THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET REGULATION

TARGETED MARKET CONDUCT FINAL EXAMINATION REPORT

OF

HERITAGE PROPERTY & CASUALTY INSURANCE COMPANY

NAIC COMPANY CODE: 14407

February 5, 2021

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EXECUTIVE SUMMARY

A targeted market conduct examination of Heritage Property & Casualty Insurance Company ("Heritage" or "the 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

Heritage Property & Casualty Insurance Company is a domestic insurer licensed and authorized to conduct business in Florida on August 17, 2012. The Company is authorized to write Homeowners Multi-Peril, Mobile Home Multi-Peril, and Commercial Multi-Peril coverage.

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

Year	Total Direct Written Premiums in Florida (Per Schedule T of the Annual Statement)
2019	$490,000732
2018	$509,648,869
2017	$530,755,824

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 Heritage pursuant to Section 624.3161, F.S. The examination was performed by a contracted examination firm, Baker Tilly Virchow Krause, 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 of 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 October 1, 2019 and ended November 24, 2020. This is the first market conduct examination of Heritage.

HERITAGE AND HURRICANE MICHAEL STATISTICS

As of October 25, 2019, in response to the Catastrophe Reporting data call, the Company reported receiving a total of 996 Hurricane Michael claims or 0.7% 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 54 complaints related to Hurricane Michael from Heritage consumers. This represents 3.0% of the total number of complaints received from all consumers reporting Hurricane Michael complaints.

TOTAL REPORTED CLAIMS AND COMPLAINTS AS OF OCTOBER 2019			
Heritage Claims	**Total Claims**	**Heritage Complaints**	**Total Complaints**
996	149,773	54	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 5.4%.

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

- 32 complaints, or 59.3% of all complaints, were reported by consumers experiencing a claim handling delay;
- 15 complaints, or 27.8% of all complaints, were made by consumers who reportedly:
  - Were issued claim underpayments;
  - Believed their claims were inappropriately denied;
  - Experienced a delay or lack of response from the Company;
  - Believed their public adjuster was not handling their claim correctly; or
  - Received notices of cancellation due to prior claims history or non-compliance with the Company's underwriting guidelines; and
- 7 complaints, or 13% of all complaints, were attributed to requests made by the Company or a policyholder to participate in mediation due to unresolved claim 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; and

- 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 the payment or on whose behalf payment is made.

CONSUMER COMPLAINTS BY REASON	
Claim Handling Delay	32
Mediation	7
Claim Underpayment	4
Claim Denial	4
Company Delay or No Response	2
Public Adjuster Handling	2
Cancellation/Nonrenewal Claims	2
Cancellation/Nonrenewal Underwriting	1
Total	**54**

At the time of the October 2019 reporting by DFS:

- Seven complaints were open pending resolution;
- 39 complaints were closed:
  - After DFS explained the Company's position to the consumer;
  - Because DFS determined the claim was settled;
  - Because DFS resolved the consumer's issue;
  - After DFS determined the Company's position was based on a contractual provision contained within the insurance policy;
  - Because the Company extended coverage to the consumer;
  - After the Company paid additional money;
  - After the notice of cancellation or non-renewal was withdrawn by the Company; and
  - After DFS determined the consumer was represented by an attorney.
- Three complaints were closed because 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;
- Four complaints were referred to mediation; and
- One notice was issued to the Office of an alleged violation of the Florida Insurance Code after the consumer's issue was satisfactorily resolved by the Company.

The notice issued to the Office was reviewed based on the scope of the examination.

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

HERITAGE COMPLAINT RESOLUTION CATEGORIES	
Open – Pending Resolution	7
Company Position Explained	17
Claim Settled	12
Issue Resolved	4
Resolved Through DFS' Mediation Program	4
Question of Fact	3
Contractual Provision	2
Coverage Extended	1
Notice of Issue – Relief	1
Cancellation/Non-Renewal Withdrawn	1
Additional Payment	1
Attorney Retained	1
Total	**54**

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 1,367 Hurricane Michael claims, an increase of 371 claims from the October 25, 2019 data call. Of the 1,367 total claims reported, the Company recorded that 1,274 claims, or 93.2%, were closed and 93 claims, or 6.8%, remained open as of the reporting date. Of the 1,274 closed claims, 1,097 claims, or 86.1%, were closed with payment, and 177, or 13.9%, 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 1,028 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:

- 658 claims closed with payment;
- 159 claims closed without payment;
- 176 reopened claims; and
- 35 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 292 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 Heritage claims subject to this examination, the total sample size required to achieve a 95% confidence level for all four categories was determined to be 292 claims.

