THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET REGULATION

TARGETED MARKET CONDUCT FINAL EXAMINATION REPORT

OF

SECURITY FIRST INSURANCE COMPANY

NAIC COMPANY CODE: 10117

February 27, 2021

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EXECUTIVE SUMMARY

A targeted market conduct examination of Security First Insurance Company ("Security First" 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

Security First Insurance Company is a domestic Property and Casualty insurer authorized to conduct business in Florida on April 8, 2005. The Company is authorized to write Homeowners Multi-Peril coverage.

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

Year	Total Direct Premiums Written in Florida (Per Schedule T of the Annual Statement)
2019	$434,027,641
2018	$422,400,849
2017	$391,403,660

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 Security First 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 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 9, 2019 and ended December 11, 2020.

The Company's last market conduct examination was completed on October 13, 2014. The scope of that targeted examination reviewed the Company's claims handling, complaint handling,

cancellations and nonrenewals, and underwriting practices. The Company's last examination yielded the following findings:

- In three instances of 46 claim files reviewed, an error percentage of 6.5%, the Company failed to timely investigate claims and improperly denied coverage, in violation of Section 627.70131, F.S.; and

- In one instance of 46 claims files reviewed, an error percentage of 2.2%, the Company incorrectly denied a claim based upon an incorrect interpretation of the insurance contract's policy provision, in violation of Section 626.877, F.S.

SECURITY FIRST AND HURRICANE MICHAEL COMPLAINT STATISTICS

As of October 25, 2019, in response to the Catastrophe Reporting data call, the Company reported receiving a total of 4,561 Hurricane Michael claims or 3.04% 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 113 complaints related to Hurricane Michael from Security First consumers. This represents 6.3% of the total number of complaints received from all consumers reporting Hurricane Michael complaints.

TOTAL REPORTED CLAIMS AND COMPLAINTS AS OF OCTOBER 2019			
Security First Claims	**Total Claims**	**Security First Complaints**	**Total Complaints**
4,561	149,773	113	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 2.48%.

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

- 55 complaints, or 48.7% of all complaints, were reported by consumers experiencing a claim handling delay;
- 32 complaints, or 28.3% of all complaints, were made by consumers who reportedly:
    - Were issued claim underpayments;
    - Received unsatisfactory settlement offers;
    - Believed their claims were inappropriately denied;
    - Experienced a delay or lack of response from the Company;
    - Received a notice of cancellation or nonrenewal due to non-compliance with the Company's underwriting guidelines;
    - Believed their public adjuster was not handling the claim appropriately;
    - Were concerned with the amount of the deductible applied to their claim; and

- 26 complaints, or 23% 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;

- 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; and

- Unsatisfactory Settlement Offer as a complaint that an adjuster's or the Company's offer to settle a claim is in an amount which is less than the insured thinks should be paid.

SECURITY FIRST CONSUMER COMPLAINTS BY REASON	
Claim Handling Delay	55
Mediation	26
Claim Underpayment	10
Unsatisfactory Settlement Offer	9
Claim Denial	6
Company Delay or No Response	3
Cancellation or Nonrenewal Claims	2
Public Adjuster Handling	1
Deductible Issue	1
Total	**113**

At the time of the October 2019 reporting by DFS:

- Four complaints were open pending resolution;
- 74 complaints were closed:
    - After DFS explained the Company's position to the consumer;
    - Because DFS determined the claim was settled;
    - 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;
    - Because DFS resolved the consumer's issue;
    - After the insurer reopened the consumer's claim;
    - Because DFS determined the Company's position was based on a contractual provision contained within the consumer's insurance policy; or
    - Because the insurer extended coverage to the consumer;
- Two consumer complaints were referred to mediation;
- Five notices were issued to the Office of alleged violations of the Florida Insurance Code after the consumers' issues were satisfactorily resolved by the Company; and

- Two notices were issued to the Office of alleged violations of the Florida Insurance Code after the consumers' issues were not satisfactorily resolved by the Company.

