



THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION MARKET REGULATION

TARGETED MARKET CONDUCT FINAL EXAMINATION REPORT

OF

FIRST PROTECTIVE INSURANCE COMPANY

NAIC COMPANY CODE: 10897

February 2, 2021

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EXECUTIVE SUMMARY

A targeted market conduct examination of First Protective Insurance Company (“First Protective” or “Company”) was performed to review and analyze specific aspects of the Company’s handling of claims generated by Hurricane Michael. This examination report includes significant findings of fact, as described in Section 624.3161, Florida Statutes (“F.S.”), and general information about the insurer to ascertain its compliance with applicable provisions of the Florida Insurance Code and its own claim handling procedures.

COMPANY OPERATIONS

First Protective Insurance Company is a domestic Property and Casualty insurer authorized to conduct business in Florida on April 3, 1998. First Protective is authorized to write Homeowners and Dwelling Fire, Allied Lines, Homeowners Multi-Peril, Commercial Multi-Peril, Other Liability, Mobile Home Multi-Peril, Mobile Home Physical Damage, Other Liability, and Miscellaneous Casualty.

Total Direct Premiums Written in Florida for all lines of business was as follows:

Year	Total Written Premium in Florida (Per Schedule T of the Annual Statement)
2019	\$323,900,983
2018	\$317,957,573
2017	\$310,044,565

On February 13, 2008, the Office approved First Protective’s use of the fictitious name, Frontline Homeowners Insurance. The Company is branded and collectively marketed with Frontline Insurance Unlimited Company to consumers as Frontline Insurance.

PURPOSE AND SCOPE OF THE EXAMINATION

The Florida Office of Insurance Regulation (“Office”) has primary responsibility for the regulation, compliance and enforcement of statutes related to the business of insurance and the monitoring of industry markets. Due to this responsibility, the Office conducted a targeted market conduct examination of First Protective pursuant to Section 624.3161, F.S. The examination was performed by a contracted examination firm, Eide Bailly, LLP. and members of the Office’s Property and Casualty Market Regulation business unit under the supervision of INS Regulatory Insurance Services, Inc. The purpose of a market conduct examination is to review an insurer’s operating practices to determine if they comply with the Florida Insurance Code, rules related to the business of insurance, procedures adopted by the Company, the provisions contained within a contract of insurance issued by the Company, or orders issued by the Office. A common element of all market conduct examinations is to evaluate an insurer’s business practices, to promote the

protection of insurance-buying consumers and to hold insurers accountable when issues or violations are found.

On October 10, 2018, Hurricane Michael, a Category 5 storm, made landfall in the Florida Panhandle near Tyndall Air Force Base. Since Hurricane Michael made landfall and as of October 2019, the Office has completed 44 data calls, and conducted analyses of the claims data reported by 400 insurance companies.

On October 10, 2019, the Office released a report entitled One Year Later: Hurricane Michael's Impact on Florida. The report stated that as of that date, Hurricane Michael had resulted in the filing of more than 149,448 claims by policyholders at an estimated cost of \$6.7 billion. As of the September 27, 2019 reporting date, insurers classified the status of those claims as follows:

- 110,979 claims closed with payment;
- 21,122 claims closed without payment; and
- 17,347 claims remained open at the time of the reporting.

Approximately 12,000 of the open claims reported were claims for damage to personal and commercial residential properties, with the majority of the remaining claims, or approximately 5,000 claims, for damage to commercial properties.

On December 19, 2018 and on July 25, 2019, the Office issued two Informational Memorandums, OIR-18-01M (attached as Addendum B) and OIR-19-04M (attached as Addendum C), directing insurers adjusting Hurricane Michael claims “to do everything possible to respond to the needs of affected Floridians, restore a sense of normalcy, and facilitate restoration and recovery of impacted communities.” All insurers were instructed to redouble efforts to resolve all open claims, using whatever resources necessary, to provide policyholders with the tools to rebuild their lives and property. Insurers were also reminded that policyholders have the right to expect prompt, efficient and fair claims adjustment service, especially after a catastrophic loss. Insurers were urged to concentrate their resources and energy on reaching out to policyholders with open Hurricane Michael claims and take all actions necessary to bring the claims to closure as quickly as possible.

This targeted market conduct examination was initiated in the wake of Hurricane Michael to review and evaluate the Company's handling of Hurricane Michael claims reported to the Company by policyholders between October 10, 2018 and August 30, 2019. The targeted examination focused on compliance with the following specific key claims handling standards which directly impact policyholders and claimants:

- Timely communication with respect to claims;
- Timely payment of claims;
- Payment of statutory interest if instances of untimely payments occurred;
- Adjustment and payment of claims in accordance with the terms and conditions of the policy contract;
- Fair claim settlement practices;

- Use of licensed and appointed claims adjusters;
- Maintaining reasonable claims records; and
- Adherence to internal claims processing standards.

