THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET REGULATION

TARGETED MARKET CONDUCT FINAL EXAMINATION REPORT

OF

TOWER HILL PREFERRED INSURANCE COMPANY

NAIC CODE: 29050

NAIC GROUP CODE: 3484

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EXECUTIVE SUMMARY

A targeted market conduct examination of Tower Hill Preferred Insurance Company ("Preferred" 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

Tower Hill Preferred Insurance Company is a domestic Property and Casualty insurer authorized to conduct business in Florida on October 29, 1997. Preferred is authorized to write Fire; Allied Lines; Homeowners Multi-Peril; Inland Marine; Boiler and Machinery; Other Liability; Private Passenger Auto Liability and Physical Damage; and Mobile Home Multi-Peril coverage. Preferred is a member of the Tower Hill Insurance Group ("Group") which, during the scope of the examination, was comprised of Preferred, Omega Insurance Company, Tower Hill Prime Insurance Company, Tower Hill Select Insurance Company, and Tower Hill Signature Insurance Company.

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

Year	Total Written Premium in Florida (Per Schedule T of the Annual Statement)
2019	$107,489,934
2018	$99,965,815
2017	$104,237,707

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 Preferred pursuant to Section 624.3161, F.S. The examination was performed by a contracted examination firm, NOVO Consulting Group, LLC 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 insurers, 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 January 22, 2021.

The last market conduct examination of Preferred was completed on November 30, 2004. The scope of that targeted examination reviewed the insurers' responses to hurricane claims and verified the insurer's compliance with the guidance provided in the Office's emergency orders.

Preferred's last examination yielded the following findings:

- In 10,596 instances of the 10,737 claims files reviewed, Preferred reviewed and acknowledged receipt of a communication with respect to a claim within 14 calendar days, as required by Rule 69O-166.024, F.A.C.

- In 16 instances of 25 complaint files reviewed, Preferred's adjusters did not timely respond to consumers or consumers had not heard from Preferred's adjusters after an inspection of the property was completed.

PREFERRED AND HURRICANE MICHAEL STATISTICS

As of October 25, 2019, in response to the Catastrophe Reporting data call, the Company reported receiving a total of 581 Hurricane Michael claims or 0.39% 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 13 complaints related to Hurricane Michael from Preferred consumers. This represents 0.7% of the total number of complaints received from all consumers reporting Hurricane Michael complaints.

TOTAL REPORTED CLAIMS AND COMPLAINTS AS OF OCTOBER 2019			
Preferred Claims	**Total Claims**	**Preferred Complaints**	**Total Complaints**
581	149,773	13	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 2.22%.

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

- Nine complaints, or 69.2% of all complaints, were reported by consumers experiencing a claim handling delay;
- Three complaints, or 23.1% of all complaints, were made by consumers who reportedly:
  - Received an unsatisfactory settlement offer;
  - Experienced a delay or lack of response from the Company; or
  - Experienced a contract dispute with the Company; and
- One complaint, or 7.7% of all complaints, were attributed to a request made by the Company or the policyholder to participate in mediation due to an unresolved claim issue.

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

CONSUMER COMPLAINTS BY REASON	
Claim Handling Delay	9
Mediation	1
Unsatisfactory Settlement Offer	1
Company Delay or No Response	1
Contract Dispute	1
Total	**13**

At the time of the October 2019 reporting by DFS:

- One complaint was open pending resolution;
- Eight complaints were closed:
  - After DFS explained the Company's position to the consumer; or
  - Because DFS determined the claim was settled;
- Two 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; and
- One notice was issued to the Office of alleged violations 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 this examination.

The remaining mediation complaint was resolved in accordance with DFS' mediation program.

PREFERRED COMPLAINT RESOLUTION CATEGORIES	
Company Position Explained	5
Claim Settled	3
Question of Fact	2
Resolved Through DFS' Mediation Program	1
Notice Issued – Relief	1
Open Pending Resolution	1
Total	**13**

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 612 Hurricane Michael claims, an increase of 31 claims from the October 25, 2019 data call. Of the 612 total claims reported, the Company recorded that 588 claims, or 96.1%, were closed and 24 claims, or 3.9%, remain open as of the reporting date. Of the 588 closed claims, 529 claims, or 90%, were closed with payment, and 59 claims, or 10%, 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 581 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:

- 174 claims closed with payment;
- 41 claims closed without payment;
- 315 reopened claims; and

- 51 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 250 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 Preferred claims subject to this examination, the total sample size required to achieve a 95% confidence level for all four categories was determined to be 250 claims.

