)(7)(iii) and
: 5(a)(9) of the Unfair Insurance
: Practices Act, Act of July 22, 1974,
: P.L. 589, No. 205 (40 P.S. §§ 1171.5)
: :
: Sections 2003(b) and 2003(a)(14)
: of Act 68 of 1998 (40 P.S. §§991.2003)
: :
: Section 1 of the Act of July 3, 1986,
: P.L. 396, No. 86 (40 P.S. § 3401)
: :
: Title 31, Pennsylvania Code, Sections
: 62.3(e)(3) and (7), 69.52(a) and (b),
: 146.6, 146.7(a)(1) and 146.7(c)(1)
: :
: Title 75, Pennsylvania Consolidated
: Statutes, Section 1822
: :
Respondent. : Docket No. MC06-06-024

CONSENT ORDER

AND NOW, this 31st day of July, 2006, this Order is hereby issued by the Deputy Insurance Commissioner of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

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

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

FINDINGS OF FACT

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

- (a) Respondent is Chubb Indemnity Insurance Company, and maintains its address at 15 Mountain View Road, Warren, New Jersey 07061.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from July 1, 2004 through June 30, 2005.

(c) On June 12, 2006, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on July 11, 2006.

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

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

(ii) Section 671-A of Act 147 of 2002 prohibits producers from transacting business within this Commonwealth without written appointment as required by the Act (40 P.S. § 310.71).

(iii) Sections 4(a) and 4(h) of the Casualty and Surety Rate Regulatory Act, No. 246 (40 P.S. § 1184), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every

rating plan and every modification of any rating plan which it proposes to use in this Commonwealth and prohibits an insurer from making or issuing a contract or policy with rates other than those approved;

- (iv) Section 1161(a) and (b) of Title 75, Pa. C.S., which states an insurer who owns, possesses or transfers a vehicle located or registered in the Commonwealth which qualifies as a salvage vehicle shall make application to the Department for a certificate of salvage for that vehicle;
- (v) Sections 1705(a)(1) & (4) of Act 1990-6, Title 75, Pa.C.S. § 1705, which requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option;
- (vi) Section 1716 of Act 1990-6, Title 75, Pa. C.S. § 1716, which requires that benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of benefits. If reasonable proof is not supplied as to all benefits, the portion supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Overdue benefits shall bear interest at the rate of 12% per annum from the date the benefits become due. In the event the insurer is found to have acted in an unreasonable manner in refusing to pay the benefits when due, the

insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended;

- (vii) Section 1731 of Act 1990-6, Title 75, Pa.C.S. § 1731, which states the named insured shall be informed that he may reject underinsured motorist coverage by signing a written rejection form;
- (viii) Section 5(a)(4) of Act 205 (40 P.S. § 1171.5), which defines an unfair method of competition and deceptive act or practice as entering into any agreement to commit, or by any concerted action committing, any act of boycott, Coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;
- (ix) Section 5(a)(7)(iii) of Act 205 (40 P.S. § 1171.5), which defines and prohibits unfair methods of competition as making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status;
- (x) Section 5(a)(9) of Act 205 (40 P.S. §1171.5), which defines an unfair act or practice as: (9) cancelling any policy of insurance covering owner-occupied

private residential properties or personal property of individuals that has been in force for 60 days or more or refusing to renew any such policy unless the policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the company; or there has been a substantial change or increase in hazard in the risk assumed by the company subsequent to the date the policy was issued; or there is a substantial increase in hazards insured against by reason of willful or negligent acts or omissions by the insured; or the insured has failed to pay any premium whether such premium is payable directly to the company or its agent or indirectly under any premium finance plan or extension of credit; or for any other reasons approved by the Commissioner pursuant to rules and regulations promulgated by the Commissioner. No cancellation or refusal to renew by any person shall be effective unless a written notice of the cancellation or refusal to renew is received by the insured whether at the address shown in the policy or at a forwarding address;

- (xi) Section 2003(a)(14) of Act 68 of 1998 (40 P.S. § 991.2003), which states an insurer may not cancel or refuse to write or renew a policy of automobile insurance for any claim under the comprehensive portion of the policy unless intentionally caused by the insured;

- (xii) Section 2003(b) of Act 68 of 1998 (40 P.S. § 991.2003), which states that an insurer may not cancel or refuse to renew a policy of automobile insurance on the basis of one accident within the 36 month period prior to the upcoming anniversary date of the policy;
- (xiii) Section 1 of Act 86 (40 P.S. § 3401), which provides that notwithstanding any other provision of law, a policy of insurance covering commercial property or casualty risks in this Commonwealth shall provide for not less than 30 days advance notice to the named insured of an increase in renewal premium. This section does not apply to policies written on a retrospective rating plan;
- (xiv) Title 31, Pennsylvania Code, Section 62.3(e)(3), which states if a motor vehicle is not listed in at least two of the sources authorized by paragraph (1)(a), or if the vehicle differs materially from the average vehicle because of factors not considered in the guide sources, the replacement value shall be calculated by the actual cost method or by the dealer quotation method. If the dealer quotation method is used, both calculations referred in this paragraph shall be made, and the higher value obtained shall be offered in the settlement;
- (xv) Title 31, Pennsylvania Code, Section 62.3(e)(7), which states the appraiser is responsible for ensuring that a copy of the total loss evaluation report be sent within five working days to the consumer by the appraiser after the appraisal

is completed. If a settlement offer is extended before the consumer receives the total loss evaluation report, the consumer shall be advised of the total loss evaluation report's contents and of the consumer's right to be sent a copy within five days after its completion;

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

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

- (xviii) Title 31, Pennsylvania Code, Section 146.6, requires that every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot reasonably be completed within 30

days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected;

(xix) Title 31, Pennsylvania Code, Section 146.7(a)(1), which requires within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial;

(xx) Title 31, Pennsylvania Code, Section 146.7(c)(1), which states if the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected; and

- (xxi) Title 75, Pennsylvania Consolidated Statutes, Section 1822, which requires not later than May 1, 1990, all applications for insurance, renewals and claim forms shall contain a statement that clearly states, in substance, the following: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.00.

