REPORT OF
MARKET CONDUCT EXAMINATION
OF

FIRST KEYSTONE RISK RETENTION GROUP, INC.

Johns Island, South Carolina

AS OF
January 27, 2009

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: March 9, 2009

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).

James R. Myers, Examiner-In-Charge

Sworn to and Subscribed Before me

This 22 Day of January, 2009

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
THERESA M. SENECA, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires Aug. 15, 2010

FIRST KEYSTONE RISK RETENTION GROUP, INC.

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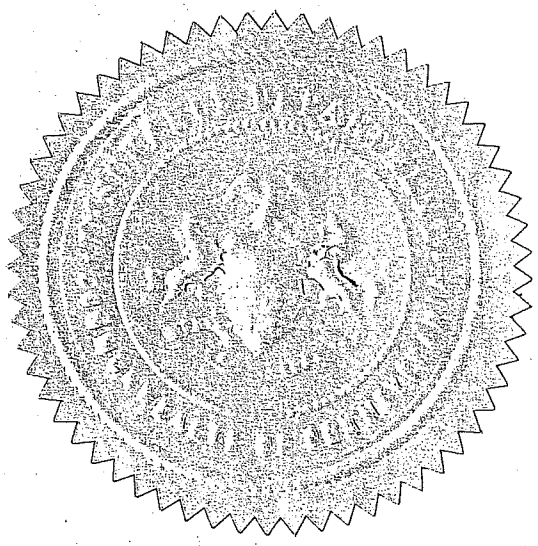
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22nd day of July, 2008, 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 Ronald A. Gallagher, 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.



Joel S. Ario
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
FIRST KEYSTONE RISK RETENTION GROUP, INC. 4421 Aramingo Avenue Philadelphia, PA 19124	:	Section 903(a) of the Insurance Department Act, Act of May 17, 1921, P.L. 789, No. 285 (40 P.S. §323.3)
	:	Act 1990-6, Sections 1701, et seq., 1711(b), 1716, and 1797(b)(1), (2) & (5) (Title 75, Pa.C.S. §§ 1701, et seq., 1711, 1716 and 1797)
	:	Sections 4, 5(a)(7)(iii) and 5(a)(10)(v)(vi) of the Unfair Insurance Practices Act, Act of July 22, 1974, P.L. 589, No. 205 (40 P.S. §§ 1171.4 and 1171.5)
	:	Sections 3(a)(2), 3(a)(3), 3(a)(3)(i) & (ii), 3(a)(4), 3(a)(5), 3(a)(6) and 4(b) of the Act of July 3, 1986, P.L. 396, No. 86 (40 P.S. §§ 3403 and 3404)
	:	Section 246 of the Act of June 11, 1947, P.L. 538, No. 246 (40 P.S. § 1184)
	:	Title 31, Pennsylvania Code, Sections 62.3, 62.4, 69.22(c), 69.52(1), 69.52(a), 69.52(b), 69.52(e), 146.3, 146.5(a), 146.5(b), 146.5(d), 146.6 and 146.7(a)(1)
	:	Title 52, Pennsylvania Code, Section 32.11(b)
	:	63 Purdons Statutes, Section 861(d)
Respondent.	:	Docket No. MC09-02-002

CONSENT ORDER

AND NOW, this 9th day of March, 2009, 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 First Keystone Risk Retention Group, and maintains its address at 4421 Aramingo Avenue, Philadelphia, Pennsylvania 19124.

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

Department covering the period from January 1, 2006 through December 31, 2007.

(c) On January 7, 2009, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on February 25, 2009, accepting the results of the Report and representing it has modified its compliance systems and practices to ensure future compliance.

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

(i) Section 903(a) of the Insurance Department Act, No. 285 (40 P.S. § 323.3), which requires every company subject to examination keep all records and documents relating to its business in such manner as may be required in order that the Department may verify whether the company has complied with the laws of this Commonwealth;

(ii) Title 75, Pennsylvania Consolidated Statutes, Section 1701, et seq., which states the ability to respond in damages for liability on account of accidents arising out of the maintenance or use of a motor vehicle in the amount of $15,000 because of injury to one person in any one accident, in the amount of $30,000 because of injury to two or more persons in any one accident, and in

the amount of $5,000 because of damage to property of others in any one accident. The financial responsibility shall be in a form acceptable to the Department of Transportation;

(iii) Title 75, Pennsylvania Consolidated Statutes, Section 1711(b), which states all insurers subject to this chapter shall make available for purchase a motor vehicle insurance policy which contains only the minimum requirements of financial responsibility and medical benefits as provided for in this chapter;

(iv) Title 75, Pennsylvania Consolidated Statutes, Section 1716, states that benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of benefits. If reasonable proof is not supplied as to all benefits, the portion supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Overdue benefits shall bear interest at the rate of 12% per annum from the date the benefits become due. In the event the insurer is found to have acted in an unreasonable manner in refusing to pay the benefits when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended;

(v) Section 1797(b)(1) of Act 1990-6, Title 75, Pa.C.S. § 1797, which requires insurers to contract jointly or separately with any peer review organization established for the purpose of evaluating treatment, health care services,

(vi) Sections 1797(b)(2) and (5) of Act 1990-6, Title 75, Pa.C.S. § 1797, states that an insurer, provider or insured may request reconsideration by the PRO of the PRO's initial determination. Such a request for reconsideration must be made within 30 days of the PRO's initial determination. If a PRO determines that medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12% per year on any amount withheld by the insurer pending PRO review;