The 292 randomly selected claims consisted of:

- 105 claims closed with payment;
- 76 claims closed without payment;
- 76 reopened claims; and
- 35 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 292 claims. The examiners reviewed and analyzed each of the 292 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 292 randomly selected Hurricane Michael claims by category: 105 claims closed with payment; 76 claims closed without payment; 76 reopened claims; and 35 open claims as of August 30, 2019.

After reviewing 105 **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 102 claims, or 97.1% of the claims closed with payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Three claims were paid after 90 days.

CLAIMS CLOSED WITH PAYMENT	
Paid Within	**Number of Claims**
0-30 days	64
31-60 days	35
61-90 days	3
Over 90 days	3
Total Claims Reviewed	**105**

The examiners determined that one claim closed with 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 two claims closed with payment 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. These factors were reasonably beyond the control of the Company and the claims were determined to have met the 90-day standard.

The results of the examination determined that 104 of the 105 claims reviewed, or 99.0% of the Company's claims closed with payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 76 **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 72 claims, or 94.7% of the claims closed with payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Four claims were denied after 90 days.

CLAIMS CLOSED WITHOUT PAYMENT	
Closed Within	**Number of Claims**
0-30 days	46
31-60 days	18
61-90 days	8
Over 90 days	4
Total Claims Reviewed	**76**

The examiners determined that the four claims closed without payment 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 results of the examination determined that 72 of the 76 claims reviewed, or 94.7% of the Company's claims closed without payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 76 **Reopened Claims**, the examiners determined that when measuring from the date the Company received the first or initial reopened or supplemental claim to the date the claim was paid or denied, the Company paid or denied 49 claims, or 64.5% 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 and eight claims remained open at the conclusion of the examination.

REOPENED CLAIMS	
Paid Within	**Number of Claims**
0-30 days	27
31-60 days	13
61-90 days	9
Over 90 days	19
Remain Open	8
Total Claims Reviewed	**76**

The examiners determined that seven reopened claims 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 12 reopened claims in the over 90 days category and the eight claims that remained open at the conclusion of the examination 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, the claim was in litigation or the claim was delayed by a legal proceeding other than

litigation. These factors were reasonably beyond the control of the Company and the claims were determined to have met the 90-day standard.

The results of the examination determined that 69 of the 76 claims reviewed, or 90.8% of the Company's reopened claims, complied with Section 627.70131(5)(a), F.S.

After reviewing 35 **Open Claims 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 eight claims, or 22.9% claims in an "open" status as of August 30, 2019, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Twenty-five claims were paid after 90 days and two claims remained open at the conclusion of the examination.

OPEN CLAIMS AS OF AUGUST 30, 2019	
Paid Within	**Number of Claims**
0-30 days	2
31-60 days	2
61-90 days	4
Over 90 days	25
Remain Open	2
Total Claims Reviewed	**35**

The examiners determined that one of the 25 open claims as of August 30, 2019 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 24 claims open as of August 30, 2019 in the over 90 days category and the two claims that remained open at the conclusion of the examination 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 or mediation. These factors were reasonably beyond the control of the Company and the claims were determined to have met the 90-day standard.

The results of the examination determined that 34 of the 35 claims reviewed, or 97.1% 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 based on subsequent events that occurred during the course of this examination.

No exceptions were noted.

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 658 Hurricane Michael claims that were closed with payment during the examination scope period. A random sample of 105 claims was selected for review and the findings of the review are as follows:

Finding 1: In one instance out of 105 claims reviewed, an error percentage of 1.0%, the Company did not pay 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 agreed with the violation.

Finding 2: In one instance out of 105 claims reviewed, an error percentage of 1.0%, the Company or the Company's independent adjusting firm did not submit an Emergency Adjuster Application

form to the Department within seven calendar days after adjusting work began, in violation of Rule 69B-220.001(5)(a), F.A.C.

COMPANY RESPONSE: The Company agreed with the violation.

CLAIMS CLOSED WITHOUT PAYMENT

The Company reported a universe of 159 Hurricane Michael claims that were closed without payment during the examination scope period. A random sample of 76 claims was selected for review and the findings of the review are as follows:

Finding 3: In four instances out of 76 claims reviewed, an error percentage of 5.3%, the Company did not pay 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 agreed with the violations.

REOPENED CLAIMS

The Company identified a universe of 176 Hurricane Michael claims that were reopened during the examination scope period. A random sample of 76 claims was selected for review and the findings of the review are as follows:

Finding 4: In 20 instances out of 76 claims reviewed, an error percentage of 26.3%, 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 the violations.

Finding 5: In seven instances out of 76 claims reviewed, an error percentage of 9.2%, the Company did not pay 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 agreed with the violations.