The seven notices issued to the Office were reviewed based on the scope of this examination.

The remaining 26 mediation complaints were resolved in accordance with DFS' mediation program.

SECURITY FIRST COMPLAINT RESOLUTION CATEGORIES	
Open – Pending Resolution	4
Company Position Explained	43
Resolved Through DFS' Mediation Program	26
Claim Settled	15
Question of Fact	9
Notice Issued – Relief	5
Issue Resolved	4
Referred to Mediation	2
Notice Issued – No Relief	2
Claim Reopened	1
Contractual Provision	1
Coverage Extended	1
Total	**113**

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 4,742 Hurricane Michael claims, an increase of 181 claims from the October 25, 2019 data call. Of the 4,742 total claims reported, the Company recorded that 4,391 claims or 92.6%, were closed and 351 claims, or 7.4%, remained open as of the reporting date. Of the 4,391 closed claims, 3,383 claims, or 77%, were closed with payment and 1,008 claims, or 23%, 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

4,536 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:

- 2,863 claims closed with payment;
- 965 claims closed without payment;
- 106 reopened claims; and
- 602 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 394 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 Security First claims subject to this examination, the total sample size required to achieve a 95% confidence level for all four categories was determined to be 394 claims.

The 394 randomly selected claims consisted of:

- 108 claims closed with payment;
- 105 claims closed without payment;
- 76 reopened claims; and
- 105 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 the 394 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 394 randomly selected Hurricane Michael claims by category: 108 claims closed with payment; 105 claims closed without payment; 76 reopened claims; and 105 open claims as of August 30, 2019.

After reviewing 108 **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 99 claims, or 91.7% of the claims closed with payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Nine claims were paid after 90 days.

CLAIMS CLOSED WITH PAYMENT	
Paid Within	**Number of Claims**
0-30 days	66
31-60 days	24
61-90 days	9
Over 90 days	9
Total Claims Reviewed	**108**

The examiners determined that the nine claims closed with payment in the over 90 days category were 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. 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 108 of the 108 claims reviewed, or 100% of the Company's claims closed with payment, complied with Section 627.71031(5)(a), F.S.

After reviewing 105 **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 104 claims, or 99.0% of the claims closed without payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. One claim was denied after 90 days.

CLAIMS CLOSED WITHOUT PAYMENT	
Closed Within	**Number of Claims**
0-30 days	94
31-60 days	8
61-90 days	2
Over 90 days	1
Total Claims Reviewed	**105**

The examiners determined that the claim closed without payment 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. These factors were 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 105 of the 105 claims reviewed, or 100% of the Company's claims closed without payment, complied with Section 627.71031(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 59 claims, or 77.6% of the reopened claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Seventeen claims were paid after 90 days.

REOPENED CLAIMS	
Paid Within	**Number of Claims**
0 – 30 days	30
31 – 60 days	17
61 – 90 days	12
Over 90 days	17
Total Claims Reviewed	**76**

The examiners determined that three 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 14 reopened claims 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. 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 73 of the 76 claims reviewed, or 96.1% of the Company's reopened claims, complied with Section 627.70131(5)(a), F.S.

After reviewing 105 **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 payment was paid or denied, the Company paid or denied 29 claims in an "open" status as of August 30, 2019, or 27.6% of the claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Fifty-six claims were paid or denied after 90 days and 20 claims remained open at the conclusion of the examination.

OPEN CLAIMS AS OF AUGUST 30, 2019	
Paid Within	**Number of Claims**
0 – 30 days	14
31 – 60 days	12
61 – 90 days	3
Over 90 days	56
Remained Open	20
Total Claims Reviewed	**105**

The examiners determined that two of the 56 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 54 open claims as of August 30, 2019 in the over 90 days category and the 20 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 103 of the 105 claims reviewed, or 98.1% of the Company claims open as of August 30, 2019, complied with Section 6237.70131(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 clams 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 two areas substantially deviated from the Company's internal standards.