(vii) Section 4 of Act 205 (40 P.S. § 1171.4), which prohibits any person to engage in this state in any trade practice which is defined or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance pursuant to this act;

(viii) 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;

(ix) Section 5(a)(10)(v)(vi) of Act 205 (40 P.S. § 1171.5), which states any of the following acts, if committed with such frequency as to indicate a business practice, shall constitute unfair claim settlement or compromise practices: Failure to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative; Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear;

(x) Section 3(a)(2) of Act 86 (40 P.S. § 3403), which requires that a nonrenewal notice be forwarded directly to the named insured or insureds at least 60 days in advance of the effective date of termination;

(xi) Section 3(a)(3) of Act 86 (40 P.S. § 3403), which requires that a cancellation notice must be forwarded to the named insured or insureds at least 60 days in advance of the effective date of termination;

(xii) Section 3(a)(3)(i) of Act 86 (40 P.S. § 3403), which states written notice of cancellation in the manner prescribed in this section must be forwarded directly to the named insured or insureds at least 60 days in advance of the effective date of termination unless the insured has made a material misrepresentation which affects the insurability of the risk, in which case the prescribed written notice of cancellation shall be forwarded directly to the

named insured at least 15 days in advance of the effective date of termination;

(xiii) Section 3(a)(3)(ii) of Act 86 (40 P.S. § 3403), which requires that a midterm cancellation notice shall be forwarded directly to the named insured or insureds at least 60 days in advance of the effective date of termination unless one or more of the following exist: The insured has failed to pay a premium when due, whether the premium is payable directly to the company or its agents or indirectly under a premium finance plan or extension of credit, in which case, the prescribed written notice of cancellation shall be forwarded directly to the named insured at least 15 days in advance of the effective date of termination;

(xiv) Section 3(a)(4) of Act 86 (40 P.S. § 3403), requires notices of midterm cancellation and nonrenewal shall be clearly labeled "Notice of Cancellation" or "Notice of Nonrenewal";

(xv) Section 3(a)(5) of Act 86 (40 P.S. § 3403), which requires that a nonrenewal notice shall state the specific reasons for nonrenewal identifying the condition, factor or loss experience which caused the nonrenewal. The notice shall provide sufficient information or data for the insured to correct the deficiency;

(xvi) Section 3(a)(6) of Act 86 (40 P.S. § 3403), which requires notices of mid-term cancellation and nonrenewal to meet the following requirements: A mid-term cancellation or nonrenewal notice shall state that, at the insured's request, the insurer shall provide loss information to the insured for at least three years or the period of time during which the insurer has provided coverage to the insured, whichever is less;

(xvii) Section 4(b) of Act 86 (40 P.S. § 3404), which requires that unearned premium be returned to the insured not later than 30 days after the effective date of termination where commercial property or casualty risks are cancelled in mid-term by the insured;

(xviii) Title 31, Pennsylvania Code, Sections 62.3 and 62.4, Applicable Standards For Appraisal, which requires: (3) A statement that there is no requirement to use any specific repair shop; and (4) A statement informing the consumer that information regarding repair facilities which will be able to repair the vehicle for the appraised amount is available from the insurer. If the consumer receives information from the insurer, the information shall include disclosure that there is no requirement to use any specific repair shop;

(xix) Title 31, Pennsylvania Code, Section 69.22(c), which 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;

(xx) Title 31, Pennsylvania Code, Section 69.52(1), which states a PRO shall complete a reconsideration within 30 days after receipt of the information submitted under subsection (k). If additional information critical for the outcome of the determination is submitted by a provider or requested by a PRO, the 30-day review period may be tolled up to 20 days for the information to be received and taken into consideration. A PRO shall send written notification of the reconsideration determination to the insurer, which shall within 5 days of receipt provide copies to providers and insureds. The written notice shall contain the basis and rationale for the reconsideration determination;

(xxi) 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 fro PRO review at the time of referral;

(xxii) 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;

(xxiii) Title 31, Pennsylvania Code, Section 69.52(e), which 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;

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

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

(xxvi) Title 31, Pennsylvania Code, Section 146.5(b), which states every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry;

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

(xxviii) 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;

(xxix) 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;

(xxx) Title 52, Pennsylvania Code, Section 32.11(b), which states the liability insurance maintained by a common or contract carrier of passengers on each motor vehicle capable of transporting fewer than 16 passengers shall be in an amount not less than $35,000 to cover liability for bodily injury, death or property damage incurred in an accident arising from authorized service. The $35,000 minimum coverage is split coverage in the amounts of $15,000 bodily injury per person, $30,000 bodily injury per accident and $5,000 property damage per accident. This coverage shall include first party medical benefits in the amount of $25,000 and first party wage loss benefits in the amount of $10,000 for passengers and pedestrians. Except as to the required amount of coverage, these benefits shall conform to 75 Pa.C.S. §§1701 – 1799.7. First party coverage of the driver of certified vehicles shall meet the requirements of 75 Pa.C.S. §1711.

(xxxi) 63 Purdons Statutes, Section 861(d) Motor Vehicle Damage Appraisers. No appraiser or his employer shall require that repairs be made in any specified repair shop.

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 Sections 4 and 5 of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 1171.4 and 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.

(c) In addition to any penalties imposed by the Department for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Department 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).

(d) Respondent's violations of Sections 3 and 4 of Act 86 (40 P.S. §§ 3403 and 3404), 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.

(e) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.5, 146.6 and 146.7 are punishable under Sections 9, 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9, 1171.10 and 1171.11), as stated above.