The 250 randomly selected claims consisted of:

- 76 claims closed with payment;
- 41 claims closed without payment;
- 82 reopened claims; and
- 51 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 250 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 250 randomly selected Hurricane Michael claims by category: 76 claims closed with payment; 41 claims closed without payment; 82 reopened claims; and 51 open claims as of August 30, 2019.

After reviewing 76 **Claims Closed with Payment,** the examiners calculated 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 66 claims, or 86.8% of the claims closed with payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Ten claims were paid after 90 days.

CLAIMS CLOSED WITH PAYMENT	
Paid Within	**Number of Claims**
0-30 days	43
31-60 days	18
61-90 days	5
Over 90 days	10
Total Claims Reviewed	**76**

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

The results of the examination determined that 76 of the 76 claims reviewed, or 100% of the Company's claims closed with payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 41 **Claims Closed Without Payment**, the examiners calculated 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 40 claims, or 97.6% of the claims closed without payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. One claim was denied after 90 days.

CLAIMS CLOSED WITHOUT PAYMENT	
Closed Within	**Number of Claims**
0-30 days	33
31-60 days	6
61-90 days	1
Over 90 days	1
Total Claims Reviewed	**41**

The examiners determined the claim in the over 90 days category was not in violation of Section 627.70131(5)(a), F.S. because Preferred 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 Preferred's control and the claim was determined to have met the

90-day standard.

The results of the examination determined that 41 of the 41 claims reviewed, or 100% of the Company's claims closed without payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 82 **Reopened Claims**, the examiners calculated 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 77 claims, or 93.9% of the reopened claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Four claims were paid or denied after 90 days and one claim remained open at the conclusion of the examination.

REOPENED CLAIMS	
Paid Within	**Number of Claims**
0-30 days	63
31-60 days	10
61-90 days	4
Over 90 days	4
Remained Open	1
Total Claims Reviewed	**82**

The examiners determined that four claims in the over 90 days category and the claim that remained open at the conclusion of the examination were not in violation of Section 627.70131(5)(a), F.S. because Preferred was pending receipt of documentation or communication needed from the policyholder or the policyholder's representative to resolve the claims. These factors were reasonably beyond Preferred's control and the claims were determined to have met the 90-day standard.

The results of the examination determined that 82 of the 82 claims reviewed, or 100% of the Company's reopened claims, complied with Section 627.70131(5)(a), F.S.

After reviewing 51 **Open Claims as of August 30, 2019**, the examiners calculated that when measuring 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 34 claims in an "open" status as of August 30, 2019, or 66.7% of the claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Seventeen claims were paid or denied after 90 days.

OPEN CLAIMS AS OF AUGUST 30, 2019	
Paid Within	**Number of Claims**
0-30 days	24
31-60 days	9
61-90 days	1
Over 90 days	17
Total Claims Reviewed	**51**

The examiners determined that one of the 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 examiners determined that 16 claims in the over 90 days category were not in violation of Section 627.70131(5)(a), F.S. because Preferred was pending receipt of documentation or communication needed from the policyholder or the policyholder's representative to resolve the claims. These factors were reasonably beyond the control of Preferred and the claims were determined to have met the 90-day standard.

The results of the examination determined that 50 of the 51 claims reviewed, or 98% 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.

The results of the adherence review determined that one area significantly deviated from the Company's internal standards. The Company's 2018 Cat Examination Training and 2018 Catastrophe Response Plan requires field adjusters to attempt contact with policyholders within 24 hours of assignment to a claim to schedule the inspection, if an inspection of the loss is required. The examiners reviewed 171 claim files to determine the Company's adherence to this standard. Of the 171 claim files reviewed, the Company conducted 54 inspections. Of the 54 inspections conducted, 27, or 50%, were scheduled within 24 hours of the adjuster's assignment to the claim.

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 174 Hurricane Michael claims that were closed with 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 1: In two instances out of 76 claims reviewed, an error percentage of 2.6%, the Company utilized persons who were 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 the violations.

CLAIMS CLOSED WITHOUT PAYMENT

The Company reported a universe of 41 Hurricane Michael claims that were closed without payment during the examination scope period. All 41 claims were selected and reviewed. No exceptions were noted.

REOPENED CLAIMS: The Company identified a universe of 315 claims that were reopened as an additional claim that had previously been adjusted pursuant to the initial claim. A random sample of 82 claims was selected for review and the findings of the review are as follows:

Finding 2: In two instances out of 82 claims reviewed, an error percentage of 2.4%, the Company utilized a person who was not licensed and appointed by an appropriate appointing entity or person as insurance adjusters at the time the claim was adjudicated; and utilized a person who was licensed but not appointed at the time the claim was adjudicated, in violation of Section 626.112(1)(a), F.S.