The examination began July 15, 2019 and ended November 4, 2020.

The last market conduct examination of First Protective was completed on April 22, 2016. The scope of that targeted examination was the review of First Protective's 2011 and 2012 Market Conduct Annual Statement ("MCAS") Homeowners Reports which included, among other things, the review of sampled claims files. The results of the last examination noted reporting errors in First Protective's MCAS data filings.

FIRST PROTECTIVE AND HURRICANE MICHAEL STATISTICS

As of October 25, 2019, in response to the Catastrophe Reporting data call, the Company reported receiving a total of 3,869 Hurricane Michael claims or 2.58% of the total number of Hurricane Michael claims reported by all insurers as of that reporting date. As of October 13, 2019, the Florida Department of Financial Services' Division of Consumer Services ("DFS") reported receiving a total of 137 complaints related to Hurricane Michael from First Protective consumers. This represents 7.65% of the total number of complaints received from all consumers reporting Hurricane Michael complaints.

TOTAL REPORTED CLAIMS AND COMPLAINTS AS OF OCTOBER 2019			
First Protective Claims	Total Claims	First Protective Complaints	Total Complaints
3,869	149,773	137	1,791

An analysis comparing the total number of Hurricane Michael complaints received by DFS to the total number of Hurricane Michael claims reported by all insurers determined that the average complaint to claims percentage was 1.44%, as of the October 2019 reporting. The Company's complaint to claims comparison percentage was 3.54%.

A review of the Company's consumer complaints by reason category, as assigned by DFS, reflects that:

- 81 complaints, or 59.1% of all complaints, were reported by consumers experiencing a claim handling delay;
- 38 complaints, or 27.7% of all complaints, were attributed to requests made by the Company or a policyholder to participate in mediation due to unresolved claim issues;

- 18 complaints, or 21.9% of all complaints, were made by consumers who:
 - Experienced a delay or lack of response from the Company;
 - Believed their claims were inappropriately denied;
 - Received unsatisfactory settlement offers;
 - Believed they were issued claim underpayments;
 - Were concerned about the quality of the repair of an insured building;
 - Were concerned with the amount of the deductible applied to their claim; or
 - Experienced other claims related, or company related issues.

DFS defines:

- Claim Handling Delay as a complaint regarding the Company's or the adjuster's delay in contacting the claimant, processing the claim, or issuing a payment;
- Claim Underpayment as an issue involving a claim that has been paid, but in an amount that is less than deemed appropriate by the person receiving payment or on whose behalf payment is being made; and
- Unsatisfactory Settlement Offer as a complaint where the adjuster's or the Company's offer to settle a claim is in an amount which is less than the amount the insured thinks should be paid.

FIRST PROTECTIVE CONSUMER COMPLAINTS BY REASON	
Claim Handling Delay	81
Mediation	38
Company Delay or No Response	5
Claim Denial	4
Unsatisfactory Settlement Offer	3
Claim Underpayment	2
Quality of Repair	1
Deductible Issue	1
Other Company Issue	1
Other Claim Issue	1
Total	137

At the time of the October 2019 reporting by DFS:

- 12 complaints were open pending resolution;
- 85 complaints were closed:

- After DFS explained the Company's position or the adjuster's position to the consumer;
- Because DFS determined the claim was settled;
- When DFS resolved the consumer's issue;
- After DFS determined that a question of fact existed wherein DFS was unable to make a determination in favor of either the policyholder or the Company;
- Because the Company extended coverage to the consumer; or
- When DFS determined that the Company's position was based on a contractual provision contained within the insurance policy; and
- Two notices were issued to the Office of alleged violations of the Florida Insurance Code; one after the consumer's issue was satisfactorily resolved by the Company and the other after DFS was unable to assist the consumer further.

The notices issued to the Office were reviewed based on the scope of this examination and did not result in additional findings related to the examination.

The remaining 38 mediation complaints were resolved in accordance with DFS' mediation program.

FIRST PROTECTIVE COMPLAINT RESOLUTION CATEGORIES	
Open – Pending Resolution	12
Company Position Explained	49
Resolved Through DFS' Mediation Program	38
Claim Settled	19
Issue Resolved	8
Question of Fact	6
Adjuster Position Explained	1
Contractual Provision	1
Coverage Extended	1
Notice of Issue – No Relief	1
Notice of Issue – Relief	1
Total	137

The examination was conducted in light of the Company's complaint statistics and was designed to analyze the adherence of the Company to specific key claims handling standards and the adherence of the Company to its own claims processing standards.