(g) Respondent's violations of 63 Purdons Statutes, Section 861(d) are punishable under 63 Purdons Statutes, Section 859, which states that any person who violates any of the provisions of this Act is guilty of a misdemeanor and upon conviction thereof, for each offense, shall be sentenced to pay a fine not exceeding five hundred dollars ($500), or to undergo imprisonment not exceeding one year, or both.

ORDER

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

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

(b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

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

(d) Respondent shall pay Forty Thousand Dollars ($40,000.00) 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. Fraser, Bureau of

Market Conduct, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

(f) After a period of 12 months from the date of this Order, Respondent shall be re-examined to verify corrective actions have been implemented.

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 it may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event there has been a breach of any of the provisions of this Order, the 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: FIRST KEYSTONE RISK RETENTION GROUP, INC., Respondent

Joseph Schmidt

President / Vice President

YURI ZALEMAN

~~Secretary / Treasurer~~ VICE PRESIDENT

Ronald A. Gallagher, Jr.

COMMONWEALTH OF PENNSYLVANIA
By: Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The market conduct examination was conducted at First Keystone Risk Retention Group, Inc.'s office located in Philadelphia, Pennsylvania, from October 27, 2008, through November 17, 2008. 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

James R. Myers
Market Conduct Examiner

June A. Coleman
Market Conduct Examiner

John J. McGinty
Market Conduct Examiner

Constance Arnold
Market Conduct Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on First Keystone Risk Retention Group, Inc., hereinafter referred to as "Company," at their office located in Philadelphia, Pennsylvania. The examination was conducted pursuant to Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2006, through December 31, 2007, 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. Commercial Automobile
   - Underwriting – Appropriate and timely notices of nonrenewal and midterm cancellations.
   - Rating – Proper use of all classification and rating plans and procedures.
2. Claims
3. Forms
4. Complaints
5. Licensing

III. COMPANY HISTORY AND LICENSING

First Keystone Risk Retention Group, Inc. was formed and authorized on September 24, 2003, by the South Carolina Department of Insurance to provide commercial automobile liability coverage to taxis and limousines in the Commonwealth of Pennsylvania.

In 2004, the Company's request to expand coverage into the state of New Jersey was submitted and approved by the South Carolina Department of Insurance. A revised business plan was submitted in the 1st quarter of 2006, to expand coverage territories in Pennsylvania and New Jersey to offer coverage in the states of Delaware and Maryland. On May 16, 2006, the South Carolina Department of Insurance approved and granted the Company an expanded coverage area along with expanded coverage options.

On December 21, 2006, the Company was approved by the South Carolina Department of Insurance to commence business in Massachusetts, Virginia, North Carolina, Georgia and South Carolina.

LICENSING

First Keystone Risk Retention Group, Inc.'s Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2008. The Company is registered to do business in Delaware, Georgia, Maryland, Massachusetts, New Jersey, North Carolina, Pennsylvania, South Carolina and Virginia. The Company's 2007 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $3,950,790. Premium volume related to the area of this review was: Other Commercial Automobile Liability $3,950,790.

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. Agency bulletins and underwriting guides were furnished for commercial automobile. The purpose of this review was to identify any inconsistencies which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature.

No violations were noted.

V. UNDERWRITING

A. Commercial Automobile

1. Midterm Cancellations

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

The purpose of the review was to determine compliance with Act 86, Section 2 (40 P.S. §3402), which prohibits cancellation except for specified reasons and Section 3 (40 P.S. §3403), which establishes the requirements, which must be met regarding the form and condition of the cancellation notice.

From the universe of 71 commercial automobile policies cancelled midterm during the experience period, 35 files were selected for review. All 35 files were received and reviewed. The 73 violations noted were based on the universe of 71 files, resulting in an error ratio of 100%.

The following findings were made:

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

Requires every company subject to examination to keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its business in such manner and for such time as may be required in order that the Department may readily verify whether the Company has complied with the laws of this Commonwealth. The 71 files were incomplete. There was no documentation in the file to indicate notification or the reason for the midterm

cancellation.

2 Violations *Act 86, Section 4(b) [40 P.S. §3404(b)]*

Requires that unearned premium be returned to the insured not later than 30 days after the effective date of termination where commercial property or casualty risks are cancelled in mid-term by the insured. The Company did not return the unearned premium to the insured within 30 days after the effective date of termination.

2. 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 review was conducted to determine compliance with Act 86, Section 3 (40 P.S. §3403), which establishes the requirements that must be met regarding the form and condition of the nonrenewal notice.

From the universe of 149 commercial automobile policies nonrenewed during the experience period, 50 files were selected for review. All 50 files were received and reviewed. The 149 violations noted were based on the universe of 149 files, resulting in an error ratio of 100%.

The following findings were made:

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

Requires every company subject to examination to keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its business in such

manner and for such time as may be required in order that the Department may readily verify whether the Company has complied with the laws of this Commonwealth. The 149 files were incomplete. There was no documentation in the file to indicate notification or the reason for nonrenewal.

VI. RATING

A. Commercial Automobile

1. New Business

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

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

From the universe of 89 commercial automobile policies written as new business without surcharges during the experience period, 40 files were selected for review. All 40 files 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. Commercial Automobile Property Damage Claims
B. Commercial Automobile First Party Medical Claims
C. Commercial Automobile First Party Medical Claims Referred to a PRO

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. Commercial Automobile Property Damage Claims

From the universe of 579 first party medical claims reported during the experience period, 75 files were selected for review. All 75 files were received and reviewed. The 46 violations noted were based on 25 files, resulting in an error ratio of 33%.

The following findings were made:

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

The claim files of an insurer shall be subject to examination by the Commissioner or by duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The Company failed to maintain the file. The file was incomplete when presented for review.

