THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET REGULATION

TARGETED MARKET CONDUCT FINAL EXAMINATION REPORT

OF

UNIVERSAL PROPERTY & CASUALTY INSURANCE COMPANY

NAIC COMPANY CODE: 10861
NAIC GROUP CODE: 4663

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EXECUTIVE SUMMARY

A targeted market conduct examination of Universal Property & Casualty Insurance Company ("Universal" 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

Universal Property & Casualty Insurance Company is a domestic Property and Casualty insurer authorized to conduct business in Florida on December 31, 1997. The Company is authorized to write Homeowners Multi-Peril, Allied Lines, Fire, Inland Marine, Other Liability, Boiler & Machinery, Burglary and Theft, and Glass coverage.

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

Year	Total Direct Written Premium In Florida (Per Schedule T of the Annual Statement)
2019	1,058,618,318
2018	1,006,886,003
2017	917,553,188

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 Universal pursuant to Section 624.3161, F.S. The examination was performed by a contracted examination firm, Examination Resources, 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 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 September 30, 2019 and ended November 2, 2020.

The last market conduct examinations of the Company were completed on May 2, 2013 and September 30, 2016. Those examinations reviewed the Company's claims handling, complaint handling, rate filing, and underwriting practices; and reviewed the Company's use of Proof of Loss forms, respectively.

The results of this current examination found no repeat violations in these areas.

UNIVERSAL AND HURRICANE MICHAEL STATISTICS

As of October 25, 2019, in response to the Catastrophe Reporting data call, Universal reported receiving a total of 7,581 Hurricane Michael claims or 5.06% of the total number of claims reported by all insurers. As of October 13, 2019, the Florida Department of Financial Services' Division of Consumer Services ("DFS") reported receiving a total of 127 complaints related to Hurricane Michael from Universal consumers. This represents 7.09% of the total number of complaints received from all consumers reporting Hurricane Michael complaints.

TOTAL REPORTED CLAIMS AND COMPLAINTS AS OF OCTOBER 2019			
Universal Claims	**Total Claims**	**Universal Complaints**	**Total Complaints**
7,581	149,773	127	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 1.70%.

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

- 73 complaints, or 57.5% of all complaints, were reported by consumers experiencing a:
  - Claim handling delay; or
  - Lack of response from the Company;
- 30 complaints, or 23.6% of all complaints, were made by consumers who reportedly:
  - Were issued claim underpayments;
  - Received unsatisfactory settlement offers;
  - Believed their claims were inappropriately denied;
  - Believed the Company was not allowing Additional Living Expense ("ALE") coverage or sufficient ALE coverage;
  - Experienced other claim issues; or
  - Expressed a concern regarding a premium refund; and
- 24 complaints, or 18.9% of all complaints, were attributed to requests made by a policyholder to participate in mediation due to unresolved claim issues.

DFS defines:

- Claim Handling Delay as a complaint regarding the Company's or the adjuster's delay in contacting the claimant, processing the claim, or issuing a payment; and
- Claim Underpayment as an issue involving a claim that has been paid, but in an amount that is less than deemed appropriate by the person receiving the payment or on whose behalf payment is made.

CONSUMER COMPLAINTS BY REASON	
Claim Handling Delay	70
Mediation	24
Claim Underpayment	12
Unsatisfactory Settlement Offer	7
Claim Denial	6
Company Delay or No Response	3
Additional Living Expense Issue	3
Other Claim Issue	1
Premium Refund	1
Total	**127**

At the time of the October 2019 reporting by DFS:

- Five complaints were open pending resolution;
- 94 complaints were closed:
    - After DFS explained the Company's position to the consumer;
    - When the consumer's claim was settled;
    - Because DFS resolved the consumer's issue;
    - When 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;
    - After an additional payment was made or coverage was extended to the consumer;
    - When the consumer retained an attorney to represent them;
    - Because the claim was reopened; or
    - After DFS determined that the Company's position was based on a contractual provision;
- One complaint was closed because the information received by DFS from the consumer was insufficient to complete the complaint file; and
- Three notices were issued to the Office of alleged violations of the Florida Insurance Code after the consumers' issues were satisfactorily resolved by the Company.

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

The remaining 24 mediation complaints were resolved in accordance with DFS' mediation program.