On November 2, 2020, in response to a new Catastrophe Reporting data call, the Company reported receiving a total of 3,902 Hurricane Michael claims, an increase of 33 claims from the October 25, 2019 data call. Of the 3,902 total claims reported, the Company recorded that 3,381 claims or 86.6%, were closed and 521 claims, or 13.4%, remained open as of the reporting date. Of the 3,381 closed claims, 2,961 claims, or 87.6%, were closed with payment and 420 claims, or 12.4%, were closed without payment.

EXAMINATION PROCEDURES

The conduct of this examination and the procedures, statistical sampling and examination processes used were consistent with and in accordance with those standards and procedures contained in the *Market Regulation Handbook* promulgated by the National Association of Insurance Commissioners (“NAIC”).

In preparation for the examination, the Company was requested to provide the total number, or universe, of Hurricane Michael claims reported with a Florida exposure during the examination’s scope period of October 10, 2018 to August 30, 2019. The Company reported receiving a total of 3,852 Hurricane Michael claims during the scope period. To facilitate a thorough review of the Company’s claims files and to address with particularity the specific key claims handling standards discussed previously in this report, the claims universe was divided into four categories: claims closed with payment, claims closed without payment, reopened claims, and claims open as of August 30, 2019. Each of the four categories were evaluated for compliance with the specific key claims handling standards.

The Company reported the universe of claims for each category as follows:

- 1,076 claims closed with payment;
- 367 claims closed without payment;
- 1,233 reopened claims; and
- 1,176 claims open as of August 30, 2019.

For purposes of this examination, the selection of claims reviewed for each of the four categories was defined as follows:

- Claims Closed With Payment: The first or initial Hurricane Michael claim filed by the named insured, policyholder, or legal representative during the scope period due to a loss occurring to a personal residential or commercial residential risk that was closed with payment during the examination’s scope period.
- Claims Closed Without Payment: The first or initial Hurricane Michael claim filed by the named insured, policyholder, or legal representative during the scope period due to a loss occurring to a personal residential or commercial residential risk that was closed without payment for any reason during the examination’s scope period. Reasons for closing a claim without payment could include but are not limited to claims valued at less than the policy’s hurricane deductible, claims determined not to be covered by the policy, or claims that were voluntarily withdrawn by the named insured or policyholder.
- Reopened Claims: The first or initial Hurricane Michael claim filed by the named insured, policyholder, or legal representative during the scope period due to a loss occurring to a personal residential or commercial residential risk that was closed for any reason and subsequently reopened upon receipt of the first supplemental claim. Section 627.70132,

F.S. defines the term “supplemental claim” or “reopened claim” as any additional claim for recovery from the insurer for losses from the same hurricane or windstorm which the insurer has previously adjusted pursuant to the initial claim.

- Claims Open as of August 30, 2019: A claim filed during the scope period by the named insured, policyholder, or legal representative due to a loss occurring to a personal residential or commercial residential risk that was in an “open” status as of August 30, 2019.

The examiners reviewed a total of 403 randomly selected Hurricane Michael claims. The number of randomly selected claims in each sample is consistent with the recommended sample size for claims in the NAIC’s *Market Regulation Handbook’s* Acceptance Samples Table. Examination results with a 95% confidence level permit those results to be extrapolated to the population of claims in each of the four claim categories. Based on the total universe of First Protective claims subject to this examination, the total sample size required to achieve a 95% confidence level for all four categories was determined to be 403 claims.

The 403 randomly selected claims consisted of:

- 107 claims closed with payment;
- 82 claims closed without payment;
- 107 reopened claims; and
- 107 claims open as of August 30, 2019.

In reviewing materials for this report, the examiners relied on records provided by the Company, including catastrophe claims information provided to the Office in its Catastrophe Reporting data calls.

REVIEW FOR COMPLIANCE WITH SECTION 627.70131, F.S.

This portion of the examination focused on the Company’s compliance, with respect to its Hurricane Michael claims, with statutory requirements and timeframes found in Section 627.70131, F. S. The review evaluated the specific key claims handling standards of timely payment of claims; timely communication with respect to a filed claim; and payment of statutory interest, if required. Other specific key claims handling standards which were evaluated are discussed in the Findings section of this report.

Section 627.70131, F. S., provides in pertinent part:

(5)(a) Within 90 days after an insurer receives notice of an initial, reopened, or supplemental property insurance claim from a policyholder, the insurer shall pay or deny such claim or a portion of the claim unless the failure to pay is caused by factors beyond the control of the insurer which reasonably prevent such payment. Any

payment of an initial or supplemental claim or portion of such claim made 90 days after the insurer receives notice of the claim, or made more than 15 days after there are no longer factors beyond the control of the insurer which reasonably prevented such payment, whichever is later, bears interest at the rate set forth in s. 55.03. Interest begins to accrue from the date the insurer receives notice of the claim. The provisions of this subsection may not be waived, voided, or nullified by the terms of the insurance policy. If there is a right to prejudgment interest, the insured shall select whether to receive prejudgment interest or interest under this subsection. Interest is payable when the claim or portion of the claim is paid. Failure to comply with this subsection constitutes a violation of this code. However, failure to comply with this subsection does not form the sole basis for a private cause of action.