CONCLUSIONS OF LAW

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

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.
- (b) Respondent's violations of Sections 641-A and 671-A of Act 147 of 2002 are punishable by the following, under Section 691-A of Act 147 of 2002 (40 P.S. § 310.91):
- (i) suspension, revocation or refusal to issue the certificate of qualification or license;
 - (ii) imposition of a civil penalty not to exceed five thousand dollars (\$5,000.00) for every violation of the Act;

- (iii) an order to cease and desist; and
- (iv) any other conditions as the Commissioner deems appropriate.

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

- (i) imposition of a civil penalty not to exceed \$50 for each violation or not more than \$500 for each such wilful violation;
- (ii) suspension of the license of any insurer which fails to comply with an Order of the Commissioner within the time limited by such Order, or any extension thereof which the Commissioner may grant.

(d) Respondent's violations of Sections 5(a)(4), 5(a)(7)(iii) and 5(a)(9) of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 1171.5) are punishable by the following, under Section 9 of the Unfair Insurance Practices Act (40 P.S. § 1171.9):

- (i) cease and desist from engaging in the prohibited activity;
- (ii) suspension or revocation of the license(s) of Respondent.

- (e) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:
- (i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);
 - (ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00).
- (f) Respondent's violations of Sections 2003 of Act 68 of 1998 are punishable by the following, under Section 2013 of the Act (40 P.S. § 991.2013): Any individual or insurer who violates any of the provisions of this article may be sentenced to pay a fine not to exceed five thousand dollars (\$5,000.00).
- (g) Respondent's violations of Section 1 Act 86 (40 P.S. §3401) are punishable under Section 8 (40 P.S. § 3408) of this act by one or more of the following causes of action:

- (i) Order that the insurer cease and desist from the violation.
 - (ii) Impose a fine or not more than \$5,000 for each violation.
- (g) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.6 and 146.7 are punishable under Sections 9, 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9, 1171.10 and 1171.11), as stated above.

ORDER

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

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.

(d) Respondent shall pay Twenty-Five Thousand Dollars (\$25,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

(e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Harbert, Administrative Assistant, Bureau of Enforcement, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

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

7. Alternatively, in the event the Deputy Commissioner finds that there has been a breach of any of the provisions of this Order, the Deputy Commissioner may declare

this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

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

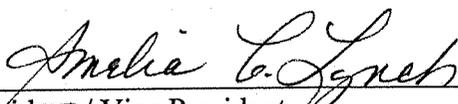
9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

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

11. This Order shall be final upon execution by the Deputy Insurance Commissioner. Only the Insurance Commissioner or a duly authorized Deputy Insurance Commissioner is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent

Order is not effective until executed by the Insurance Commissioner or a duly authorized Deputy Insurance Commissioner.

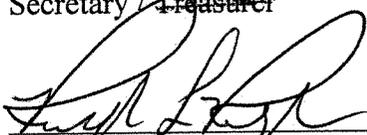
BY: CHUBB INDEMNITY INSURANCE
COMPANY, Respondent



President / Vice President



Secretary / Treasurer



RANDOLPH L. KOHRBAUGH
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The market conduct examination was conducted at Chubb Indemnity Insurance Company's offices located in Chesapeake, Virginia; Philadelphia, Pennsylvania and Whitehouse Station, New Jersey, from November 28, 2005, through January 20, 2006. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

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

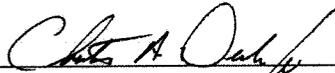
In certain areas of review listed in this Report, the examiners will refer to "error ratio." This error ratio is calculated by dividing the number of policies with violations by the total number of policies reviewed. For example, if 100 policies are reviewed and it is determined that there are 20 violations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

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

the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the officers and employees of the Company during the course of the examination is hereby acknowledged.

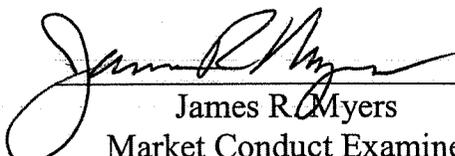
The undersigned participated in this examination and in preparation of this Report.



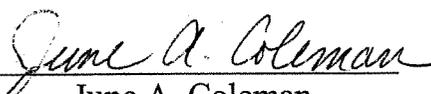
Chester A. Derk, Jr., AIE, HIA
Market Conduct Division Chief



M. Katherine Sutton, AIC
Market Conduct Examiner



James R. Myers
Market Conduct Examiner



June A. Coleman
Market Conduct Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on Chubb Indemnity Insurance Company, hereinafter referred to as “Company,” at their offices located in Chesapeake, Virginia; Philadelphia, Pennsylvania and Whitehouse Station, New Jersey. The examination was conducted pursuant to Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of July 1, 2004, through June 30, 2005, unless otherwise noted. The purpose of the examination was to determine the Company’s compliance with Pennsylvania insurance laws and regulations.

The examination focused on Company operations in the following areas:

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

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

3. Workers’ Compensation
 - Underwriting – Appropriate and timely notices of nonrenewal and renewals.

4. Claims

5. Forms

6. Advertising

7. Complaints

8. Licensing

III. COMPANY HISTORY AND LICENSING

Chubb Indemnity Insurance Company was incorporated under the laws of New York on November 3, 1922, as Sun Indemnity Company of New York, which subsequently changed its name to Sun Insurance Company of New York. Concurrent with the sale of the Company of Federal Insurance Company on February 3, 1994, the name was changed to its' current title.