14 Violations *Title 31, Pa. Code, Section 146.5(a)*

Every insurer, upon receiving notification of a claim, shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company did not acknowledge the 14 claims within 10 working days.

20 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 a timely status letter for the 20 claims noted.

11 Violations Act 205, Section 4 [40 P.S. §1171.4]

Unfair methods of competition and unfair or deceptive acts or practices prohibited. No person shall engage in this state in any trade practice which is defined or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance pursuant to this act.

AND

Act 205, Section 5(a)(10)(v)(vi) [40 P.S. §1171.5(a)(10)(v)(vi)]
Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failure to affirm and deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the Company or it's representative; Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to promptly settle the 11 claims after poof of loss had been presented or to affirm or deny the coverage.

B. Commercial Automobile First Party Medical Claims

From the universe of 134 commercial automobile first party medical claims reported during the experience period, 50 claim files were selected for review. All 50 files were received and reviewed. The 25 files noted were based on 10 files, resulting in an error ratio of 20%.

The following findings were made:

4 Violations *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 failed to pay bills within 30 days for the 4 claim files noted.

4 Violations *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 4 claims that were not paid within 30 days.

6 Violations *Title 31, Pa. Code, Section 146.5(a)*

Every insurer, upon receiving notification of a claim, shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given

to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company did not acknowledge the 6 claims noted within 10 working days.

7 Violations *Title 31, Pa. Code, Section 146.5(d)*

Requires an insurer, upon receiving notification of a claim, shall provide within ten working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable requirements of the insurer. The Company did not provide the application for benefits form to the claimant within ten working days for the 7 files noted.

4 Violations *Title 31, Pa. Code, Section 146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the 4 claims noted.

C. Commercial Automobile First Party Medical Claims Referred to a PRO

The universe of 38 commercial automobile first party medical claims referred to a peer review organization was selected for review. All 38 files were received and reviewed. The Company was also asked to provide a copy of all peer review contracts in place during the experience period.

One contract was received and reviewed. The 58 violations noted were based on 23 files, resulting in an error ratio of 61%.

The following findings were made:

3 Violations *Title 31, Pa. Code, Section 69.22(c)*

Requires the insurer when an insured's first-party limits have been exhausted, to provide notice to the provider and the insured within 30 days of the receipt of the provider's bill. The Company failed to provide notice to the provider and insured that the first-party limits were exhausted.

2 Violations *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 Company failed to provide written notice to the provider at the time of referral when it had referred bills to a PRO.

10 Violations *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 failed to pay medical bills within 30 days.

10 Violations 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.

AND

Title 75, Pa. C.S. §1797(b)(1)

Peer review plan for challenges to reasonableness and necessity of treatment. Peer review plan. Insurers shall contract jointly or separately with any peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person. Such evaluation shall be for the purpose of confirming that such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary. An insurer's challenge must be made to a PRO within 90 days of the insurer's receipt of the provider's bill for treatment or services or may be made at any time for continuing treatment or services. The Company failed to submit bill for services to a PRO within 90 days of the insurer's receipt of the bill.

3 Violations Title 31, Pa. Code, Section 69.52(e)

Requires an insurer to provide copies of the Peer Review Organization's written analysis to the provider and the insured within 5 days of receipt. The Company failed to provide a copy of the PRO written analysis to the insured for 1 claim file and failed to provide a copy of the PRO written

analysis to the provider and insured within 5 days of receipt for the remaining 2 claim files.

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

A PRO shall complete a reconsideration within 30 days after receipt of the information submitted under subsection (k). If additional information critical for the outcome of the determination is submitted by a provider or requested by a PRO, the 30-day review period may be tolled up to 20 days for the information to be received and taken into consideration. A PRO shall send written notification of the reconsideration determination to the insurer, which shall within 5 days of receipt provide copies to providers and insureds. The written notice shall contain the basis and rationale for the reconsideration determination. The Company failed to provide a copy of the PRO reconsideration determination to the insured.

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

The claim files of an insurer shall be subject to examination by the Commissioner or by duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The Company failed to maintain claim files. One file presented was incomplete. Two claim files failed to provide date stamps on documents and the events could not be reconstructed. The remaining 4 claim files did not include the proper dates on letters and compliance could not be determined.

8 Violations *Title 31, Pa. Code, Section 146.5(d)*

Requires an insurer, upon receiving notification of a claim, shall provide within ten working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable requirements of the insurer. The Company did not provide the necessary claim forms to the claimant within ten working days for the 8 files noted.

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

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

12 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 12

claims noted.

2 Violations *Title 31, Pa. Code, Section 146.7(a)(1)*

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide a written denial to the claimant for the 2 claim files noted.

5 Violations *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 5 claims that were not paid within 30 days prior to submitting to a PRO.

3 Violations *Title 75, Pa. C.S. §1797(b)(2) & (5)*

PRO reconsideration. An insurer, provider or insured may request reconsideration by the PRO of the PRO's initial determination. Such a request for reconsideration must be made within 30 days of the PRO's initial determination. If a

PRO determines that medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12% per year on any amount withheld by the insurer pending PRO review. The Company failed to pay interest on a PRO first party medical bill when the bills were not paid within 30 days.

The following concerns were noted:

Concern: During the examination of the claim files, it was often difficult to ascertain when the medical bills and other documents were received. Sometimes there would be a date stamp on the first page of several bills that were received. Other times there was just an envelope stapled to the stack of bills or a letter. The Company should make certain that all medical bills received are properly date stamped.