UNIVERSAL COMPLAINT RESOLUTION CATEGORIES	
Company Position Explained	43
Claim Settled	28
Resolved Through DFS' Mediation Program	24
Question of Fact	9
Issue Resolved	6
Open – Pending Resolution	5
Notice Issued – Relief	3
Additional Payment	3
Coverage Extended	2
Attorney Retained	1
Claim Reopened	1
Contractual Provision	1
Insufficient Information	1
Total	**127**

The examination considered 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 7,853 Hurricane Michael claims, an increase of 272 claims from the October 25, 2019 data call. Of the 7,853 total claims reported, the Company recorded that 7,749 claims, or 98.7%, were closed and 104 claims, or 1.3%, remained open as of the reporting date. Of the 7,749 closed claims, 6,571, or 84.8%, were closed with payment and 1,178, or 15.2%, 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 7,475 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:

- 2,911 claims closed with payment;
- 1,172 claims closed without payment;
- 2,870 reopened claims; and
- 522 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 428 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 Universal

claims subject to this examination, the total sample size required to achieve a 95% confidence level for all four categories was determined to be 428 claims.

The 428 randomly selected claims consisted of:

- 108 claims closed with payment;
- 107 claims closed without payment;
- 108 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 428 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 428 randomly selected Hurricane Michael claims by category: 108 claims closed with payment; 107 claims closed without payment; 108 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 initial claim to the date the claim payment was made to the policyholder, the Company paid 107 claims, or 99.1% of the claims closed with payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. One claim was paid after 90 days.

CLAIMS CLOSED WITH PAYMENT	
Paid Within	**Number of Claims**
0-30 days	85
31-60 days	21
61-90 days	1
Over 90 days	1
Total Claims Reviewed	**108**

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

After reviewing 107 **Claims Closed Without Payment**, the examiners determined that when measuring from the date the Company received notice of the first or initial claim to the date the claim was denied, the Company denied 105 claims, or 98.3% of the claims closed without payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Two claims were denied after 90 days.

CLAIMS CLOSED WITHOUT PAYMENT	
Closed Within	**Number of Claims**
0-30 days	81
31-60 days	16
61-90 days	8
Over 90 days	2
Total Claims Reviewed	**107**

The examiners determined that the two claims in the over 90 days category are 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 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-days standard.

The results of the examination determined that 107 of the 107 claims reviewed, or 100% of the Company's claims closed without payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 108 **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 89 claims, or 82.4% of the reopened claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Nineteen claims were paid or denied after 90 days.

REOPENED CLAIMS	
Paid Within	**Number of Claims**
0 – 30 days	64
31 – 60 days	22
61 – 90 days	3
Over 90 days	19
Total Claims Reviewed	**108**

The examiners determined that three of the 19 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 16 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, the claim was in litigation or the claim was participating in the mediation or appraisal process. 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 105 of the 108 claims reviewed, or 97.2% 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 initial, reopened, or supplemental claim to the date the claim was paid or denied, the Company paid or denied ten claims in an "open" status as of August 30, 2019, or 9.5% of the claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Eighty-seven claims were either paid or denied after 90 days and eight claims remained open at the conclusion of the examination.

OPEN CLAIMS AS OF AUGUST 30, 2019	
Paid Within	**Number of Claims**
0 – 30 days	2
31 – 60 days	5
61 – 90 days	3
Over 90 days	87
Remained Open	8
Total Claims Reviewed	**105**

The examiners determined that the 87 claims in the over 90 days category and the eight claims that remained opened at the conclusion of the examination 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 claims, the claims were litigation, or the claims were participating in the appraisal process. 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 105 of the 105 claims reviewed, or 100% of the Company's claims open as of August 30, 2019, complied with Section 627.70131(5)(a), F.S.

ADHERENCE REVIEW

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

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

No exceptions were noted.

FINDINGS

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

The statutory standards that were reviewed are Section 627.70131(1)(a), F.S., requiring the timely acknowledgement of claims communications, Section 626.112, F.S., requiring 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 2,911 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 five instances out of 108 claims reviewed, an error percentage of 4.6%, the Company utilized persons who were licensed but who were not 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 and stated as a point of training going forward, the Company will advise its adjusting firms to be more cognizant of the appointments' stated effective dates in relation to the adjusters' start dates.

CLAIMS CLOSED WITHOUT PAYMENT

The Company reported a universe of 1,172 Hurricane Michael claims that were closed without payment during the examination scope period. A random sample of 107 claims was selected for review and the findings of the review are as follows:

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

COMPANY RESPONSE: The Company agreed with the violation.

Finding 3: In one instance out of 107 claims reviewed, an error percentage of 0.9%, the Company utilized a person who was licensed but who was not appointed by an appropriate appointing entity or person as an insurance adjuster at the time the claim was adjudicated, in violation of Section 626.112(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with the violation and stated as a point of training going forward, the Company will advise its adjusting firms to be more cognizant of the appointments' stated effective dates in relation to the adjusters' start dates.