LICENSING

Chubb Indemnity Insurance Company's Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2006. The Company is licensed in all states, Puerto Rico and the District of Columbia. The Company's 2005 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as \$29,319,355. Premium volume related to the areas of this review were: Homeowners multiple peril \$5,414, 917; Inland Marine \$1,293,537; Workers' Compensation \$1,455,530; Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (personal injury protection) \$1,455,480; Other Private Passenger Auto Liability \$8,211,128 and Private Passenger Auto Physical Damage \$10,452,465.

IV. UNDERWRITING PRACTICES AND PROCEDURES

As part of the examination, the Company was requested to supply manuals, underwriting guides, bulletins, directives or other forms of underwriting procedure communications for each line of business being reviewed. Underwriting guides were furnished for private passenger automobile personal lines property and commercial risks. 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 Act 205, Section 5(a)(7)(iii) [40 P.S. §1171.5(a)(7)(iii)]

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined. “Unfair Methods of Competition” and “Unfair or Deceptive Practices” in the business of insurance means: Unfairly discriminating by means of: Making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status. The Company’s guidelines used occupation, place of residence and age as a basis for imposing additional underwriting standards and practices.

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

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or

intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance. The Company's underwriting guidelines required supporting coverage, which is prohibited.

V. UNDERWRITING

A. Private Passenger Automobile

1. 60-Day Cancellations

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

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

The universe of 17 private passenger automobile files identified as being cancelled in the first 60 days of new business was selected for review. All 17 files selected were received and reviewed. The violation noted resulted in an error ratio of 6%.

The following finding was made:

1 Violation Act 68, Section 2003(a)(14) [40 P.S. §991.2003(a)(14)]
Discrimination Prohibited. An insurer may not cancel or refuse to write or renew a policy of automobile insurance for any claim under the comprehensive portion of the policy unless intentionally caused by the insured. The Company canceled the policy due to a comprehensive claim.

2. Midterm Cancellations

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

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

From the universe of 465 private passenger automobile files identified as midterm cancellations by the Company, 100 files were selected for review. All 100 files selected were received and reviewed. No violations were noted.

3. Nonrenewals

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

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

The universe of 56 private passenger automobile files identified as nonrenewals by the Company was selected for review. All 56 files selected were received and reviewed. No violations were noted.

B. Private Passenger Automobile – Assigned Risk

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

C. Property

1. 60-Day Cancellations

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

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

The universe of 18 homeowner policies, which were cancelled within the first 60 days of new business was selected for review. All 18 files selected were received and reviewed. No violations were noted.

2. Midterm Cancellations

A midterm cancellation is any policy termination that occurs at any time other than the twelve-month policy anniversary date.

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

From the universe of 164 property policies which were cancelled midterm during the experience period, 70 files were selected for review. The property policies consisted of homeowners and tenant homeowners. All 70 files requested were received and reviewed. The violation noted resulted in an error ratio of 1%.

The following finding was made:

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

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

AND

Adjudication: Mohanal/Lebanon Mutual, P95-08-048 (1998).

When the insurer notifies its agent of an allegedly hazardous condition on the insureds' property together with recommendations to correct the condition but does not notify the insureds, a cancellation based upon a failure to comply with the recommendations violates Act 205. The Company did not notify the insured of the required corrections or recommendations.

3. Nonrenewals

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

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

The universe of 13 property policies which were nonrenewed during the experience period was selected for review. The property policies consisted of homeowners, tenant homeowners and inland marine. All 13 files requested were received and reviewed. The 6 violations noted were based on 6 files, resulting in an error ratio of 46%.

The following findings were made:

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

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

AND

Adjudication: Mohanal/Lebanon Mutual, P95-08-048 (1998).

When the insurer notifies its agent of an allegedly hazardous condition on the insureds' property together with recommendations to correct the condition but does not notify the insureds, a cancellation based upon a failure to comply with the recommendations violates Act 205. The Company did not notify the insured of the required corrections or recommendations for the 5 files noted.

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

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined. Entering into any agreement to commit, or by any concerted action committing, any act of boycott,

coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance. The policy was nonrenewed due to lack of supporting business.

4. Declinations

A declination is any application that is received and the Company declines to write the coverage.

The primary purpose of the review was to determine compliance with Act 205, Unfair Insurance Practices Act, Section 5(a)(7)(iii) [40 P.S. §1171.5(a)(7)(iii)], discriminatory reasons.

The universe of 10 personal lines files identified as declinations by the Company was selected for review. All 10 files selected were received and reviewed. No violations were noted.

D. Workers' Compensation

1. Nonrenewals

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

The review was conducted to determine compliance with Act 86, Section 3 (40 P.S. §3403), which establishes notice requirements for nonrenewals.

The universe of 1 workers' compensation policy nonrenewed during the experience period was selected for review. The file selected was received and reviewed. No violations were noted.

2. Renewals

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

The purpose of the review was to measure compliance with Act 86, Section 1 (40 P.S. §3401), which requires 30 days advance notice of an increase in renewal premium.

The universe of 9 workers' compensation policies which were renewed during the experience period was selected for review. All 9 files selected were received and reviewed. The 4 violations noted were based on 4 files, resulting in an error ratio of 44%.