To determine the Company's adherence to these statutory requirements and timeframes, the examiners conducted detailed analyses of 403 claims. The examiners reviewed and analyzed each of the claims to determine if the claims were paid or denied within 90 days after the Company received notice of the initial, reopened or supplemental claim. In accordance with the statute, the examiners also analyzed whether factors reasonably beyond the control of the Company may have prevented payment of that claim within 90 days. In instances where factors reasonably beyond the control of the Company existed, the claims were determined to have met the 90-day standard, as provided in Section 627.70131(5)(a), F.S. The examiners applied those statutory requirements and timeframes to each of the 403 randomly selected Hurricane Michael claims by category: 107 claims closed with payment; 82 claims closed without payment; 107 reopened claims; and 107 open claims as of August 30, 2019.

After reviewing 107 **Claims Closed With Payment**, the examiners determined that when measuring from the date the Company received notice of the first or the initial claim to the date the claim payment was made to the policyholder, the Company paid 106 claims, or 99.1% of the claims closed with payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. One claim was paid after 90 days.

CLAIMS CLOSED WITH PAYMENT	
Paid Within	Number of Claims
0-30 days	50
31-60 days	52
61-90 days	4
Over 90 days	1
Total Claims Reviewed	107

The examiners determined that the claim in the over 90 days category was not in violation of Section 627.70131(5)(a), F.S. because the Company was pending receipt of documentation or communication needed from the policyholder or the policyholder's representative to resolve the claim. This factor was reasonably beyond the control of the Company and the claim was determined to have met the 90-day standard.

The results of the examination determined that 107 of the 107 claims reviewed, or 100% of the Company's claims closed with payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 82 **Claims Closed Without Payment**, the examiners determined that when measuring from the date the Company received notice of the first or the initial claim to the date the claim was denied, the Company denied 80 claims, or 97.6% of the claims closed without payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Two claims were denied after 90 days.

CLAIMS CLOSED WITHOUT PAYMENT	
Paid Within	Number of Claims
0-30 days	32
31-60 days	42
61-90 days	6
Over 90 days	2
Total Claims Reviewed	82

The examiners determined that one of the two claims closed without payment in the over 90 days category is in violation of Section 627.70131(5)(a), F.S. because no factors existed beyond the control of the Company to reasonably prevent paying or denying the claim within 90 days.

The remaining claim closed without payment in the over 90 days category was determined not to be in violation of Section 627.70131(5)(a), F.S. because the Company was pending receipt of documentation of communication needed from the policyholder or the policyholder's representative to resolve the claim. This factor was reasonably beyond the control of the Company and the claim was determined to have met the 90-day standard.

The results of the examination determined 81 of the 82 claims reviewed, or 98.8% of the Company's claims closed without payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 107 **Reopened Claims**, the examiners determined that when measuring from the date the Company received the first or the initial reopened or supplemental claim to the date the claim was paid or denied, the Company paid or denied 88 claims, or 82.2% of the reopened claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Nineteen claims were paid or denied after 90 days.

REOPENED CLAIMS	
Paid Within	Number of Claims
0-30 days	52
31-60 days	22
61-90 days	14
Over 90 days	19
Total Claims Reviewed	107

The examiners determined that 19 reopened claims in the over 90 days category were not in violation of Section 627.70131, F.S. because the Company was pending receipt of documentation or communication needed from the policyholder or the policyholder's representative to resolve the claims or the claims were in litigation or participating in the appraisal process.

The results of the examination determined that 107 of the 107 claims reviewed, or 100% of the Company's reopened claims, complied with Section 627.70131(5)(a), F.S.

After reviewing 107 **Claims Open as of August 30, 2019**, the examiners determined that when calculating from the date the Company received notice of the first or the initial, reopened, or supplemental claim to the date the claim was paid or denied, the Company paid or denied 29 claims in an "open" status as of August 30, 2019, or 27.1% of the claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Seventy-eight claims were paid or denied after 90 days.

CLAIMS OPEN AS OF AUGUST 30, 2019	
Paid Within	Number of Claims
0-30 days	7
31-60 days	12
61-90 days	10
Over 90 days	78
Total Claims Reviewed	107

The examiners determined that seven of the 78 open claims as of August 30, 2019 in the over 90 days category are in violation of Section 627.70131(5)(a), F.S. because no factors existed beyond the control of the Company to reasonably prevent paying or denying the claims within 90 days.