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

The second violation is contained within this report because, while the adjuster's license was active on the date the claim was adjudicated, the adjuster's appointment was not active on that same date. The referenced statute requires insurance adjusters to be both licensed by DFS and appointed by an appropriate entity or person.

OPEN CLAIMS AS OF AUGUST 30, 2019

The Company reported a universe of 51 Hurricane Michael claims that were open as of August 30, 2019. All 51 claims were selected and reviewed. The findings of the review are as follows:

Finding 3: In one instance out of 51 claims reviewed, an error percentage of 2.0%, the Company did not pay or deny the claim within 90 days after receiving notice of the claim from the policyholder, in violation of Section 627.70131(5)(a), F.S.

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;
- 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 claims adjusters to participate in claims activities; and
- Ensure field adjusters consistently adhere to internal standards that require them to contact policyholders within 24 hours of their assignment to a claim to schedule the inspection if an inspection of the loss is required.

CONCLUSION

This targeted market conduct examination of Preferred 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 250 Hurricane Michael claims. This report contains a number of recommendations for improvement and remediation that should be implemented by the Company. It does not document what regulatory or administrative action may be taken by the Office. Any such action taken as a result of this targeted market conduct examination will be the subject of a separate Order issued by the Office.

EXAMINATION FINAL REPORT SUBMISSION

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

ADDENDUM A

CLAIMS OVERVIEW

Cat Claims Infrastructure

The Tower Hill Group ("Group") coordinated catastrophe claims operations for all member insurers with reported Hurricane Michael claims which included Preferred, Omega Insurance Company, Tower Hill Prime Insurance Company, Tower Hill Select Insurance Company, and Tower Hill Signature Insurance Company. The Group's Catastrophe Response Plan for Hurricane Michael was executed when the volume of hurricane-related claims exceeded 500. The First Notice of Loss (FNOL) was the initial step in reporting a claim for the Group's policyholders. The Group provided policyholders with four methods for reporting claims:

- Online using a customer log-in that allowed customers to access their online account to file a claim;
- Quick FNOL; a link accessed via text message that was sent to customers identified as having a property insured in the path of the storm and for whom the Group had policyholder cell phone numbers;
- The policyholder's agent; and
- Standard telephone call.

Upon receiving a claim, the Group's claims system automatically assigned claims for monitoring and review based on the following criteria:

- Regardless of the severity of the reported damage (light, moderate, severe, or total loss) all claims were assigned to an inside examiner, an adjuster employed by the Group, for monitoring;
- Severe and total loss severity claims were automatically assigned to an independent field adjuster as well as an inside examiner; thereby assigning two reviewers to each claim; and
- Light and moderate severity claims were assigned to independent field adjusters and were only reviewed by the inside examiner, if needed.

The Group's inside examiners and employees from supporting departments were able to communicate through the Group's claims systems allowing for better quality and high efficiency claims handling. The Group's inside examiners also had full access to communicate with every field adjusting firm assigned to handle Hurricane Michael claims.

Customer Service

During Hurricane Michael, the Group employed customer service team members in their Gainesville, Florida ("Gainesville") and Lexington, Kentucky ("Lexington") locations. Lexington was assigned as the primary location for receiving FNOL, as it was located outside of Florida where Hurricane Michael made landfall. The Group set up 38 workstations in the Lexington office for temporary employees assigned to assist during Hurricane Michael and had the capability of adding up to 45 more temporary employees, if necessary.

A maximum of 30 temporary employees were hired to assist with responding to Hurricane Michael

telephone calls for a combined total of 60 employees which were located as follows:

- A total of 20 temporary employees were located in the Lexington office;
- A total of 10 temporary employees were located in the Gainesville office; and
- A total of 30 permanent customer service call center employees were split evenly between the Lexington and Gainesville offices.

Temporary employees received training on the Citadel claims system and the Group's FNOL guidelines prior to Hurricane Michael making landfall and in preparation for answering calls. The Gainesville location was used as a backup if additional resources were needed or in the event technical issues occurred in the Lexington office. The Group had the capacity to add an additional 44 temporary employees within the Gainesville location, if needed.

The Group's team of independent field adjusters were hired from Bluegrass Independent Adjusters ("Bluegrass") to provide claims scope and estimating services related to severe or total loss claims. Also assigned as the Group's initial response wave for Hurricane Michael, Bluegrass ensured up to 50 independent field adjusters were ready for deployment. If more than 50 independent field adjusters were needed, the Group hired other vendor partners to provide claims handling services. The Group's entire claims activity was managed by the designated field staff and they reported to the Group's Field CAT manager.