The following findings were made:

4 Violations Act 86, Section 1 [40 P.S. §3401]

This section provides that notwithstanding any other provision of law, a policy of insurance covering commercial property or casualty risks in this Commonwealth shall provide for not less than 30 days advance notice to the named insured of an increase in renewal premium. This section does not apply to policies written on a retrospective rating plan. The Company did not provide at least 30 days advance notice to the named insured of an increase in renewal premium for the 4 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 Act 246, Sections 4(a) and (h) [40 P.S. §1184], which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at that time. Files were also reviewed to determine compliance with all provisions of Act 6 of 1990 and Act 68, Section 2005(c) [40 P.S. §991.2005(c)], which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other additional amount that is charged as a result of a claim having been made under a policy of insurance or as a result of any other factors.

The Company processes and issues personal automobile policies using an automated system. In order to verify the automated system, several policies were manually rated to ensure the computer had been programmed correctly. Once the computer programming had been verified, only the input data needed to be verified. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile – New Business Without Surcharges

From the universe of 342 private passenger automobile policies identified as new business without surcharges by the Company, 50 files were selected for review. All 50 files requested were received and reviewed. No violations were noted.

The following concern was noted:

The Company is currently not itemizing the premium amounts by coverage for the invoice required by Title 75, Pa. C.S. §1791.1(a). The Company must implement this procedure going forward.

Private Passenger Automobile – New Business With Surcharges

The universe of 18 private passenger automobile policies identified as new business with surcharges was selected for review. All 18 files requested were received and reviewed. The 2 violations noted were based on 2 files, resulting in an error ratio of 11%.

The following findings were made:

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

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

1 Violation Title 75, Pa. C.S. §1731(c)

The named insured shall be informed that he may reject underinsured motorist coverage by signing a written rejection form. The violation noted was the result of the policy being issued without underinsured motorist coverage and no evidence of a signed written rejection form in the file.

The following concern was noted:

The Company is currently not itemizing the premium amounts by coverage for the invoice required by Title 75, Pa. C.S. §1791.1(a). The Company must implement this procedure going forward.

2. Renewals

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

The purpose of the review was to measure compliance with Act 246, Sections 4(a) and (h) (40 P.S. §1184), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time. Files were also reviewed to determine compliance with Act 68, Section 2005(c) (40 P.S. §991.2005(c)), which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other additional amount that is charged as a result of a claim having been made under a policy of insurance, or as a result of any other factors.

The Company processes and issues personal automobile policies using an automated system. In order to verify the automated system, several policies were manually rated to ensure the computer had been programmed correctly. Once the computer programming had been verified, only the input data needed to be verified. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile – Renewals Without Surcharges

From the universe of 3,914 private passenger automobile policies renewed without surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. No violations were noted.

The following concern was noted:

The Company is currently not itemizing the premium amounts by coverage for the invoice required under Title 75, Pa. C.S. §1791.1(a). The Company must implement this procedure going forward.

Private Passenger Automobile – Renewals With Surcharges

From the universe of 709 private passenger automobile policies renewed with surcharges during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. No violations were noted.

The following concern was noted:

The Company is currently not itemizing the premium amounts by coverage for the invoice required by Title 75, Pa. C.S. §1791.1(a). The Company must implement this procedure going forward.

Private Passenger Automobile Renewed in a Higher Plan

From the universe of 212 private passenger automobile policies identified as renewals in a higher plan, 100 files were selected for review. All 100 files requested were received and reviewed. No violations were noted.

B. Private Passenger Automobile – Assigned Risk

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

C. Homeowners

1. New Business

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

The purpose of the review was to measure compliance with Act 246, Sections 4(a) and (h) (40 P.S. §1184), which require every insurer to file with the Insurance Commissioner every manual of classifications, rules and

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

Homeowner Rating – New Business Without Surcharges

From the universe of 393 homeowner policies written as new business without surcharges during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The violation noted resulted in an error ratio of 2%.

The following finding was made:

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

Requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time of issue. The Company failed to grant an insured the valuable articles credit in accordance to the Company's rate filing, which resulted in an overcharge of \$215.

2. Renewals

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

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

Homeowner Rating – Renewals Without Surcharges

From the universe of 1,662 homeowner policies renewed without surcharges during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. No violations were noted.

VII. CLAIMS

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

The Claims review consisted of the following areas of review:

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

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

A. Automobile Property Damage Claims

From the universe of 380 private passenger automobile property damage claims reported during the experience period, 75 files were selected for review. All 75 files requested were received and reviewed. The violation noted resulted in an error ratio of 1%.

The following finding was made:

1 Violation Title 31, Pa. Code, Section 146.6

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

B. Automobile Comprehensive Claims

From the universe of 509 private passenger automobile comprehensive claims reported during the experience period, 75 files were selected for review. All 75 files requested were received and reviewed. No violations were noted.

C. Automobile Collision Claims

From the universe of 932 private passenger automobile collision claims reported during the experience period, 75 files were selected for review. All 75 files requested were received and reviewed. The 4 violations noted were based on 3 files, resulting in an error ratio of 4%.

The following findings were made:

3 Violations Title 31, Pa. Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such

investigation cannot reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the 3 claims noted.

1 Violation Title 31, Pa. Code, Section 146.7(a)(1)

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to deny the claim in writing and have a copy of the denial in the file.

D. Automobile Total Loss Claims

From the universe of 132 private passenger automobile total loss claims reported during the experience period, 73 files were selected for review. All 73 files selected were received and reviewed. The 141 violations noted were based on the universe of 132 files, resulting in an error ratio of 100%.

The following findings were made:

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

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

(b) Application for certificate of salvage. – An owner who transfers a vehicle to be destroyed or dismantled, salvaged or recycled shall assign the certificate of title to the person to whom the vehicle is transferred. Except as provided in Section 1163, the transferee shall immediately present the assigned certificate of title to the Department or an authorized agent of the Department with an application for a certificate of salvage upon a form furnished and prescribed by the Department. An insurer as defined in Section 1702 to which title to a vehicle is assigned upon payment to the insured or claimant of the replacement value of a vehicle shall be regarded as a transferee under this subsection. The 3 files noted did not reflect a salvage title was obtained.