The remaining 71 open claims as of August 30, 2019 in the over 90 days category were determined not to be in violation of Section 627.70131(5)(a), F.S. because the Company was pending receipt of documentation or communication needed from the policyholder or the policyholder's representative to resolve the claim or the claim was in litigation, mediation, or participating in the appraisal process.

The results of the examination determined that 100 of the 107 claims reviewed, or 93.5% of the Company's claims open as of August 30, 2019, complied with Section 627.70131(5)(a), F.S.

ADHERENCE REVIEW

In addition to reviewing the Company's claims practices to determine compliance with specific key claims handling standards, the examiners evaluated the Company's compliance with its own internal claims procedures.

To determine the Company's adherence to its own claims processing standards, the examiners reviewed materials and information provided by the Company and compared them to the information and data contained within the claims files. The full review is contained in Addendum A of this report. Additional adherence determinations contained within this report may have been made based on subsequent events that occurred during the course of this examination.

The results of the adherence review determined that one area deviated from the Company's internal standards. Frontline's written procedures required field adjusters to contact policyholders within 24 hours of assignment to schedule inspections. The examiners' review of the claim files determined the Company, on average, met this standard only 80% of the time when inspections or re-inspections were required.

FINDINGS

The following Findings, or violations, are compiled from the Office's and the contracted examiners' analysis of the Company's adherence to specific key claims handling standards and the Company's adherence to its own claims processing standards. Each Finding includes the Company's response to each violation, and, in certain cases, additional conclusions made, when necessary.

The statutory standards that were reviewed are Section 627.70131(1)(a), F.S., requiring the timely acknowledgement of claims communications, Section 626.112, F.S., requiring the use of licensed and appointed claims adjusters, Section 626.877, F.S., requiring the adjustment of claims in accordance with the terms and conditions of the insurance contract, and Section 626.9541, F.S., that defines unfair trade practices.

CLAIMS CLOSED WITH PAYMENT

The Company reported a universe of Hurricane Michael claims that were closed with payment during the examination scope period. A random sample of 107 claims was selected for review and the findings of the review are as follows:

Finding 1: In one instance out of 107 claims reviewed, an error percentage of 0.9%, the Company utilized a person who was not licensed or appointed by an appropriate appointing entity or person as an insurance adjuster at the time the claim was adjudicated, in violation of Section 626.112(1)(a), F.S.

COMPANY RESPONSE: The Company disagreed with the violation.

Finding 2: In one instance out of 107 claims reviewed, an error percentage of 0.9%, the Company failed to maintain reasonable claims records, in violation of Section 627.318, F.S.

COMPANY RESPONSE: The Company agreed with the violation.

CLAIMS CLOSED WITHOUT PAYMENT

The Company reported a universe of 367 Hurricane Michael claims that were closed without payment during the examination scope period. A random sample of 82 claims was selected for review and the findings of the review are as follows:

Finding 3: In one instance out of 82 claims reviewed, an error percentage of 1.2%, the Company did not deny the claim within 90 days after receiving notice of the claim from the policyholder, in violation of Section 627.70131(5)(a), F.S.

COMPANY RESPONSE: The Company disagreed with the violation because the amount of the claim was less than the deductible and was not denied.

The violation was retained in this report because the final determination that the claim amount was less than the deductible was not made within 90 days.

Finding 4: In one instance out of 82 claims reviewed, an error percentage of 1.2%, the Company failed to maintain reasonable claims records, in violation of Section 627.318, F.S.

COMPANY RESPONSE: The Company agreed with the violation.

REOPENED CLAIMS

The Company identified a universe of 1,233 Hurricane Michael claims that were reopened as an additional claim that had previously been adjusted pursuant to the initial claim. A random sample of 107 claims was selected for review. No exceptions were noted.

OPEN CLAIMS AS OF AUGUST 30, 2019

The Company reported a universe of 1,176 Hurricane Michael claims that were open as of August 30, 2019. A random sample of 107 claims was selected for review and the findings of the review are as follows:

Finding 5: In seven instances out of 107 claims reviewed, an error percentage of 6.5%, the Company did not pay or deny the claim within 90 days after receiving notice of the claim from the policyholder, in violation of Section 627.70131(5)(a), F.S. Interest was also not paid on the claims as required by the statute.

COMPANY RESPONSE: The Company agreed with the violations. The Company reported that the required interest was paid to the policyholders prior to the conclusion of the examination.