Concern: During the examination of the claim files, it was noted that the post mark stamping on envelopes were cut off from the envelopes. The Company should ensure that the envelopes remain intact.

Concern: During the examination of the claim files, it was noted that handwritten corrections were made on the repricing of medical invoices. The Company should obtain correct repricing information before issuing the Explanation of Benefits.

VIII. FORMS

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

The following findings were made:

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

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined. "Unfair Methods of Competition" and "Unfair or Deceptive Practices" in the business of insurance means: Unfairly discriminating by means of: Making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethic group, age, sex, family size, occupation, place of residence or marital status. The terms "underwriting standards and practices" or "eligibility rules" do not include the promulgation of rates if made or promulgated in accordance with the appropriate rate regulatory act

of this Commonwealth and regulations promulgated by the Commissioner pursuant to such act. The Driver Endorsement Surcharge Fee-Schedule Policy of the Commercial Lines Policy states: "Policy Age Restrictions: No coverage will be available for drivers under the age of 23 or over the age of 75."

2 Violations *Act 86, Section 3(a)(2) [40 P.S. §3403(a)(2)]*

Requires that a nonrenewal notice be forwarded directly to the named insured or insureds at least 60 days in advance of the effective date of the termination. The Company's notice of cancellation form failed to provide 60 days notice of nonrenewal. The 2 incorrect forms were the Notice of Cancellation Form and The Business Auto Coverage Form in the commercial lines policy under Section VII which states: "If we decide not to renew or continue this policy we will mail or deliver to you written notice at least 30 days before the end of the policy period.

2 Violations *Act 86, Section 3(a)(3) [40 P.S. §3403(a)(3)]*

Requires that a cancellation notice must be forwarded to the named insured or insureds at least 60 days in advance of the effective date of termination. The Company failed to provide 60 days notice of cancellation. The 2 incorrect forms were the Notice of Cancellation Form and The Business Auto Coverage Form in the commercial lines policy under Section VII which states: "A. Cancellation of Liability Policy, 2. b. 30 days before the effective date of cancellation if we cancel for any other reason."

2 Violations *Act 86, Section 3(a)(3)(i) [40 P.S. §3403(a)(3)(i)]*

Written notice of cancellation in the manner prescribed in this section must be forwarded directly to the named insured or insureds at least 60 days in advance of the effective date of termination unless the insured has made a material misrepresentation which affects the insurability of the risk, in which case the prescribed written notice of cancellation shall be forwarded directly to the named insured at least 15 days in advance of the effect date of termination. The Company failed to provide 15 days notice of cancellation for misrepresentation. The 2 incorrect forms were the Notice of Cancellation Form and The Business Auto Coverage Form in the commercial lines policy under Section VII which states: "A. Cancellation of Liability Policy, 2.a. 10 days before the effective date of cancellation if we cancel for nonpayment of premium; or 2. b. 30 days before the effective date of cancellation if we cancel for any other reason."

2 Violations *Act 86, Section 3(a)(3)(ii) [40 P.S. §3403(a)(3)(ii)]*

Requires that a Midterm cancellation notice shall be forwarded directly to the named insured or insureds at least 60 days in advance of the effective date of termination unless one or more of the following exist: The insured has failed to pay a premium when due, whether the premium is payable directly to the company or its agents or indirectly under a premium finance plan or extension of credit, in which case, the prescribed written notice of cancellation shall be forwarded directly to the named insured at least 15 days in advance of the effective date of termination. The Company failed to provide 15 days notice of cancellation for nonpayment of premium. The 2 incorrect forms were the Notice of Cancellation Form and The

Business Auto Coverage Form in the commercial lines policy under Section VII which states: "A. Cancellation of Liability Policy, 2.a. 10 days before the effective date of cancellation if we cancel for nonpayment of premium.

1 Violation *Act 86, Section 3(a)(4) [40 P.S. §3403(a)(4)]*

Notice Requirements for Midterm Cancellations and Nonrenewals. Notices of midterm cancellation and nonrenewal shall be clearly labeled "Notice of Cancellation" or "Notice of Nonrenewal". The Company's Notice of Nonrenewal form was not clearly labeled "Notice of Nonrenewal".

2 Violations *Act 86, Section 3(a)(5) [40 P.S. §3403(a)(5)]*

Requires that a nonrenewal notice shall state the specific reasons for the nonrenewal. The reasons shall identify the condition, factor or loss experience, which caused the nonrenewal. The notice shall provide sufficient information or data for the insured to correct the deficiency. The Company's Notice of Cancellation Form and Notice of Nonrenewal Form did not meet this requirement.

2 Violations *Act 86, Section 3(a)(6) [40 P.S. §3403(a)(6)]*

Requires that a nonrenewal notice shall state that at the insured's request, the insurer shall provide loss information to the insured for at least three years or the period of time during which the insurer has provided coverage to the insured, whichever is less. The Company's Notice of Cancellation form and Notice of Nonrenewal form did not meet this requirement.

2 Violations *Title 75, Pa. C.S. §1701 et seq.*

The ability to respond in damages for liability on account of accidents arising out of the maintenance or use of a motor vehicle in the amount of $15,000 because of injury to one person in any one accident, in the amount of $30,000 because of injury to two or more persons in any one accident and in the amount of $5,000 because of damage to property of others in any one accident. The financial responsibility shall be in a form acceptable tot the Department of Transportation. The Company's endorsements FKEPA 1003 in the commercial lines policy-reinstatement of liability limits and KEPA 1009 in the commercial lines policy-SIR Endorsement were not in compliance with this requirement. The Company must maintain minimum coverages.