Hurricane Michael Training

The Group provides training to their adjusters for all catastrophic events called CAT Examination Just in Time ("JIT") Training. JIT training was completed twice during the 2018 calendar year; training was provided in an e-learning environment prior to hurricane season in February-March 2018, and in-person, instructor-led JIT training was provided at the time of Hurricane Michael's landfall.

Pre-hurricane season online JIT training is provided for all contracted vendors. Once contracted, all vendors also complete the Tower Hill Catastrophe Certification that consists of 10 or more hours of online training and requires contracted vendors to complete and pass all sections of the training. Training is required to be completed annually.

Sufficiency and clarity of claims file documentation

The Group's claims files and accompanying records are well maintained. Each claim file reviewed was determined to be sufficiently clear and specific so that pertinent events and dates of these events could be reconstructed for review during the examination.

Physical Equipment

All physical equipment required to perform field adjusting services was provided by the Group's contracted vendors. The only claims-related equipment provided by the Group to the contracted vendors was system based estimating software. All claims-related documents were sent through a secure email that uploaded to the Group's secure claims management platform, called Image Right, for review and future reference. Vendors were only able to access claims documents through

the Group's restricted VPN access portal.

Fee Schedules
Fee schedules for the reimbursement of contracted independent field adjusters consisted of flat rates that were paid for providing diagrams, photos, claims estimates and reports, or for the reimbursement of mileage and other administrative costs. No additional fees were paid to conduct re-inspections or to correct identified estimate errors.

Claims Handling Process
All claims estimates submitted by independent field adjusters and other vendor partners received an initial and a second quality control ("QC") review. During the initial QC review, a field team lead confirmed that the estimate included all reported claims related damages, photos to support the estimated damages, and accurate diagrams or dimensions based on the inspected structure. Once approved, the estimate was sent to the policyholder's claim file for a second QC review by the Group's inside examiner. Upon completion of both QC reviews, all claims estimates and payments were reviewed by an inside examination management team member to ensure all coverages and payments were accurate before release to the policyholder. Once approved, the Group moved forward with settling the policyholder's claim.

The initial estimate amounts written by the field adjusters were reasonable and timely submitted for review and payment. Initial payments were also timely issued. In most instances, the Group closed claims files after the issuance of the initial claims payment and within 90 days in accordance with the statute.

Responsiveness to Policyholders
Policyholders typically received an acknowledgment letter from the Group within one to five days after they reported their claim. Claims acknowledgment letters included the appropriate notices of the policyholder's right to participate in the mediation program and the Homeowner Claims Bill of Rights.

The Group's 2018 Cat Examination JIT Training and 2018 Catastrophe Response Plan requires field adjusters to attempt contact with policyholders within 24 hours of assignment to a claim to schedule the inspection, if an inspection of the loss is required. The examiners reviewed 171 claim files to determine the Company's adherence to this standard. Of the 171 claim files reviewed, the Company conducted 54 inspections. Of the 54 inspections conducted, 27, or 50%, were scheduled within 24 hours of the adjuster's assignment to the claim.

Additional Living Expense
During Hurricane Michael, the Group streamlined the additional living expense ("ALE") process to ensure policyholders quickly received the money needed to secure temporary housing. In addition, the Group utilized temporary housing vendors to assist policyholders with locating appropriate properties and pricing. Policyholders were also able to deal directly with temporary housing vendors to setup and manage their ALE claims directly. At the onset of a claim, ALE advances were issued for every policyholder identified as requiring ALE coverage. These advances were issued on first contact with the policyholder, provided coverage for up to six months, when needed, and were based on current temporary housing prices to ensure payments

were sufficient to cover housing needs. The Group allowed policyholders to rent recreational vehicles, travel trailers, motor homes, etc. to place on their property, if requested, and assisted policyholders with locating necessary resources, when needed. The Group issued full ALE limits when total losses were identified.

Number of Assigned Adjusters

During the examination, the examiners noted, in certain circumstances, multiple adjusters were assigned to a single claim. The Company was requested to provide data to show the total number of claims adjusters that were assigned to 167 claims files reviewed for this purpose during the examination. Based on the Company's response, 26 claims, or 15.57% of the claims reviewed, had one adjuster assigned throughout the lifecycle of the claim; 65 claims, or 38.92% of the claims reviewed, had two to three adjusters assigned; and 39 claims, or 23.35% of the claims reviewed, had four to five adjusters assigned throughout the lifecycle of the claim. In one case, the Company reported 10 claims adjusters were assigned to a single claim.

Number of Adjusters Assigned	Number of Claim Files	Percentage
1	26	15.57%
2	33	19.76%
3	32	19.16%
4	21	12.57%
5	18	10.78%
6	9	5.39%
7	13	7.78%
8	11	6.59%
9	3	1.80%
10	1	0.60%
Total	**167**	**100%**

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.