The first area related to the Company's implementation of a newly created enterprise-wide call center, Customer and Agent Response Experts ("CARE"). Policyholders, claimants, agents, and adjusters experienced significant hold times during the months of September and October 2019. During both months, the largest percentage of calls were on hold between five minutes and 30 minutes. The Company resolved the issue by November 2019 as the average hold time for the month was recorded as 0:46 seconds.

The second area related to internal server issues that affected the Company's ability to assist consumers during an Insurance Village held on November 15, 2019. The Company stated its Information Technology Department created necessary workarounds that enabled employees to continue with normal work assignments in support of agents and policyholders. The Company also confirmed that its in-house sales call center queue suffered intermittent outages that impacted the Company's ability to sell new policies but did not impact the Company's ability to service existing policyholders. Though a policyholder attempted to work with the Company's claims adjuster during the Insurance Village on November 15, 2019, the adjuster was not able to assist the policyholder due to the internal server issues.

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 2,863 Hurricane Michael claims that were closed with payment during the examination scope period. A random sample of 108 claims was selected for review and the findings of the review are as follows:

Finding 1: In 13 instances out of 108 claims reviewed, an error percentage of 13%, the Company utilized persons who were either not licensed or appointed by an appropriate appointing entity or person as insurance adjusters at the time the claim was adjudicated, in violation of Section 626.112(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with 12 of the violations but disagreed with one violation.

The violation was retained in the examination report because the field adjuster was neither licensed nor appointed on the date the field adjuster completed the inspection.

Finding 2: In eight instances out of 108 claims reviewed, an error percentage of 7.4%, the Company failed to maintain reasonable claims records, in violation of Section 627.318, F.S.

COMPANY RESPONSE: The Company agreed with the violations.

Finding 3: In one instance out of 108 claims reviewed, an error percentage of 0.9%, the Company's adjuster failed to adjust the claim in accordance with the terms and conditions of the contract, as required by Section 626.877, F.S.

COMPANY RESPONSE: The Company agreed with the violation.

CLAIMS WITHOUT PAYMENT

The Company reported a universe of 965 Hurricane Michael claims that were closed without 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 4: In five instances out of 105 claims reviewed, an error percentage of 4.8%, the Company utilized persons who were either not licensed or appointed by an appropriate appointing entity or person as insurance adjusters at the time the claim was adjudicated, in violation of Section 626.112(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with four of the violations but disagreed with one violation.

The violation was retained in the examination report because the desk examiner was licensed but was not appointed on the dates the desk examiner was assigned to the claim.

Finding 5: 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.

REOPENED CLAIMS

The Company identified a universe of 106 Hurricane Michael claims that were reopened as an additional claim that had previously been adjusted pursuant to the initial claim. A random sample of 76 claims was selected for review and the findings of the review are as follows:

Finding 6: In three instances out of 76 claims reviewed, an error percentage of 3.9%, the Company did not pay or deny the claims 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 to the policyholder as required by the statute.

COMPANY RESPONSE: The Company agreed with one violation but disagreed with two violations.

Both violations were retained in this report because the Company did not provide documentation to support that either claim was paid within 90 days or that factors existed beyond the control of the Company to reasonably prevent paying or denying the claims within 90 days.

Finding 7: In two instances out of 76 claims reviewed, an error percentage of 2.6%, the Company utilized persons who were either not licensed or appointed by an appropriate appointing entity or person as insurance adjusters at the time the claim was adjudicated, in violation of Section 626.112(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with one violation but disagreed with the second violation.

The violation was retained in the examination report because the desk examiner was licensed but was not appointed on the dates the desk examiner was assigned to the claim.

Finding 8: In two instances out of 76 claims reviewed, an error percentage of 1.9%, 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 9: In one instance out of 76 claims reviewed, an error percentage of 1.3%, the Company's adjusters made a material misrepresentation to the policyholder by issuing proceeds payable under the policy that effected the settlement of the claims on less favorable terms than those provided by the insurance policy, in violation of Section 626.9541(1)(i)2., F.S.

COMPANY RESPONSE: The Company agreed with the violation.