3 Violations Title 31, Pa. Code, Section 62.3(e)(3)

If a motor vehicle is not listed in at least two of the sources authorized by paragraph (1)(a), or if the vehicle differs materially from the average vehicle because of factors not considered in the guide sources, the replacement value shall be calculated by the actual cost method or by the dealer

quotation method. If the dealer quotation method is used, both calculations referred in this paragraph shall be made, and the higher value obtained shall be offered in the settlement. The Company only used one source guide in determining valuation for the 3 files noted.

132 Violations Title 31, Pa. Code, Section 62.3(e)(7)

The appraiser is responsible for ensuring that a copy of the total loss evaluation report be sent within 5 working days to the consumer by the appraiser after the appraisal is completed. If a settlement offer is extended before the consumer receives the total loss evaluation report, the consumer shall be advised of the total loss evaluation report's contents and of the consumer's right to be sent a copy of within 5 days after its completion. The Company did not provide a copy of the total loss evaluation to the insured for the 132 claims noted.

3 Violations Title 31, Pa. Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the 3 claims noted.

Concern: It was noticed that on four occasions a Certificate of Salvage was obtained from a state other than Pennsylvania. The Company should be securing a Certificate of Salvage obtained from the Commonwealth of Pennsylvania on all Pennsylvania registered vehicles involved in total loss claims.

E. Automobile First Party Medical Claims

The universe of 9 private passenger automobile first party medical claims reported during the experience period was selected for review. All 9 files requested were received and reviewed. The 3 violations noted were based on 1 file, resulting in an error ratio of 11%.

The following findings were made:

1 Violation Title 31, Pa. Code, Section 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to provide a status letter to the provider.

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

Requires an insurer to pay bills for care that are not referred to a Peer Review Organization within 30 days after the

insurer receives sufficient documentation supporting the bill.
The Company did not pay the claim within 30 days.

1 Violation Title 75, Pa. C.S. §1716

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

F. Automobile First Party Medical Claims Referred to a PRO

The universe of 15 private passenger automobile first party medical claims referred to a peer review organization was selected for review. All 15 claim files requested were received and reviewed. The Company was requested to provide copies of any contracts with the peer review organization it has contracted. The contract was received and reviewed. The violation noted resulted in an error ratio of 7%.

The following finding was made:

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

Requires an insurer to refer a provider's bill to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with PRO procedures, standards and practices, to believe it necessary that a PRO determine the reasonableness and necessity of care, the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care. The insurer shall notify a provider, in writing, when referring bills for PRO review at the time of referral. The violation resulted from failure to give proper notice to the provider at the time of referral.

G. Homeowner Claims

From the universe of 377 homeowner claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The 3 violations noted were based on 3 files, resulting in an error ratio of 6%.

The following findings were made:

3 Violations Title 31, Pa. Code, Section 146.6

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

Company did not provide timely status letters for the 3 claims noted.

VIII. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy forms used in order to verify compliance with Insurance Company Law, Section 354 (40 P.S. §477b), Approval of Policies, Contracts, etc., Prohibiting the Use Thereof Unless Approved. During the experience period of the examination, Section 354 provided that it shall be unlawful for any insurance company to issue, sell, or dispose of any policy contract or certificate covering fire, marine, title and all forms of casualty insurance or use applications, riders, or endorsements in connection therewith, until the forms have been submitted to and formally approved by the Insurance Commissioner. All underwriting and claim files were also reviewed to verify compliance with Act 165 of 1994 [18 Pa. CS §4117(k)(1)] and Title 75, Pa. C.S. §1822, which requires all insurers to provide an insurance fraud notice on all applications for insurance, all claims forms and all renewals of coverage.

The following findings were made:

Automobile Rating – New Business With Surcharges

2 Violations Title 75, Pa. C.S. §1822

Warning notice on application for insurance and claim forms. Not later than May 1, 1990, all applications for insurance, renewals and claim forms shall contain a statement that clearly states in substance the following: "Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000." The Company did not provide the fraud warning on applications for insurance for 2 files.

IX. ADVERTISING

The Company was requested to provide copies of all advertising, sales material and internet advertisements in use during the experience period.

The purpose of this review was to determine compliance with Act 205, Section 5 [40 P.S. §1171.5], which defines unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, as well as Title 31, Pennsylvania Code, Section 51.2(c) and Section 51.61.

The Company provided 14 pieces of advertising which included brochures and pamphlets. Internet advertising was also reviewed. No violations were noted.

X. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of their consumer complaint logs for the preceding four years. The Company identified 12 consumer complaints received during the experience period and provided all consumer complaint logs requested. The 12 complaint files were requested, received and reviewed.

The purpose of the review was to determine compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5(a)(11) of the Act requires a Company to maintain a complete record of all complaints received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint.

The following findings were made:

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

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

premium when due or for any other reasons approved by the Commissioner. The Company nonrenewed the policy for an unacceptable loss history.

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

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

The following synopsis reflects the nature of the 12 complaints that were reviewed.

• 6	Cancellation/Nonrenewal	50%
• 4	Claims Related	33%
• 2	Premium Related	17%
<hr/>		<hr/>
12		100%

XI. LICENSING

In order to determine compliance by the Company and its agency force with the licensing requirements applicable to Section 641.1(a) [40 P.S. §310.41(a) and Section 671-A [40 P.S. §310.71] of the Insurance Department Act No. 147, the Company was requested to furnish a list of all active producers during the experience period and a listing of all producers terminated during the experience period. Underwriting files were checked to verify proper licensing and appointment.