Finding 6: In six instances out of 76 claims reviewed, an error percentage of 7.9%, the Company failed to maintain reasonable claims records, in violation of Section 627.318, F.S.

COMPANY RESPONSE: The Company agreed with five of the six violations and disagreed with one violation.

The violation was retained in this report because the documentation provided was not related to and did not match the claim file reviewed.

Finding 7: In two instances out of 76 claims reviewed, an error percentage of 2.6%, the Company or the Company's independent adjusting firm did not submit an Emergency Adjuster Application form to the Department within seven calendar days after adjusting work began, in violation of Rule 69B-220.001(5)(a), F.A.C.

COMPANY RESPONSE: The Company agreed with the violations.

OPEN CLAIMS AS OF AUGUST 30, 2019

The Company identified a universe of 35 Hurricane Michael claims that were open as of August 30, 2019. The entire universe of 35 claims was reviewed and the findings of the review are as follows:

Finding 8: In one instance out of 35 claims reviewed, an error percentage of 2.6%, the Company did not pay 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 agreed with the violation.

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; the claims proceeds payable under the policies are issued in accordance with those provided by the insurance policy; 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;

- Improve its claims system technology to ensure accurate claims records are created and maintained within the claims files; and

- Eliminate the ability for unlicensed and non-appointed claims adjusters to participate in claims activities.

CONCLUSION

This targeted market conduct examination of Heritage 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 one area within the Company's Reopened claim files where significant improvement is required related to the Company's timely communication with respect to claims. The examination 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 292 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 Infrastructure

The Company employs an experienced team of over 100 full-time claims examiners. The claims function is led by a Chief Claims Officer ("CCO") who has over 20 years of claims handling experience. The CCO has four direct reports who are responsible for various operational functions: a Manager for Quality/Audit; two Vice Presidents of Claims, one who oversees property claim operations, and another who oversees liability, litigation, and the special investigation unit; and an Education Coordinator. In addition, the Company has a legal department as well as a claims support team. The claims employees are located in the Company's Clearwater, Florida and Sunrise, Florida offices.

In 2013, the Company acquired SVM Restoration Services, Inc. ("SVM"), one of the largest service providers in the Contractors' Alliance Network. The acquisition included SVM's employees, equipment, and vehicles. SVM was rebranded as the Heritage Claims Response Team. The SVM acquisition allowed the Company to offer water mitigation and mold remediation services which are performed by Company employees. In 2015, the Company acquired BRC Restoration Specialists, Inc. ("BRC"), a regional contractor which provides additional resources to the Contractors' Alliance Network. The acquisition included BRC's employees, equipment, and vehicles. This acquisition added building construction services for personal and commercial properties to the Company's resource team.

In addition to the in-house resources provided by SVM and BRC, the Company maintains a network of general contractors, mitigation vendors, tree service providers, and roofers throughout Florida, each with significant catastrophe response experience. Many of the Company's claims partners have been involved in multiple catastrophic events, dating back to Hurricane Andrew in August 1992.

The Company's systems permit internal staff to work remotely in the event of a catastrophe. The Company has two call center locations, in addition to a voice-over-internet protocol phone system, with functionality to respond in times of high phone volume. Further, the Company has partnered with a vendor to provide overflow and after-hours call center services.

The Company uses a suite of estimating and claims management tools produced by Xactware, including Xactimate, Xactware's claims-estimating solution, as well as XactAnalysis, Xactware's assignment and analytical tool.

CAT Preparedness and Training

The Company has a formally documented CAT Preparedness Manual. The manual incorporates the Company's general claims handling processes and procedures from its standard claims handling manual and is also supplemented with specific requirements during CAT events. The CAT Preparedness Manual provides specific guidelines and procedures on the topics outlined below:

- CAT Leadership Team
- Catastrophe Preparedness
    - Personal Preparedness
    - Heritage Preparedness
- Personal Lines CAT Claims Process and Staffing
    - Claims Reporting
    - Claim Assignment
    - Accountabilities/Adjustment Process

Specific to Hurricane Michael, the Company prepared and followed a CAT checklist which provided responsible staff and managers with detailed tasks to perform within a certain number of days before landfall.

The Company administers training programs for adjusters primarily through the following channels:

- Catastrophe Preparedness and Expectations Meeting throughout the year. Specific topics include:
    - Preparedness
    - Employee roles and expectations in the claim process
    - The role of the Desk Examiner
    - Policy Cheat Sheets
    - Narrative Report
    - Large Loss Handling
    - Best Practices

- "Live" Claims practices, in which the Company assigns approximately five claims per week to independent adjusting (IA) firms, keep adjusters up to date on the Company's claims handling procedures.