2 Violations *Title 75, Pa. C.S. §1711(b)*

Required benefits-minimum policy. All insurers subject to this chapter shall make available for purchase a motor vehicle insurance policy which contains only the minimum requirements of financial responsibility and medical benefits as provided for in this chapter.

AND

Title 52, Pa. Code, Section 32.11(b)

The liability insurance maintained by a common or contract carrier of passengers on each motor vehicle capable of transporting fewer than 16 passengers shall be in an amount not less than $35,000 to cover liability for bodily injury, death or property damage incurred in an accident arising from authorized service. The $35,000 minimum coverage is split coverage in the amounts of $15,000 bodily injury per person, $30,000 bodily injury per accident and $5,000 property damage per accident. This coverage shall include

first party medical benefits in the amount of $25,000 and first party wage loss benefits in the amount of $10,000 for passengers and pedestrians. Except as to the required amount of coverage, these benefits shall conform to 75, Pa. C.S. §1701-1799.7. First party coverage of the driver of certificated vehicles shall meet the requirements of 75, Pa. C.S. §1711. The Company failed to comply with minimum insurance coverages. Only $5,000 first party medical benefits was being provided. The Company cannot waive bodily injury and property damage liability. The Company's Waiver FKWPA 1031 Additional Benefits Waiver indicated this was being done.

IX. 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 17 consumer complaints received during the experience period and provided all consumer complaint logs requested. All 17 complaints 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:

16 Violations Title 31, Pa. Code, Section 146.5(a)

> Every insurer, upon receiving notification of a claim, shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company did not acknowledge the claim within 10 working days for the 16 files noted.

7 Violations *Title 31, Pa. Code, Section 146.5(b)*

Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry. The Company failed to respond to a Department inquiry in a timely manner for the 7 claims noted.

16 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 16 claims noted.

16 Violations *Act 205, Section 4 [40 P.S. §1171.4]*

Unfair methods of competition and unfair or deceptive acts or practices prohibited. No person shall engage in this state in any trade practice which is defined or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance pursuant to this act.

AND

Act 205, Section 5(a)(10)(v)(vi) [40 P.S. §1171.5(a)(10)(v)(vi)]

Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failure to affirm and deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the Company

or it's representative; Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to promptly settle the 16 claims after poof of loss had been presented or to affirm or deny the coverage.

2 Violations *63 P.S. Section 861(d)*

Motor Vehicle Damage Appraisers: Section 861(d). Compliance with act. No appraiser or his employer shall require that repairs be made in any specific shop.

AND

Title 31, Pa. Code, Section 62.3 & 4

Applicable standards for appraisal. (3) A statement that there is no requirement to use any specific repair shop. (4) A statement informing the consumer that information regarding repair facilities which will be able to repair the vehicle for the appraised amount is available from the insurer. If the consumer receives information from the insurer, the information shall include disclosure that there is no requirement to use any specific repair shop. The Company steered claimants to a particular body shop for the 2 files noted, which is prohibited.

The following synopsis reflects the nature of the 17 complaints that were reviewed.

• 17	Claims Related	100%
17		100%

X. 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.

No violations were noted.

XI. RECOMMENDATIONS

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

1. The Company must reinforce its internal underwriting controls to ensure that all records and documents are maintained in accordance with Insurance Department Act, Section 903(a) [40 P.S. §323.3], so that violations noted in the Report do not occur in the future.

2. The Company must review and revise internal control procedures to ensure compliance relative to commercial cancellation and nonrenewal requirements of Act 86, Sections 3 and 4 [40 P.S. §§3403 and 3404], so that the 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 Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices so that the violations relating to maintaining files, acknowledgement of claims, providing claim forms, responding to Department inquiries, status letters and acceptance and denial of claims, as noted in the Report, do not occur in the future.

4. 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.

5. The Company must review the first party medical claims, which have not been paid within 30 days. Those claims that have not been paid within 30 days shall bear interest at the rate of 12% 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.

6. The Company must review Title 31, Pa. Code, Section 69.22 with its claim staff to ensure that the insured is properly notified that first-party medical benefits have been exhausted.

7. The Company must review Title 31, Pa. Code, Section 69.52(a) with its claim staff to ensure that providers are notified in writing when referring bills for PRO review at the time of referral.

8. The Company must review Title 31, Pa. Code, Section 69.52(1) with its claim staff to ensure that providers and insureds are provided copies of a reconsideration determination from a peer review organization within 5 days of receipt.

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

10. The Company must review Title 75, Pa. C.S. §1797(b)(2)&(5) with its claim staff to ensure that payment is made when a peer review determination has been made and the reconsideration period has passed. The Company must pay to the provider the outstanding amount plus

interest at 12% per year on any amount withheld by the insurer pending the PRO review.

11. The Company must review Act 205, Section 4 [40 P.S. §1171.4] and Act 205, Section 5(a)(10)(v)(vi) [40 P.S. §1171.5(a)(10)(v)(vi)] to ensure that claims are fairly and promptly settled after the proof of loss have been presented.

12. The Company must review Title 31, Pa. Code, Section 69.52(b) and Title 75, Pa. C.S. §1797(b)(1) to ensure that if the Company chooses to challenge the reasonableness and necessity of treatment, medical bills are referred to a PRO within 90 days of the insurer's receipt of the bill.

13. The Company must revise their practice and forms for use in Pennsylvania to ensure that the Company does not exclude applicants from being eligible to obtain insurance for reasons established in Act 205, Section 5(a)(7)(iii) [40 P.S. §1171.5(a)(7)(iii)].