Finding 4: In one instance out of 107 claims reviewed, an error percentage of 0.9%, the Company or the Company's independent adjusting firm did not submit an Emergency Adjuster Application form to DFS within seven calendar days after adjusting work began, in violation of Rule 69B-220.001(5)(a), Florida Administrative Code ("F.A.C.")

COMPANY RESPONSE: The Company disagreed with the violation.

The violation was retained in this report because neither the Company nor the Company's independent adjusting firm submitted an Emergency Adjuster Application form to DFS within seven calendar days after adjusting work began.

REOPENED CLAIMS

The Company identified a universe of 2,870 Hurricane Michael claims that were reopened as an additional claim that had previously been adjusted pursuant to the initial claim. A random sample of 108 claims was selected for review and the findings of the review are as follows:

Finding 5: In three instances out of 108 claims reviewed, an error percentage of 2.8%, 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.

COMPANY RESPONSE: The Company agreed with the violations.

Finding 6: In seven instances out of 108 claims reviewed, an error percentage of 6.5%, 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 six of the seven violations and disagreed with one violation because the Company paid the claim 23 days after the claim was filed.

The violation was retained in this report because the Company did not pay or acknowledge the claim within 14 days as required by the statute.

Finding 7: In two instances out of 108 claims reviewed, an error percentage of 1.9%, the Company utilized persons who were licensed but who were not 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 and stated as a point of training going forward, the Company will advise its adjusting firms to be more cognizant of the appointments' stated effective dates in relation to the adjusters' start dates.

OPEN CLAIMS AS OF AUGUST 30, 2019

The Company reported a universe of 522 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 8: In four instances out of 105 claims reviewed, an error percentage of 3.8%, 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 105 claims reviewed, an error percentage of 1.0%, the Company failed to maintain reasonable claims records, in violation of Section 627.318, F.S.

COMPANY RESPONSE: The Company disagreed with the violation and provided additional documentation from the claim file to support that the policyholder was provided with a claim acknowledgement.

The violation was retained in this report because the additional documentation provided did not acknowledge the receipt of the policyholder's prior communication. Section 627.70131(2), F.S., requires acknowledgements to be responsive to the communication.

Finding 10: In three instances out of 105 claims reviewed, an error percentage of 2.9%, the Company utilized persons who were licensed but who were not 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 and stated as a point of training going forward, the Company will advise its adjusting firms to be more cognizant of the appointments' stated effective dates in relation to the adjusters' start dates.

RECOMMENDATIONS

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

It is recommended that the Company:

- Ensure that all initial, supplemental or reopened claims will be paid or denied, in whole or in part, within 90 days; that the acknowledgement of all claims communications will occur within statutorily mandated timeframes; and that all claims files will contain reasonable records in order for the Office or its examiners to determine the Company's compliance with the applicable provisions of the insurance code;

- Ensure that statutorily required interest is automatically included in claims payments to policyholders when claims are not paid within statutory timeframes and no factors exist beyond the control of the Company to reasonably prevent paying or denying the claims within 90 days;

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

- Ensure the Company or the Company's independent adjusting firms submit Emergency Adjuster Application forms to DFS within seven calendar days after adjusting work begins.

CONCLUSION

This targeted market conduct examination of Universal Property & Casualty Insurance Company 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 428 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 DRAFT REPORT SUBMISSION

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

ADDENDUM A

CLAIMS OVERVIEW

The examination included a review of the Company's claims handling procedures, Catastrophe preparedness, the types of monitoring in place to ensure adherence with the claim guidelines/processes, internal audit functions, adjuster training and system resources.

All claims were handled by Universal Adjusting Corporation ("UAC"), now known as Alder Adjusting Corporation. UAC has handled claims on behalf of the Company since 1999.

Universal's Response: *Although UAC uses employed personnel for field adjusting when practicable, such as with daily claims, it also maintains relationships with prominent independent adjusting firms to provide additional capacity, especially in times of peak demand such as following hurricanes*.

During the examination, the examiners noted, in certain circumstances, multiple claims adjusters were assigned to a single claim.

Universal's Response: *The reasons for having multiple adjusters are remarkably consistent. Except in the rarest of cases, each claim has a field adjuster and an initial desk adjuster. Multiple adjusters might appear on a file as they are designed to increase the speed and efficiency of the claims department and/or align claims personnel with specialize aspects of the claim*.