Finding 6: In five instances out of 107 claims reviewed, an error percentage of 4.7%, the Company did not timely acknowledge receipt of claims communications within 14 calendar days, in violation of Section 627.70131(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with two violations and disagreed with three violations because:

- In one instance, the uploaded files were not readable, and the adjuster needed to obtain more legible documents;
- In the second instance, the claim was previously participating in the appraisal process; and
- In the third instance, the Company admitted the claim file was not addressed in the timeliest manner. However, due to the reassignment of the claim to a new adjuster, the claim exemplified an example of factors beyond the control of the insurer which reasonably prevented a timely acknowledgement.

The violations were retained in this report because the statute requires insurers to review and acknowledge receipt of all claims communications within 14 calendar days despite being illegible, if the claim is participating in an alternative dispute resolution process, or in the event the claim is reassigned to a new adjuster, unless payment is made within that period of time.

RECOMMENDATIONS

The following Recommendations were compiled from the Findings contained within this report. The Company is to provide a written report to the Office of actions taken on each Recommendation within 60 days of the Company's receipt of the Office's Final Examination Report.

It is recommended that the Company:

- Ensure that all initial, supplemental or reopened claims will be paid or denied, in whole or in part, within 90 days; that the acknowledgement of all claims communications will occur within statutorily mandated timeframes; and that all claims files will contain reasonable records in order for the Office or its examiners to determine the Company's compliance with the applicable provisions of the insurance code;
- Ensure that statutorily required interest is automatically included in claims payments to policyholders when claims are not paid within statutory timeframes and no factors exist beyond the control of the Company to reasonably prevent paying or denying the claims within 90 days;
- Eliminate the ability for unlicensed persons to participate in claims activities; and
- Ensure field adjusters consistently adhere to its own claims processing standards that require field adjusters to contact policyholders within 24 hours of assignment to schedule inspections.

CONCLUSION

This targeted market conduct examination of First Protective was designed to review and evaluate whether the Company's handling of Hurricane Michael claims was in compliance with the specific key claims handling standards required by statute, the provisions of the insurance policy issued by the Company, or the Company's own claims processing standards. During the examination, the Office and the Office's contracted examiners identified findings and made recommendations for remediation to be implemented by the Company. The examination identified no improper general business practices related to claims and determined that the Company was diligent when investigating Hurricane Michael claims and when accurately paying such claims.

This examination report and the Findings contained therein are the result of a factual, data-driven analysis of the claims handling practices of the Company, as reflected in its handling of 403 Hurricane Michael claims. This report contains a number of recommendations for improvement and remediation that should be implemented by the Company. It does not document what regulatory or administrative action may be taken by the Office. Any such action taken as a result of this targeted market conduct examination will be the subject of a separate Order issued by the Office.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issues this Final Report based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company.

ADDENDUM A

CLAIMS OVERVIEW

The Company utilizes Frontline Insurance Managers Inc. (“Frontline”), an affiliated entity, as managing general agent for all operational support. Frontline utilizes independent adjusting firms to provide desk and field adjusting services during catastrophic or weather-related claims events. The examiners’ review determined Frontline did not have formal written agreements with the independent adjustment firms used to adjust the Company’s Hurricane Michael claims other than fee schedules which were provided to the examiners for review. Monetary compensation consisted of an incrementally scaled flat fee based on the size of each claim. Also, built into the fee schedule were flat rate amounts to be paid in the event of erroneous claims assignments, when excess Coverage A losses (total losses) occurred, and to reimburse for additional time and expenses, with management approval.

Frontline provided its 2017 Catastrophe Preparedness and Response Management Guide (“Guide”) to the examiners for review. The Guide described all phases of the Company’s catastrophe claims handling processes, from pre-planning to implementation and included instructions, guidelines, or procedures for:

- The appropriate methods of loss reporting;
- The use of Xactimate claims software;
- Documenting personal property or contents losses;
- The payment of tree and debris removal;
- The issuance of emergency funds to policyholders;
- Submitting required reports; and
- The use of water extraction or other vendors.

During the initial contact with policyholders, Frontline established the policyholder’s preferred method of contact and provided the policyholder with an explanation of the claims handling process. Policyholders were also provided with the names of vendors to whom their claims were assigned. Frontline was proactive in working with policyholders to mitigate further property damage through strategic alliances with vendors and made suggestions for roof tarping, water mitigation, and mold remediation services. Frontline performed peer reviews when water mitigation invoices were received from non-preferred vendors when the amounts billed were not in line with preferred vendor pricing.

It is Frontline’s practice to close a claim when settlement is made with the policyholder, when there are no actionable claims items pending, or when a policyholder no longer responds to claims communications. Claims are reopened when supplemental claim information is received from the policyholder or the policyholder’s representative. Frontline releases recoverable depreciation to policyholders upon receipt of a Certificate of Completion or when evidence of completion is provided. In some cases, Frontline released recoverable depreciation upon presentation of a signed contract for repairs.