The following findings were made:

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

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

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

Bruce K. Niles, Inc.

9 Violations Insurance Department Act, No. 147, Section 671-A

(40 P.S. §310.71)

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

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

(1) Delineates the services to be provided; and

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

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

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

(e) Appointment fee – An appointment fee of \$12.50 will be billed annually to the insurer for each producer appointed by the insurer during the preceding calendar year regardless of the length of time the producer held the appointment with the insurer. The appointment fee may be modified by regulation.

(f) Reporting – An insurer shall, upon request, certify to the Department the names of all licensees appointed by the insurer. The following producers were found to be writing policies but were not found in Insurance Department records as having an appointment. The Company failed to file a notice of appointment and submit appointment fees to the Department.

Lane McVicker, LLC
Frank Crystal & Co., Inc.
First National Insurance Agency, LLC
Haas & Wilkerson
Fonner Insurance Associates, Inc.
Commerce National Insurance
Hardenbergh Insurance Group, Inc.
Robert J. McAllister Agency, Inc.
Iroquois Services Corp.

XII. RECOMMENDATIONS

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

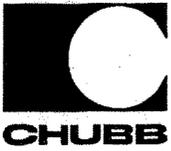
1. The Company must review and revise internal control procedures to ensure compliance with cancellation notice requirements of Act 68, Section 2003 [40 P.S. §991.2003], so that the violations noted in the Report do not occur in the future.
2. The Company must review Act 205, Section 5(a)(9) [40 P.S. §1171.5(a)(9)] to ensure compliance with nonrenewal notice requirements so that the violations noted in the Report do not occur in the future.
3. The Company must review Act 86, Section 1 [40 P.S. §3401], to ensure that violations regarding notification to the insured of an increase in premium do not occur in the future.
4. The Company must review Act 246, Section 4 [40 P.S. §1184] and take appropriate measures to ensure the rating violation noted in the Report does not occur in the future.
5. The premium overcharge noted in the rating section of this report must be refunded to the insured and proof of such refund must be provided to the Insurance Department within 30 days of the Report issue date.

6. The Company should review and revise internal control procedures to ensure compliance with the claims handling requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices so that the violations relating to status letters and denials, as noted in the Report, do not occur in the future.
7. The Company must review Title 31, Pa. Code, Section 69.52(b) with its claim staff to ensure that first party medical bills are paid within 30 days. Those claims that have not been paid within 30 days shall bear interest at the rate of 12% annum from the date the benefits become due as required by Title 75, Pa. C.S. §1716. The interest amount must be paid to the claimant and proof of such payment must be provided to the Insurance Department within 30 days of the Report issue date.
8. The Company must review Title 75, Pa. C.S. §1161(a)&(b) with its claim staff to ensure that salvage certificates are obtained and are retained with the claim file.
9. The Company must review Title 31, Pennsylvania Code, Sections 62.3(e)(3) and 62.3(e)(7) regarding total loss evaluations as noted in the Report do not occur in the future.
10. The Company must ensure that all applications contain a statement that clearly states in substance the following: “Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing false, incomplete information or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.” This is to ensure

that violations noted under Title 75, Pa. C.S. §1822 do not occur in the future.

11. The Company must ensure all producers are properly licensed and appointed, as required by Section 641.1(a) and Section 671-A [40 P.S. §310.41(a) and 40 P.S. §310.71] of the Insurance Department Act No. 147, prior to accepting any business from any producer.
12. The Company must revise and reissue their underwriting guidelines for use in Pennsylvania to ensure that the guidelines do not exclude applicants from being eligible to obtain insurance based on age, occupation and place of residence.
13. The Company must review Act 205, Section 5(a)(4) [40 P.S. §1171.5(a)(4)] to ensure that the violations relative to supporting coverage noted in the Report does not occur in the future and remove such requirements from all underwriting guidelines.

XIII. COMPANY RESPONSE



CHUBB GROUP OF INSURANCE COMPANIES

15 Mountain View Road, P.O. Box 1615, Warren, NJ 07061-1615

July 11, 2006
VIA DHL

Mr. Chester A. Derk Jr., AIE, HIA
Market Conduct Division Chief
Commonwealth of Pennsylvania Insurance Department
Bureau of Enforcement / Market Conduct Division
1321 Strawberry Square
Harrisburg, PA 17120

**Re: Examination Warrant Number: 05-M17-063
Chubb Indemnity Company**

Dear Mr. Derk:

We have received and reviewed the Report of Examination dated June 12, 2006. This response will address the 13 recommendations found on pages 39 - 41 of the Report.

RECOMMENDATION #1

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

INSURANCE DEPARTMENT CRITICISM:

The Company canceled one (1) policy based on one accident, and one (1) policy due to a comprehensive claim.

COMPANY RESPONSE:

The Company will send a directive during the week of July 17, 2006 to all our underwriters who handle Pennsylvania private passenger automobile business, indicating that they cannot decline, cancel, or non-renew a policy because of comprehensive claims or because the insured had just one chargeable accident in the preceding 36 months. Furthermore, we will instruct our field underwriting managers to look for any instances where underwriters have failed comply with Pennsylvania's cancellations and nonrenewal regulations when they conduct their routine underwriting audits.

RECOMMENDATION #2

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

INSURANCE DEPARTMENT CRITICISM:

The Company was criticized for not notifying the insured of the required corrections or recommendations on six (6) policies.

COMPANY RESPONSE:

To address this, the Company will send a directive during the week of July 17, 2006 to all our underwriters who handle Pennsylvania business that, if they intend to make mandatory recommendations and the insured's failure to comply could result in cancellation of the policy, they must notify the insured directly of the recommendations and the potential consequence of not complying. In addition, by the end of the 3rd quarter 2006, the Company will update our electronic library of cancellation and nonrenewal regulations, GCCANCL, to reflect that in Pennsylvania the Company must advise the insured directly about mandatory recommendations and that failure to do so would result in an invalid cancellation or nonrenewal.