The Company begins Catastrophe planning in January of each year and secures commitments from independent adjusting firms for each hurricane season by June 1. There is no termination date reflected in the commitments although the process is performed annually and independent adjusting firms may be retained, added or removed from the Company's list depending on each year's assessment. The agreements with each independent adjusting firm were reviewed as part of the examination and it was determined that all of the agreements are similar in nature.

The Company has established written claims handling procedures which are intended to provide general guidelines and enhance policyholder service through uniform and efficient claims handling.

The Company was requested to provide a summary of the oversight process that is in place to ensure established guidelines and procedures are followed as intended.

Universal's Response: *The monitoring of our claims processes occurs through the structure of our claims department and through automation in our claims system. Refinement of our claims process is a continuous process of evaluating our prior experience and market conditions, improving our workflows and systems, and updating our systems. With each hurricane or other event, this feedback loop begins anew to help ensure our processes adapt to the market and remain compliant with regulatory requirements.*

In our claims department, we have supervisors and members of management who monitor the process and supervise personnel. Our claims management system allows us to manage the claims process and workflows.

The Company was requested to provide a summary of measures taken as a result of Hurricane Michael to ensure proper resolution of claims.

Universal's Response: *We engage in a continuous process of evaluating prior events, enhancing our procedures and systems, and preparing for future events. Each year, our catastrophe planning begins well in advance of the hurricane season and continues up to and following landfall of any events that might occur.*

The Company was asked to provide data to determine if it met the FNOL Service Level.

Universal's Response: *The test includes 100% of the calls received between 10/7/2018 and 10/31/2018 selecting the storm claim reporting prompt. With a 99.86% success rate, the goal was met.*

The Company was asked to provide information regarding the training provided to claims adjusters employed by the Company.

Universal's Response: *Each employed adjuster attains the core competencies by completing the educational requirements for licensing and by meeting the continuing education requirements on an ongoing basis. Our claims adjuster employees then receive company-specific training that relates to their roles within the company.*

The Company was asked to provide information regarding any training afforded to claims adjusters employed by independent adjusting firms that are contracted by the Company in response to hurricanes.

Universal's Response: *We provide training on processes and procedures to each vendor's point of contact. In addition, we train each vendor on the use of our claims administration system and its capabilities. We evaluate these vendors annually based upon our experience with them. We have maintained relationships with many of these firms for a number of years, which gives us a first-hand perspective on the competency and professionalism of their personnel.*

The Company provides adjusters from independent adjusting firms with access to its claims system.

Universal's Response: *The adjusters are required to use business equipment to complete their job tasks; no personal equipment is used by contracted adjusters.*

On January 10, 2020, a request was sent to the Company for information regarding situations where it appeared that the Company may have taken longer than 14 days to review and acknowledge receipt of claims communications. Specifically, claims files did not always contain