Frontline upgraded its claims administration system from the AS400 platform to the Guidewire platform during the scope period of this examination. Frontline provided training prior to the implementation of the new Guidewire platform to all internal users and independent adjusters with the need to utilize the system. The training included an overview and detailed review of the functionality of the Guidewire system, workflow functions, and Frontline’s customer service expectations.

The new Guidewire claims platform provided a portal for policyholders, agents, or vendors to upload claims documentation directly into a claim file and allowed parties to the claim to view certain claims documentation. Additionally, for policyholders who were unable to create an online portal login, Frontline created a web-based upload system where anyone associated with a claim could upload claims documents into the claims file. Upon upload, an activity and an alert were automatically generated for review by the assigned claims adjuster.

Frontline utilized a call center in Texas for claims reporting. Approximately 78% of all Hurricane Michael claims were reported by calls to the call center. The remaining claims were reported to Frontline by the policyholder’s agent (16%) or via the online portal (6%). During Hurricane Michael, Frontline’s Catastrophe Center was operational seven days a week. Once claims information was received it was entered directly into the Guidewire platform. Desk adjusters were assigned on the same day the claim was uploaded to Guidewire and a claim acknowledgement package was sent to the policyholder.

Individual claims were processed by either the desk or field adjuster. Depending on claims volume, capacity, and skill sets, Frontline re-balanced workloads by reassigning claims to different adjusters. During the examination, the examiners noted, in certain circumstances, multiple adjusters were assigned to a single claim. The Company was requested to provide data to show the total number of claims adjusters that were assigned to 387 claims files reviewed for this purpose during the examination. Based on the Company’s response, 217 claims, or 56% of the claims reviewed, had one adjuster assigned throughout the lifecycle of the claim; 110 claims, or 28.5% of the claims reviewed, had two to three adjusters assigned; and 34 claims, or 8.7% of the claims reviewed, had four to five adjusters assigned throughout the lifecycle of the claim. In one case, the Company reported 15 claims adjusters were assigned to a single claim.

Number of Adjusters Assigned	Number of Claim Files	Percentage
1	217	56.0%
2	73	18.9%
3	37	9.6%
4	23	5.9%
5	11	2.8%
6	6	1.6%
7	3	0.8%

8	4	1.0%
9	5	1.3%
10	2	0.5%
11	0	0%
12	2	0.5%
13	1	0.3%
14	2	0.5%
15	1	0.3%
Total	387	100%

Frontline’s CAT Field Report Standards required adjusters to contact policyholders within 24 hours of assignment to schedule inspections. The examiners’ review of the claim files determined the Company, on average, met this standard 80% of the time when inspections or re-inspections were required.

Frontline categorized claims as Desk Handled (simple fast-tracked claims), Moderately Difficult (claims that may require re-inspection or negotiation), or Complex (high dollar losses, complicated claims issues, or claims with public adjuster or attorney involvement). Moderately Difficult and Complex claims categories required longer processing timeframes. Frontline’s policy of timely performing site inspections and making an initial claim settlement resulted in the timely closure of many claim files reviewed. For claims where both wind and flood damage occurred, Frontline’s adjusters made coverage determinations with the assistance of a consulting engineer.

In instances where claims were not a total loss, Frontline made an initial claim settlement based on the site inspection within 90 days of the policyholder’s first notice of the loss. Policyholders were instructed to obtain estimates for repairs. If the repair estimates exceeded Frontline’s initial settlement amount, policyholders were instructed to submit the repair estimates to Frontline as a supplemental claim for consideration. Policyholders were also instructed how to submit claims for losses related to personal property, business interruption, and additional living expenses, as needed.

Frontline’s policy was to pay the undisputed claim amounts, once determined. Disputed claim amounts were resolved by conducting re-inspections, or by requesting to participate in the DFS mediation program or the appraisal process outlined in the policy. The language contained in the appraisal clause required Frontline to issue appraisal awards within 20 days after reaching a written agreement with the policyholder or within 60 days after entry of a final judgement or the filing of an appraisal award or mediation settlement.

Frontline’s 2017 Catastrophe Preparedness and Response Management Guide allowed adjusters to advance \$1,500 in emergency funds to policyholders in the form of debit cards when additional living expenses were needed. In response to Hurricane Irma, Frontline utilized debit cards to issue emergency funds but because few policyholders requested to use them, Frontline implemented a more customer friendly electronic funds transfer (“EFT”) option where policyholders could receive cash advances against future claim payments up to \$5,000 in less than two days.

During Hurricane Michael, the Company stated emergency cash funds were not automatically offered unless specifically requested by the policyholder. The examiners documented that the Company issued six emergency cash advances requested by policyholders during the examination scope period, all of which were paid within 24 hours.