OPEN CLAIMS AS OF AUGUST 30, 2019

The Company reported a universe 602 Hurricane Michael claims that were open as of August 30, 2019. A random sample of 105 claims was selected for review and the findings of the review are as follows:

Finding 10: In four instances out of 105 claims reviewed, an error percentage of 3.8%, the Company utilized persons who were either not licensed or appointed by an appropriate appointing entity or person as insurance adjusters at the time the claim was adjudicated, in violation of Section 626.112(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with three of the violations but disagreed with one violation.

The violation was retained in this report because the field adjuster was licensed but was not appointed on the date the field adjuster completed the inspection.

Finding 11: In two instances out of 105 claims reviewed, an error percentage of 1.9%, the Company did not pay or deny the claims 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 to the policyholder as required by the statute.

COMPANY RESPONSE: The Company disagreed with both violations.

Both violations were retained in this report because the Company did not provide documentation to support that either claim was paid within 90 days or that factors existed beyond the control of the Company to reasonably prevent paying or denying the claims within 90 days.

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; that 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;

- Eliminate the ability for unlicensed or un-appointed independent or emergency claims adjusters to participate in claims activities; and

- Continuously monitor call center hold times and internal server issues to reduce policyholder delays and inconvenience especially after catastrophic events occur and while participating in DFS Insurance Villages.

CONCLUSION

This targeted market conduct examination of Security First 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 394 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

The Company maintains a current Catastrophe Management Guide which includes directions and reactive steps after as disaster and business continuity strategies for weather events predicted to make landfall anywhere in the State of Florida. The Company currently utilizes six Third Party Administrators ("TPA") to provide field adjuster and desk examination services during catastrophic events. The TPA's have committed 860 field adjusters and 410 desk examiners to the Company in the event of a catastrophe. The TPA's are able to provide additional field adjusters, as needed. Safelite Solutions, the Company's contracted call center, provides two call centers across the country and has multiple facilities for server back-up as well as. The Company's Catastrophe Plan is the framework the Company uses as a guide during changing circumstances produced by weather events.

The TPA's utilize the Company's claims systems when providing claim handling services. The TPA agreements require the TPA to ensure all adjusters are properly licensed and appointed prior to adjudicating claims, are available for assignment during hurricane season, and comply with federal, state, and local laws. The TPA agreements also stipulate the Company will provide knowledgeable personnel to facilitate its services in accordance with the agreement, have discretion to assign claims and maintain ultimate responsibility for authorizing claim payments and claim settlements.

The Company provides live, instructor-led, adjuster training programs that are conducted by a third-party training resource. The Company's goal is to conduct quarterly training sessions, but training is provided more often, if deemed necessary. The Company offers reimbursement for Continuing Education ("CE") courses as required by DFS. Field adjusters are welcome to participate in CE vendor training sessions that are part of the provided claims training. CE training and completion is tracked by the CE provider and is submitted to the DFS to ensure compliance requirements are met. The Company provided desk examiner training for field adjusters and desk examiners in December 2018 and April 2019.

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 330 claims files reviewed for this purpose during the examination. Based on the Company's response, 120 claims, or 36.3% of the claims reviewed, had one to three adjusters assigned throughout the lifecycle of the claim; 89 claims, or 26.9% of the claims reviewed, had four to six adjusters assigned; and 78 claims, or 23.64% of the claims reviewed, had seven to ten adjusters assigned throughout the lifecycle of the claim. In one case, the Company reported 17 claims adjusters were assigned to a single claim.

Number of Adjusters Assigned	Number of Claim Files	Percentage
1	2	0.61%
2	62	18.79%
3	56	16.97%
4	33	10%
5	25	7.58%
6	31	9.39%
7	22	6.67%
8	20	6.06%
9	19	5.76%
10	17	5.15%
11	13	3.94%
12	14	4.24%
13	2	0.61%
14	7	2.12%
15	5	1.52%
16	1	0.30%
17	1	0.30%
Total	**330**	**100%**

The Company's claims administration system is integrated with its agency and administration portals. The claims system captures file notes, creates outgoing documents, and saves incoming attachments. The system also includes a section for policy contract documentation which the Company imports into the attachments. Policyholders and vendors are able to upload estimates, receipts, and transmittals into the claims system via email to a central document repository.