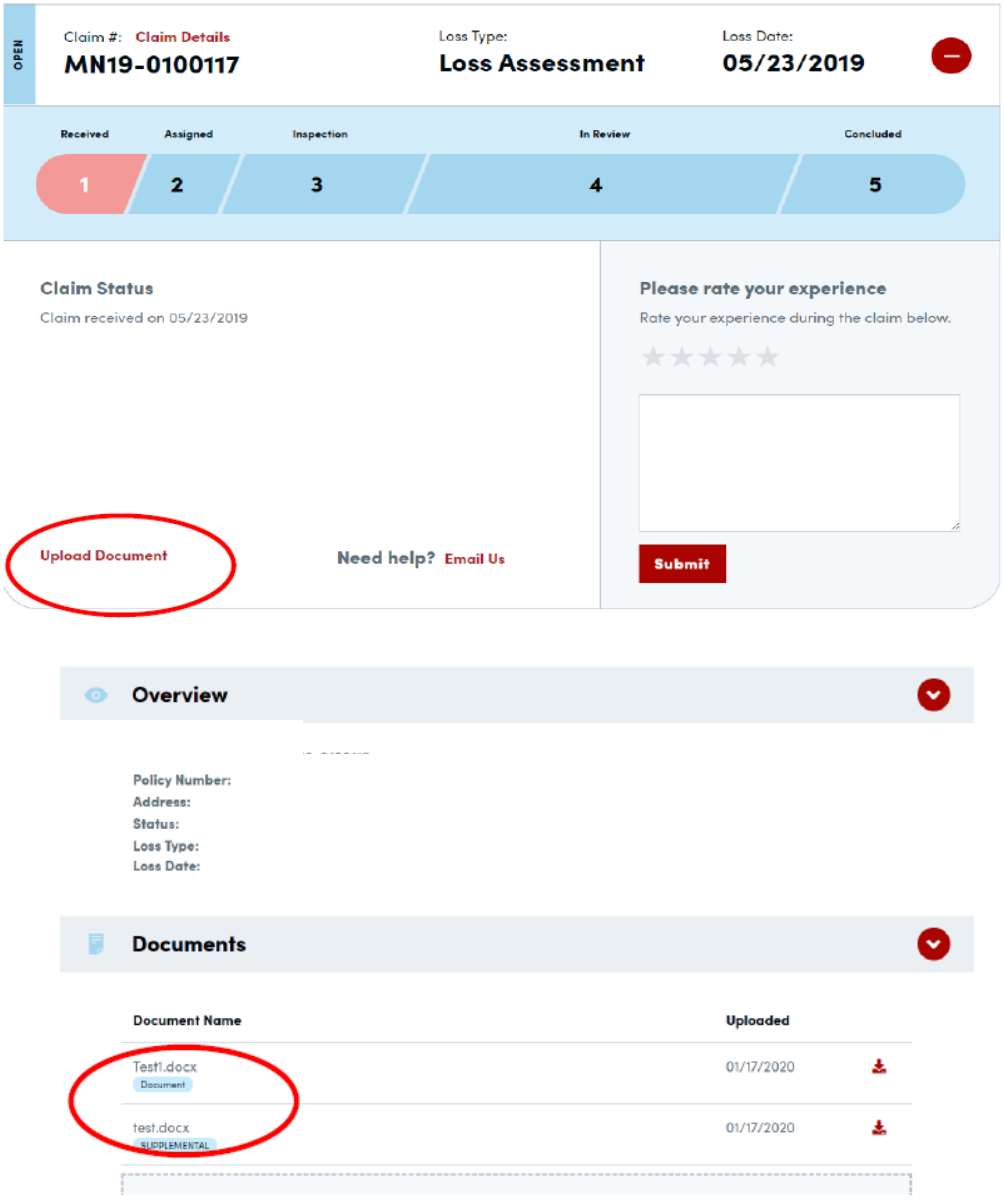
documentation regarding the Company's timely acknowledgement of the initial notice of a claim by a policyholder or the acknowledgement of claims information when it was submitted via fax, uploaded through the Company's customer web portal, or submitted using the Company's claimshelp@universalproperty.com ("*claimshelp*") email address.

In instances where the Company received emails via *claimshelp,* the Company provided documentation to support that policyholders were timely emailed auto-generated acknowledgements confirming receipt of their initial notices of loss. The auto-generated email acknowledgements included the assigned claim numbers and notified policyholders that adjusters would contact the policyholders to discuss the claims and schedule inspections, if required. The auto-generated email acknowledgements explained the policyholders' duties after a loss, provided additional contact information for the Company, and contained information about how policyholders could register to use the Company's online account management system ("web portal"). While the Company's system auto-generates emails in response to initial notices of loss, it does not maintain a copy of the emailed acknowledgment in policyholder claims files.

Universal's Response: *We have dedicated personnel who monitor the emails received at the claimshelp address. These employees are responsible for receiving the emails, reviewing them to determine the applicable claim files, and assigning the emails to the relevant files for evaluation by our desk adjusters. The claimshelp email address essentially serves as a centralized intake for electronic transmissions, in much the same way the mailroom serves as a centralized intake for mail. The centralized intake helps us monitor and track information sent to the company electronically.*

Emails received at the claimshelp address are reviewed as quickly as possible so they can be assigned to the relevant claim files. When an email is assigned to the appropriate claim file, it is reviewed by the desk adjuster for appropriate handling depending on the nature of the information received.

The Company confirmed that policyholders who upload documents through the Company's customer web portal are able to see that the documents were successfully uploaded in real time. Policyholders are able to log in to their accounts at any time to confirm the status and the details of their claim. After documents are uploaded, the Company stated they are reviewed and processed according to the type of information provided by the policyholder. The Company provided the screen shots of the online portal confirming receipt of a claim and highlighting a policyholder's ability to upload and confirm the Company's receipt of claims documents, and as shown below:



The Company confirmed there is no auto-generated acknowledgement of claims communications if they are submitted by policyholders via fax.

Universal's Response: *Upon reviewing this issue with the IT department, the technology associated with faxes does not allow for reliable automated communications. The faxes are converted to electronic documents, which then are assigned to the relevant files. The documents then are processed and responded to according to their contents (such as whether they provide receipts for ALE, requests for supplements, etc.).*

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.