RECOMMENDATION #3

The Company must review Act 86, Section 1 [40 P.S. §3401] to ensure that violations regarding notification to the insured of an increase in premium do not occur in the future.

INSURANCE DEPARTMENT CRITICISM:

The Company did not provide at least 30 days advance notice to the named insured of an increase in renewal premium for 4 commercial workers' compensation policies noted.

COMPANY RESPONSE:

On June 14, 2006 the Company issued a directive to commercial lines' field staff, which clarified and re-emphasized the requirements for 30 days advance notice to the named insured in Pennsylvania of an increase in renewal premium. Additionally, commercial lines' compliance training program will be updated by September 30, 2006 to include this topic, which should assist in our compliance efforts.

RECOMMENDATION #4:

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

INSURANCE DEPARTMENT CRITICISM:

The Company failed to grant an insured the valuable articles credit in accordance with the Company's rate filing, which resulted in an overcharge of \$215.

COMPANY RESPONSE:

Effective September 19, 2005, the Company's Masterpiece System was programmed to automatically provide the credit for valuable articles coverage when the coverage is added mid-term. Prior to that date, the credit had to be applied manually for all such first time mid-term additions of VAC. Automating the process should eliminate such errors in the future.

RECOMMENDATION #5:

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

INSURANCE DEPARTMENT CRITICISM:

The Company failed to grant an insured the valuable articles credit in accordance with the Company's rate filing, which resulted in an overcharge of \$215.

COMPANY RESPONSE:

Proof that the overcharge of \$215 was returned to the insured was sent to the Insurance Department on April 26, 2006. This consisted of a copy of the letter the agent sent the insured explaining the error and evidence that the credit of \$215 was applied to the policy.

RECOMMENDATION #6

The company should review and revise internal control procedures to ensure compliance with the claims handling requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices so that the violations relating to status letters and denials, as noted in the Report, do not occur in the future.

INSURANCE DEPARTMENT CRITICISM:

The Company was cited for:

- eleven (11) violations because it did not provide a timely status letter for the claims noted;
- one (1) violation because it dialed to deny the claim in writing and have a copy of the denial in the file.

COMPANY RESPONSE:

The Company will send a directive by August 15, 2006 to all staff handling Pennsylvania losses regarding the specific requirement of the Pennsylvania Unfair Claims Settlement Practices Act. An automatic electronic reminder has been implemented in the system to remind the adjuster of Pennsylvania requirements. Compliance will be monitored through random mini-audits by claim supervisors, field management and through audits coordinated by the Home Office Claim Audit Manager.

RECOMMENDATION #7

The Company must review Title 31, PA Code, Section 69.52(b) with its claim staff to ensure that first party medical bills are paid within 30 days. Those claims that have not been paid within 30 days shall bear interest at the rate of 12% annum from the date the benefits became due as required by Title 75, Pa. C.S. §1716. The interest amount must be paid to the claimant and proof of such payment must be provided to the Insurance Department within 30 days of the Report issue date.

INSURANCE DEPARTMENT CRITICISM:

The Company was cited for:

- not paying a medical bill within 30 days on one (1) policy;
- not paying interest on a claim that wasn't paid within 30 days on that same policy.

COMPANY RESPONSE:

Interest has been paid on the medical bill that was not paid within 30 days, and proof of payment was provided to the Insurance Department on April 26, 2006. The Company will send a directive by August 15, 2006 to all staff handling Pennsylvania losses regarding the timeliness of medical payments. Compliance will be monitored through random mini-audits conducted by claim supervisors, field management and through audits coordinated by the Home Office Claim Audit Manager.

RECOMMENDATION #8

The Company must review Title 75, Pa. C.S. §1161(a)&(b) with its claim staff to ensure that salvage certificates are obtained and are retained with the claim file.

INSURANCE DEPARTMENT CRITICISM:

The Company was cited for not obtaining a salvage title on three (3) files.

COMPANY RESPONSE:

The Company will ensure that salvage certificates are obtained on all total loss vehicles and retained in the claim file, and that Pennsylvania salvage certificates are obtained on all vehicles located or registered in Pennsylvania. Additionally, an electronic automatic reminder will be implemented in the Claim system to remind the adjusters of Pennsylvania requirements. Compliance will be monitored through random mini-audits conducted by claim supervisors, field management and through audits coordinated by the Home Office Claim Audit Manager.

RECOMMENDATION #9

The Company must review Title 31, Pennsylvania Code, Sections 62.3(e)(3) and 62.3(e)(7) regarding total loss evaluations, as noted in the Report, to ensure the violations do not occur in the future.

INSURANCE DEPARTMENT CRITICISM:

The Company was criticized for:

- using only one source guide in determining valuation for the three (3) files listed;
- not providing a copy of the total loss evaluation to the insured for one hundred thirty two (132) claims noted.

COMPANY RESPONSE:

A directive will be sent by August 15, 2006 to all staff handling Pennsylvania total losses regarding the specific requirement of the Pennsylvania Unfair Claims Settlement Practices Act to utilize more than one source guide in determining valuation, and to provide total loss evaluations. An electronic automatic reminder will be implemented in the Claim system to remind the adjuster of Pennsylvania requirements. Compliance will be monitored through random mini-audits conducted by claim supervisors, field management and through audits coordinated by the Home Office Claim Audit Manager.