Notices of claims are primarily received by policyholders via telephone call and internet chatbot. The Company's procedure is to assign the loss to an adjuster on the same day the notice of a claim is received from the policyholder or the policyholder's representative. Policyholder contact (voice to voice) is attempted by the assigned adjuster within 24 hours of receipt of the claim assignment. If the adjuster is unable to contact the insured or a representative within 48 hours, a contact letter or email is sent to the policyholder or the policyholder's representative. A follow-up is made if there is no response within 10 days of the mailed contact letter. Claim acknowledgment is mailed via the United States Postal Service and includes the Homeowner Bill of Rights and the Notice of Right to Mediation. The Company reported that it also emailed claim acknowledgment letters containing a link to the Homeowner Bill of Rights for those insureds who were difficult to contact. Documentation of timely mailed and emailed claim acknowledgment letters were noted in the Company's claim files. The Company is proactive in working with insureds to mitigate further property damage through strategic alliances with tarping, water mitigation, mold remediation companies.

During the initial contact with the policyholder, the adjuster establishes the policyholder's preferred method of contact. It is the Company's stated policy that phone calls must be returned no later than the next business day and written correspondence must be returned within two business days.

The Company's internal catastrophe TPA presentation requires adjusters to document that appointments for site inspections are set with the policyholder within 48 hours from the date the loss was reported. The review of the Company's claims files determined that the Company, on average, met this requirement 95.6% of the time. The Company's internal catastrophe Adjuster Guidelines require the inspection of the damaged property to take place within four business days of the adjuster's receipt of the assignment. The review of the Company's claim files determined that the Company, on average, met this requirement 94.2% of the time.

When the inspection is completed the field adjuster transmits the estimate, generally the day after the inspection, through the claims portal for the Company's review. The Company evaluates the claim within 72 hours of receipt of the inspection estimate. Once the final settlement is determined, payment authorization is required to be obtained from the adjuster's manager or examiner if the amount of the damages exceed the adjuster's authority. For requested payments in excess of $25,000, authorization must be obtained from a Senior Examiner or above. It is the Company's policy that if there is a dispute over the total amount of the claim, the undisputed portion is released. The review of the Company's claim files determined the undisputed portion of the claim was settled timely. It is the Company's policy to send claim settlements no later than one business day from the approval date.

The Company made initial claims payments for Dwelling - Coverage A and Other Structures – Coverage B based on the initial site inspection. Policyholders were instructed to obtain and submit supplemental claims and estimates for repairs in the event repair estimates exceeded the Company's initial claim payment amount. The Company paid Additional Living Expense ("ALE") benefits on an incurred basis.

The Company categorized claims as: (1) Desk Handled-Simple Fast-Tracked Claims; (2) Moderately Difficult – may require re-inspection and negotiations; (3) Complex – High dollar losses, complicated claim issues, public adjuster and/or attorney involvement. Moderately Difficult and Complex Claims were recorded as having longer processing lives. Claims deemed to be total losses were noted to have Coverages A and B quickly settled, ALE benefits were paid as incurred for the remainder of the policy term, and Personal Property - Coverage C was paid upon submission of the personal property inventory by the policyholder. The Company released recoverable depreciation to the policyholder upon receipt of a Certificate of Completion or evidence of claim settlement with the contractor. In some cases, recoverable depreciation was released upon presentation of a contractor/policyholder signed contract for repairs.