14. The Company must review Title 75, Pa. C.S. §1711(b) and Title 52, Pa. Code, Section 32.11(b) and revise procedures to ensure that all minimum insurance coverages are available and not waived.

15. The Company must review 63 P.S. Section 861(d) and Title 31, Pa. Code, Section 62.3&4 and revise procedures to ensure that the Company does not steer claimants to a particular body shop in the future.

16. The Company must review Title 75, Pa. C.S. §1701 et seq. and revise all procedures to ensure that the Company maintains minimum coverages in the future.

XII. COMPANY RESPONSE

FIRST KEYSTONE RISK RETENTION GROUP Inc.
4421 Aramingo Ave, Philadelphia, PA 19124 Telephone: 215-235-5000 Facsimile: 215-235-5582

February 25, 2009

Mr. Chester A. Derk Jr., AIE,HIA
Market Conduct Division Chief
Commonwealth of Pennsylvania
Insurance Department
Bureau of Market Conduct – Property and Casualty Division
1227 Strawberry Square
Harrisburg, PA 17120

Dear Mr. Derk:

We appreciate the diligent effort of the Pennsylvania Department of Insurance in performing the Marketing Conduct Examination of First Keystone Risk Retention Group, Inc. We believe in the benefit of the Department's review of the Company's practices to ensure compliance with the Insurance Laws of Pennsylvania.

The following represents the complete First Keystone Risk Retention Group, Inc.'s reply to the Pennsylvania Market Conduct Examination Report relating to Examination Warrant Number 08-M22-010.

UNDERWRITING

Commercial Automobile

Midterm Cancellations – Compliance with Act 86, Section 2 (40 P.S. § 3402)
and Section 3 (40 P.S. § 3403)
Insurance Department Act, Section 903(a) [40 P.S. §323.3]

Company Action: The Company Underwriting system is to be modified to generate and retain both an electronic and hard copy of all midterm cancellation forms. The midterm cancellation form will clearly indicate the reason for the midterm cancellation.

Midterm Cancellations – Compliance with Act 86, Section 4(b) [40 P.S. §3404(b)]

Company Action: The Company Underwriting system is to be modified to ensure that all unearned premium is returned to the insured within 30 days after the effective date of termination.

Nonrenewals – Compliance with Act 86, Section 3 (40 P.S. § 3403)
Insurance Department Act, Section 903(a) [40 P.S. §323.3]

Company Action: The Company Underwriting system is to be modified to generate and retain both an electronic and hard copy of all Nonrenewal Notification forms. The Nonrenewal Notification form will clearly indicate the reason for nonrenewal.

CLAIMS

Commercial Automobile Property Damage Claims

Claims Files – Compliance with Title 31, Pa. Code, Section 146.3

Company Action: The Company standard operating procedure of date stamping claims correspondence has been changed to now date stamp every page of claims correspondence received to ensure compliance. In addition, standard operating procedures are to be implemented to retain all notes and working papers to allow for the reconstruction of pertinent dates and event when reviewed.

Claims Files – Compliance with Title 31, Pa. Code, Section 146.5(a)

Company Action: The Company's Claims system is to be modified to automatically generate an acknowledgement of receipt of a claim, that will be send to the appropriate parties within ten working days of receipt of notice.

Claims Files – Compliance with Title 31, Pa. Code, Section 146.6

Company Action: The Company's Claims system is to be modified to track the number of days for an investigation of a claim to allow for proper notification to the claimant. The notification will include a reasonable written explanation for any delay.

Claims Files – Compliance with Act 205, Section 4 [40 P.S. § 1171.4]
And
Act 205, Section 5 (a) (10) (v) (vi) {40P.S. §1171.5 (a) (10) (v) (vi)]

Company Action: The Company intends to comply with both sections of the above-mentioned Pennsylvania Insurance Code and promptly settle all claims after proof of loss has been presented or to affirm or deny the coverage within a reasonable time. Both system and standard operating procedure changes are to be made to ensure compliance with this code.

Commercial Automobile First Party Medical Claims

Claims Files – Compliance with Title 31, Pa. Code, Section 69.52(b)

Company Action: The Company intends to comply with this section of the Pennsylvania Insurance Code and pay bills within 30 days after the receipt of sufficient documentation supporting the bill. Both system and standard operating procedure changes are to be made to ensure compliance with this code.

Claims Files – Compliance with Title 75, Pa. C. S. § 1716

Company Action: The Company intends to comply with this section of the Pennsylvania Insurance Code and pay the appropriate interest on bills not paid within 30 days after the receipt of sufficient documentation supporting the bill. Both system and standard operating procedures changes are to be made to ensure compliance with this code. The Company has paid interest on all bills that were identified as violations during the examination.

Claims Files – Compliance with Title 31, Pa. Code, Section 146.5(a)

Company Action: The Company's Claims system is to be modified to automatically generate an acknowledgement of receipt of a claim, that will be send to the appropriate parties within ten working days of receipt.

Claims Files – Compliance with Title 31, Pa. Code, Section 146.5(d)

Company Action: The Company's Claims system and standard operating procedures will be modified to track the number of working days from receipt of a notification of a claim, and will automatically generate all necessary claims forms and instructions relating to the application for benefits. The application forms and instructions will be provided to the claimant within ten working days from receipt of claim notification.

Claims Files – Compliance with Title 31, Pa. Code, Section 146.6

Company Action: The Company's Claims system will be modified to track the number of days for an investigation of a claim to allow for proper notification to the claimant. The notification will include a reasonable written explanation for any delay.