RECOMMENDATION #10

The Company must ensure that all applications contain a statement that clearly states in substance the following: "Any person who knowingly and with intent to injure or

defraud an insurer files an application or claim containing false, incomplete information or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.” This is to ensure that violation noted under Title 75, Pa. C.S. §1822 do not occur in the future.

INSURANCE DEPARTMENT CRITICISM:

The Company did not provide the fraud warning on applications for insurance for two (2) files.

COMPANY RESPONSE:

The Company is in the process of amending our Fraud Warning wording to reflect the exact wording as it appears in the regulation in conjunction with our next Pennsylvania Vehicle Supplemental form change. These changes are expected to be completed by August 1, 2006. The updated form will then be sent to the Pennsylvania Insurance Department Market Conduct Division Chief, Mr. Chet Derk, for his review. Once we receive his feedback, we will file the changes. After the filing is approved we will change our Fraud Warning to comply with the statement under Title 75 Pa. C.S. §1822.

RECOMMENDATION #11:

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

INSURANCE DEPARTMENT CRITICISM:

The Company was cited for:

- One (1) violation because the producer was found to be writing and / or soliciting policies but was not found in the Insurance Departments records as holding a Pennsylvania producer license;
- Nine (9) violations because the producers were found to be writing policies but the Company failed to file an appointment and submit the appointment fee to the department.

COMPANY RESPONSE:

The Company has taken the following actions to ensure all producers are properly licensed and appointed:

- *For the 5 violations noted where producers were not properly licensed in Pennsylvania, our Agency Services Department has contacted each of these producers and instructed them to obtain a Pennsylvania license immediately.*
- *For the 9 violations where properly licensed producers did not hold the correct appointments for the Chubb Indemnity Company, appointments have been filed with the state.*

To ensure that every producer writing business in Chubb Indemnity Company is properly appointed, a monthly report is generated which identifies any producers not appointed and is sent to the responsible branch office. This report is also sent to producers on a quarterly basis.

To improve compliance with license and appointment requirements for our commercial lines systems, we will supplement current procedures with a manual workflow to ensure that producer licensing and appointments are reviewed. This new workflow will be distributed to all US field staff via a communication to be published on August 2, 2006, with an implementation date of September 1, 2006. This manual workflow will remain in place until such time it is replaced with an enhanced automated process that edits for all producer licensing and appointment requirements.

To improve compliance with these requirements for our personal lines system, in May 2006 we implemented an automated process to verify that producers are properly licensed and appointed. Our personal lines policy issuance system (Masterpiece) now automatically checks a data base of license and appointment information (PALIS) maintained by the Company's Agency Services Department. If licensing and / or appointment information is not found in PALIS, then policy issuance is blocked. A System Error message is generated advising that the Agency Services Department must be contacted to set up a license and / or appointment. Once this is done, PALIS is updated which enables Masterpiece to issue the policy for the producer.

RECOMMENDATION #12

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

INSURANCE DEPARTMENT CRITICISM:

The Company was criticized because the underwriting guidelines referred to age, occupation and place of residence as the basis for imposing additional underwriting standards and practices.

COMPANY RESPONSE:

With regard to the agents' binding restriction for "An operator over 68 years or licensed less than 3 years," we signed a Consent Order in conjunction with the Pennsylvania Insurance Department's examination of Great Northern conducted in July 2005 stating that we would remove this binding restriction. This change was implemented effective May 29, 2006.

On May 15, 2006, we had a conversation with Chet Derk, the Pennsylvania Market Conduct Division Chief, and he agreed that Chubb's binding guideline for agents, which restricts the binding coverage for "individuals who receive considerable publicity," does not discriminate based on occupation. However, he cautioned us to make sure that this not be used as a pretext for discriminating based on occupation. To address this, we will send out a directive during the week of July 17, 2006 to our field underwriter, reiterating our position that Chubb does not discriminate with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status. We will also emphasize that we cannot decline to write a risk simply because the nature of a prospective insured's occupation (sports figure, entertainer, politician, TV personality, etc.) thrusts him or her into the public eye.

The Company is in the process of revising our agents' binding guideline for "property that is located out of your local area" to read "residence located outside the producer's

geographic marketing area, due to lack of familiarity with hazards (i.e. earthquake, wildfire, distance to coast, etc.) or unique state rating and/or regulatory requirements." This will be included with the next filing submitted to the Insurance Department for approval (which will be for the revisions to the Pennsylvania Vehicle Supplemental form). We believe this change will clarify why we ask agents to contact us prior to binding coverage for risks located outside of their geographic marketing area. Risks located in areas that agents are unfamiliar with may have serious catastrophe management concerns. In addition, the agents are unlikely to be familiar the writing companies used in other states or the eligibility requirements for them. During our Exit Conference call on May 15, 2006, Chet Derk agreed to this revision.

RECOMMENDATION #13

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

INSURANCE DEPARTMENT CRITICISM:

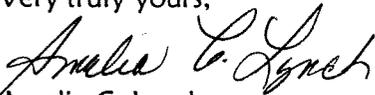
The Company was cited because underwriting guidelines for homes and contents required supporting coverage, which is prohibited.

COMPANY RESPONSE:

The Company has removed the agents' binding restriction that reads "Seasonal, secondary, or tenant occupied residences, unless we insure the owner's primary residence" from our agents' binding guidelines effective May 29, 2006.

We appreciate the professionalism and efficiency of your staff during the examination and the continued cooperation and assistance with respect to our specific issues / questions in resolving this examination. Should you require additional information or have any questions, please let me know.

Very truly yours,



Amelia C. Lynch
Senior Vice President and Insurance Compliance Officer

Cc: D. Fiorot
M. Dayter
M. Leahy
R. Vreeland
E. Lehmer
A. Rocco
K. Bridgman
A. Ball