Subsequent Event 1:

On October 30, 2019, during the course of the examination, the Office received notification that calls to the Company's Claims Customer Response Unit ("CCR") were placed on hold for 20 minutes or more before being answered. On October 30, 2019, the Office called the CCR

telephone number, confirmed the hold time was greater than 20 minutes, and contacted the Company. The Company stated that it had recently made the decision to create an enterprise-wide call center, Customer and Agent Response Experts ("CARE"), by combining the underwriting and claims call centers to better service customers, agents, and strategic partners. The Company confirmed the initial integration of CARE occurred on November 4, 2019, when the Company moved to its new headquarters. The Company stated it created a call transition plan to move calls directly to the appropriate area based on a claim's assigned status of First Response, Assessment, or Settlement and Repair. The Company indicated its multi-phased plan incorporated the use of enhanced chatbot technology, skill-based call routing, and places an emphasis on customer service training and development for new CARE unit employees and the Company's assigned claims adjusters.

A review of the Company's call logs by the Office for the months of September and October 2019 reflect that the average hold times were 8:06 minutes and 10:36 minutes, respectively. The longest hold times were recorded as two hours, 13 minutes on September 21, 2019 and one hour, 56 minutes on October 23, 2019. During both months, the largest percentage of calls were on hold between five minutes and 30 minutes.

SEPTEMBER 2019 CCR CALL LOG		
Hold Time	**Number of Calls**	**Percentage of Total**
0 minutes	1,011	5.4%
0:01-5:00 minutes	7,149	38.5%
5:01-15:00 minutes	7,692	41.4%
15:01-30:00 minutes	2,398	13%
30:01-45:00 minutes	244	1.3%
45:01-60:00 minutes	49	0.3%
Over 60:00 minutes	25	0.1%
Totals	**18,568**	**100%**

OCTOBER 2019 CCR CALL LOG		
Hold Time	**Number of Calls**	**Percentage of Total**
0 minutes	1,057	5.0%
0:01-5:00 minutes	6,209	29.2%
5:01-15:00 minutes	8,286	39.0%
15:01-30:00 minutes	5,087	24.0%
30:01-45:00 minutes	488	2.3%
45:01-60:00 minutes	86	0.4%
Over 60:00 minutes	26	0.1%
Totals	**21,239**	**100%**

In December 2019, the Office requested, and the Company provided, call logs for the month of November 2019. The Office's review of the Company's call log reflects that the Company

received a total of 28,438 calls between November 5, 2019, and November 29, 2019, and the average hold time was reduced to 0:46 seconds. The longest hold time was recorded on November 18, 2019, as 27 minutes, 47 seconds. The largest percentage of calls received from policyholders experienced no hold times or hold times of five minutes or less.

NOVEMBER 2019 CARE CALL LOG		
Hold Time	**Number of Calls**	**Percentage of Total**
0 minutes	15,623	54.9%
0:01-5:00 minutes	12,159	42.8%
5:01-15:00 minutes	630	2.2%
15:01-30:00 minutes	26	0.1%
30:01-45:00 minutes	0	0%
45:01-60:00 minutes	0	0%
Over 60:00 minutes	0	0%
Totals	**28,438**	**100%**

Subsequent Event 2:

The Office received a complaint on November 21, 2019, after a Security First policyholder attended the DFS Insurance Village on November 15, 2019. The purpose of the DFS Insurance Villages is to assist policyholders with the claims process and to provide policyholders with face-to-face interaction and direct communication with their insurance companies. The insurers are requested to send claims adjusters with the appropriate authority to assist policyholders, address and resolve claims issues, and, when appropriate, issue claims checks either during the event or shortly thereafter.

In the complaint, the policyholder reported that the Company's claims adjuster informed her she could not receive assistance with her claim during the visit to the Insurance Village because the Company's computers and call center had not been functioning properly all week. The Office contacted the Company for a response.

While the Company confirmed that it suffered internal server issues, the Company stated its Information Technology Department created necessary workarounds that enabled employees to continue with normal work assignments in support of agents and policyholders. The Company also confirmed that its in-house sales call center queue suffered intermittent outages that impacted the Company's ability to sell new policies but did not impact the Company's ability to service existing policyholders.

Though the policyholder attempted to work with the Company's claims adjuster during the Insurance Village on November 15, 2019, the adjuster was not able to assist the policyholder due to the internal server issues.

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.