The Company stated Frontline recently enhanced claims communications with its customers, including live portal updates and automated email communications with respect to claims activities, beginning when a claim is assigned to an adjuster. Frontline has stated its management and owners have reviewed past claims performance and is continuously reviewing claims handling practices and identifying areas to make its customer experience timelier and more efficient.

The Company reported that on November 19, 2019, Frontline hired a Senior Vice President of Claims with 25 years of property and casualty claims experience, and process and data analytics experience, whose focus is to streamline, review and revamp the entire claims structure. Frontline's newly designed claims management model integrates Lean Six Sigma mythologies. The use of end to end processes improve performance by systematically removing waste and reducing variation to create the most efficient and effective approach to claims handling. Upon first notice of loss, the policyholder is immediately transferred to a claims representative to begin the claims handling process. If an inspection of the damage is necessary, a "task" is sent to a field claims representative to complete the inspection and settle the claim on-site. If the customer is in need of emergency services, they are taken care of immediately. If the loss is complex, involves litigation or liability, or does not otherwise meet the requirements of an in-office claim, the claim is moved to the appropriate area for handling. Frontline believes this streamlined approach is in the best interest of its customers, reduces the number of "file touches" and results in timely claim resolutions. Frontline is also in the process of implementing ClaimsXperience™, an application that enables adjusters to virtually adjust and conclude selected losses immediately.

Frontline contracted with Crawford and Company, one of the largest national third party administrators, to assist with resolving random claims volume spikes to claims associated with large scale catastrophes. This additional service ensures consistent and immediate access to highly skilled and trained claims adjusters.

ADDENDUM B



INFORMATIONAL MEMORANDUM OIR-18-01M ISSUED

December 19, 2018

Florida Office of Insurance Regulation
David Altmaier, Commissioner

TO ALL PROPERTY AND CASUALTY INSURERS AUTHORIZED TO DO BUSINESS IN FLORIDA

HURRICANE MICHAEL CLAIMS RESPONSE

Hurricane Michael made landfall in the Florida Panhandle on October 10, 2018, causing estimated total insured losses of \$4.5 billion and generating more than 133,000 claims as of December 17, 2018. According to data filed with the Florida Office of Insurance Regulation, more than 90,000 claims have been closed. However, there are more than 42,000 claims that remain open. Insurers are reminded of Section 626.9541(1)(i)4., Florida Statutes, which requires that property insurers must pay:

...undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

To facilitate the payment of Hurricane Michael claims, it is important that insurers have sufficient claim adjustment and consumer service resources to provide policyholders with access to effective customer service. Insurers may need to augment available claim or customer service resources, establish mobile claims offices in the Florida Panhandle, initiate outbound calls to claimants, or take other action to provide quality policyholder service. The Office expects insurers not only to comply with the provisions of Florida law but also to do everything possible to respond to the needs of affected Floridians, restore a sense of normalcy, and facilitate restoration and recovery in impacted communities.

If you have any questions regarding this memorandum, please contact Virginia Christy at Virginia.Christy@floir.com or (850) 413-5019.

ADDENDUM C



INFORMATIONAL MEMORANDUM OIR-19-04M ISSUED JULY 25, 2019

Florida Office of Insurance Regulation
David Altmaier, Commissioner

TO ALL PROPERTY AND CASUALTY INSURERS AUTHORIZED TO DO BUSINESS IN FLORIDA

HURRICANE MICHAEL CLAIMS RESPONSE

This Hurricane Michael Informational Memorandum supplements [Informational Memorandum OIR-18-01M](#), which was issued on December 19, 2018. That Informational Memorandum directed insurers adjusting Hurricane Michael claims to not only comply with required provisions of Florida law but also “to do everything possible to respond to the needs of affected Floridians, restore a sense of normalcy, and facilitate restoration and recovery in impacted communities.”

As of June 28, 2019, insurers reported that a total of 147,877 Hurricane Michael claims had been filed. While 126,208 claims were reported closed, 21,669 claims remained open.

More than 20,000 Floridians with open claims need assistance. Insurers should redouble efforts to resolve all open claims, using whatever resources are necessary, to provide policyholders with the tools to rebuild their lives and property.

The Office of Insurance Regulation (Office) will be issuing an enhanced data call to collect additional information from insurers regarding open Hurricane Michael claims. This information will assist the Office in evaluating claim payment trends and identifying potential impediments to the prompt closure of claims.

Policyholders have the right to expect prompt, efficient and fair claims adjustment service, especially after a catastrophic loss. The Office demands nothing less. Insurers should therefore concentrate their resources and energy on reaching out to policyholders with open Hurricane Michael claims and taking all actions necessary to bring the claim to closure as quickly as possible.

If you have any questions regarding this memorandum, please contact Susanne Murphy at Susanne.Murphy@floiir.com or (850) 413-5083.