Claims File Documentation and Systems

For reporting claims, policyholders utilized the Company's toll-free telephone number to contact the First Notice of Loss Unit or contacted their agent who was able to file a claim on their behalf. The Company transitioned from the West Point Insurance Solutions claims system to the Majesco policy and claims system. As policies are renewed, they are transferred from West Point into Majesco. Both West Point and Majesco serve to integrate the claims process between desk examiners, management, and members of customer service. Tasks such as dispatching claims to desk examiners and field adjusters, the inspection of properties, the preparation of claims estimates, coverage decisions, the preparation of settlement letters, and the initiation and processing of claims payments are all performed manually. The Company uses Xactimate and XactAnalysis software to act as a "bridge" between field adjusters and desk examiners. The Company used the correct documentation when making coverage determinations. Documents, such as settlement letters, denial letters, and withdrawal letters are manually generated by desk examiners however claims acknowledgement letters are automatically generated.

Claims Handling Process

The Company's Claim Handling Guidelines Catastrophe Best Practices document ("Guidelines"), dated September 2018, directs claims handling for catastrophes. The Company recognizes that timelines for a catastrophic event may be different than those established for non-catastrophic claims given the resultant increase in claims volume. During catastrophe operations, the Guidelines require claims examiners to make voice to voice contact with the insured within 14 days from the assignment of the claim and document the claim file notes regarding the contact attempts and the resulting discussion with the insured. An analysis of the claims files determined that, on average, the Company met the requirement for claims examiners to make voice to voice contact with the insured within 14 days from receiving the assignment of the claim 90% of the time.

The Guidelines require a system generated contact letter to be sent to the insured via regular mail within four days from when the loss is reported. The Company's adjusters may also contact the insured's agent to verify contact information when necessary.

Within a short period of time after the acknowledgment letter is sent, the field adjuster assigned to the claim will schedule an on-site inspection of the property. In certain cases, the Company experienced difficulty with reaching policyholders causing a delay in scheduling or completing the inspection. Many of the delays were attributed to downed power lines and cell towers, or the evacuation or scheduling conflicts of the insured.

Once the field adjuster inspected the property and provided the Company with their estimate of the insured damages, the policyholder was promptly contacted, and settlement of the claim followed shortly thereafter. After the desk examiner spoke with the policyholder about the claim, a letter explaining the details of the settlement or explaining the reasons for a claim denial was sent to the policyholder. Claims payments were initiated on the same day or the day after the settlement was reached with the policyholder. Claims were closed once final claims payments were made to the policyholder.

If additional claims documentation was received from a policyholder or a policyholder's representative, the claim was reopened, and the documentation reviewed. A reinspection of the damaged property was scheduled when any significant variations in estimates occurred. In instances where all parties were able to agree on undisputed damages, payments were promptly made.

The claims files reflect instances where the adjuster handling the claim was reassigned. The Company indicated that claims files could be reassigned due to workflow issues or because the field examiner was no longer under contract with Heritage. The Company was requested to provide data to show the total number of claims adjusters that were assigned to 195 claims files reviewed for this purpose during the examination. Based on the Company's response, 50 claims, or 25% of the claims reviewed, had one to three adjusters assigned; and 73 claims, or 37% of the claims reviewed, had four to six adjusters assigned throughout the lifecycle of the claim. In one case, the Company reported 19 claims adjusters were assigned to a single claim.

Number of Adjusters Assigned	Number of Claim Files	Percentage
0	1	0.5%
1	8	4.1%
2	41	21%
3	34	17.4%
4	26	13.3%
5	13	6.7%
6	10	5.1%
7	9	4.6%
8	7	3.6%
9	9	4.6%
10	12	6.2%
11	8	4.1%
12	6	3.1%
13	3	1.5%
14	1	0.5%
15	2	1%
16	4	2.1%
19	1	0.5%
Total	195	100%

Following Hurricane Michael, in 2019, the Company instituted a Claims Cycle Time Analytics dashboard for management to utilize to ensure losses are reviewed and addressed within 14 days. Heritage stated that the Company takes its obligation to policyholders and the obligation to remain compliant with Florida Statutes very seriously. In 2019, the Company established a Quality Assurance ("QA") business unit within the Claims Department. The head of the QA business unit reports directly to the Chief Claims Officer and is responsible for monitoring and ensuring compliance with Heritage claim handling guidelines and the Florida Statutes. The Company reports it has three employees in this business unit and are adding two additional employees. This business unit uses a dashboard constructed using the Company's data warehouse. The Company's claims managers have access to and are responsible for reviewing the various compliance related dashboards and the QA business unit also uses these tools as a backstop.

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@floir.com or (850) 413-5083.