Commercial Automobile First Party Medical Claims Referred to a PRO

Claims Files – Compliance with Title 31, Pa. Code, Section 69.22 (c)

Company Action: The Company's Claims system will be modified to automatically generate a notification to the provider and insured when first-party limits are exhausted. An electronic copy and a hard copy of the notification will be retained as part of the claim file.

Claims Files – Compliance with Title 31, Pa. Code, Section 69.52 (a)

Company Action: The Company's Claims system and standard operating procedures will be modified to automatically generate a notification to the provider when referring bills for PRO review. An electronic copy and a hard copy of the notification to the provider will be retained as part of the claim file.

Claims Files – Compliance with Title 31, Pa. Code, Section 69.52(b)

Company Action: The Company intends to comply with this section of the Pennsylvania Insurance Code and pay bills within 30 days after the receipt of sufficient documentation supporting the bill. Both system and standard operating procedure changes are to be made to ensure compliance with this code.

Claims Files – Compliance with Title 75, PA C.S. §1797 (b) (1)

Company Action: The Company intends to comply with this section of the Pennsylvania Insurance Code and submit bills for services to a PRO within 90 days of the receipt of the bill. Both system and standard operating procedure changes are to be made to ensure compliance with this code.

Claims Files – Compliance with Title 31, Pa. Code, Section 69.52(e)

Company Action: The Company intends to comply with this section of the Pennsylvania Insurance Code. Standard operating procedure changes are to be made to ensure compliance with this code.

Claims Files – Compliance with Title 31, Pa. Code, Section 69.52(1)

Company Action: The Company intends to comply with this section of the Pennsylvania Insurance Code. Standard operating procedure changes are to be made to ensure compliance with this code.

Claims Files – Compliance with Title 31, Pa. Code, Section 146.3

Company Action: : The Company standard operating procedure of date stamping claims correspondence has been changed to now date stamp every page of claims correspondence received and to retain all necessary documentation in the claims file. All correspondence will have a date automatically printed on the document.

Claims Files – Compliance with Title 31, Pa. Code, Section 146.5(d)

Company Action: The Company's Claims system and standard operating procedures will be modified to track the number of working days from receipt a notification of a claim, and will automatically generate all necessary claims forms and instructions relating to the application for benefits to be provided to the claimant within ten working days.

Claims Files – Compliance with Title 31, Pa. Code, Section 146.5(a)

Company Action: The Company's Claims system will be modified to track the number on working days from receipt of notification of a claim. The system will automatically generate an acknowledgement of receipt of a claim, that will be sent to the appropriate parties. A copy of the notification will be retained as part of the claim file

Claims Files – Compliance with Title 31, Pa. Code, Section 146.6

Company Action: The Company's Claims system will be modified to track the number of days necessary for an investigation of a claim and to allow for proper notification to the claimant, if the investigation is delayed beyond 30 days.

Claims Files – Compliance with Title 31, Pa. Code, Section 146.7 (a) (1)

Company Action: The Company's Claims system and standard operating procedures will be modified to ensure proper notification of either acceptance or denial of a first party claim within the defined period of 15 days. An electronic copy and a hard copy of the notification to the claimant will be retained as part of the claim file.

Claims Files – Compliance with Title 75, Pa. C. S. § 1716

Company Action: The Company intends to comply with this section of the Pennsylvania Insurance Code and pay the appropriate interest on bills not paid within 30 days after the receipt of sufficient documentation supporting the bill. Both system and standard operating procedure changes are to be made to ensure compliance with this code. The Company has paid interest on all bills that were identified as exceptions during the examination.

Claims Files – Compliance with Title 75, Pa. C. S. § 1797 (b) (2) & (5)

Company Action: The Company intends to comply with this section of the Pennsylvania Insurance Code and pay the appropriate interest on bills not paid during the PRO period, which bills were deemed reasonable and necessary. Both system and standard operating procedures changes are to be made to ensure compliance with this code. The Company has paid interest on all bills that were identified as violations during the examination.

Concerns

- The Company duly noted the Departments concerns relating to the claims files and is taking the appropriate action to address these concerns. System changes, standard operating procedures and additional resources will be part of the resolution.
- The Company's modified standard operating procedure will date stamp every page of the medical bills received.
- The Company intends to properly retain all post-marked envelopes received.
- The Company has purchased and implemented revised re-pricing software to address the issue of hand-written corrections of medical bills.

Forms

Company Action: The Company intends to comply with Insurance Company Law, Section 354 (40 P.S. §477b) and Act 165 of 1994 [18 Pa. CS §4117(k)(1)]. All exceptions identified by the Examination will be addressed and the appropriate action taken to ensure compliance with the Insurance Law of Pennsylvania.

Consumer Complaints

Company Action: The Company intends to comply with the Unfair Insurance Practices Act, No 205 (40 P.S. §1171). All exceptions identified by the Examination will be addressed and the appropriate action taken to ensure compliance with this Act.

Company Action: The Company intends to comply with Insurance Company Law, Section 354 (40 P.S. §477b) and Act 165 of 1994 [18 Pa. CS §4117(k)(1)]. All exceptions identified by the Examination will be addressed and the appropriate action taken to ensure compliance with the Insurance Law of Pennsylvania.

Recommendations

The Company appreciates the recommendations as outlined by the Pennsylvania Department of Insurance and intends to execute all of the recommendations.

In conclusion, First Keystone looks forward to working with the Pennsylvania Department of Insurance and to resolve all the issues raised as a consequence of this examination.

Respectfully Submitted,

Joseph Schmidt

Joseph Schmidt
President
First Keystone Risk Retention Group, Inc.