THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET REGULATION

TARGET MARKET CONDUCT
FINAL REPORT OF EXAMINATION

OF

OCEAN HARBOR CASUALTY INSURANCE COMPANY
NAIC COMPANY CODE #12360

ISSUED

April 25, 2019

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EXECUTIVE SUMMARY

A targeted market conduct examination of Ocean Harbor Casualty Insurance Company was performed to determine compliance with the Florida Insurance Code. This examination report includes significant findings of fact, as mentioned in Section 624.3161, Florida Statutes, and general information about the insurer and its compliance with applicable provisions of the Florida Insurance Code. The examination findings are compiled at the end of this report in Appendix A. The majority of the findings relate to the Company's lack of formal standards for the proper investigation of claims and consequential failure to timely process claims.

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Regulation, conducted a targeted examination of Ocean Harbor Casualty Insurance Company (Company) pursuant to Section 624.3161, Florida Statutes. Examination Resources, LLC, performed the examination. The examination scope period was January 1, 2016, through May 31, 2017, and was conducted on the Company's private passenger automobile insurance line of business. The examination began onsite September 5, 2017, through September 7, 2017, and ended offsite on December 15, 2017.

The purpose of the examination was to confirm the Company's compliance with the Florida Insurance Code and review its internal policies and procedures relating to:

- Complaint Handling;
- Cancellations, Nonrenewals and Rescissions;
- Claims Handling;
- Underwriting and Rating Practices; and,
- Agent Licensing.

Examiners relied on the information and records provided by the Company for this examination report. Examination procedures were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners (NAIC).

COMPANY OPERATIONS

The Company is a Florida domestic property and casualty insurer, authorized to conduct insurance business in the state on September 30, 1993. The Company is also licensed in California, Alabama, Louisiana, Mississippi, New Jersey, New York, Oklahoma, South Carolina and Texas. In Florida, the Company primarily writes private passenger automobile liability and physical damage coverage, but is also licensed to write Fire, Allied Lines, Homeowners Multi-Peril, and Mobile Home Physical Damage. Total Written Premium in Florida for 2016 and 2017:

Year	Total Written Premium in Florida (Per Schedule T of the Annual Statement)
2016	$160,478,033
2017	$204,612,113

A non-affiliated Managing General Agent (MGA), Pearl Holding Company (PEARL) processes Florida business and handles claims for the Company.

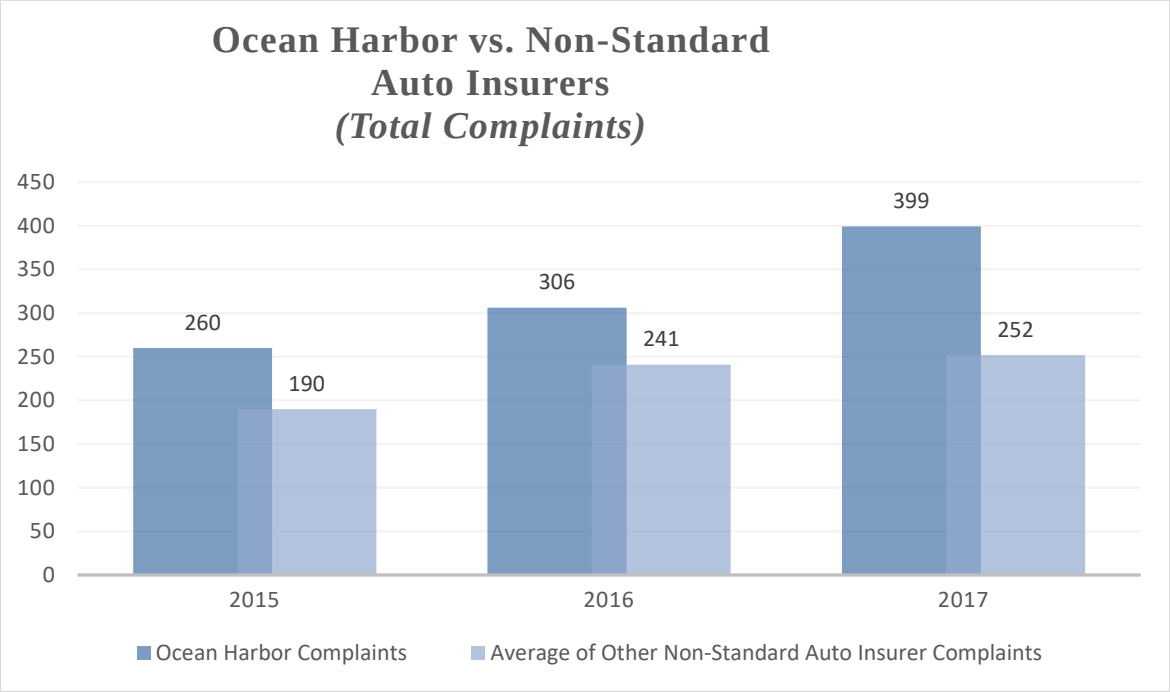
All insurance is sold through independent agents. The Company requires its agents to be members of comparative rating services such as QuickQuote, AccuAuto, TruePremium or ITC. These rating services provide comparative rates for multiple automobile insurance companies in Florida.

COMPLAINT HANDLING

Complaints filed with the Department of Financial Services (DFS) involving Ocean Harbor significantly exceed that of similar insurance companies. The majority of complaints are related to allegations of claims handling delays. The examination identified a number of areas in the claims handling process that tend to delay claim resolution, increase customer dissatisfaction, and heighten regulatory scrutiny. Should the Company positively address Claims Handling procedures and training, a significant reduction in Complaints would likely result.

CONSUMER COMPLAINT DATA

Research and analysis of complaint data for 2015, 2016, and 2017 indicates the Company had significantly more complaints than its industry peers in Florida.



Another compilation of complaint data further suggests that the Company would benefit from a thorough review of its claims and customer service practices and procedures. The DFS Consumer Services Company Complaint Comparison that follows shows the number of consumer complaints logged for an insurer on an annual basis, comparing the complaint count to other insurers with

similar premium volume. Results for Ocean Harbor for 2015-2017 reflect complaint activity that is outside of the norm.

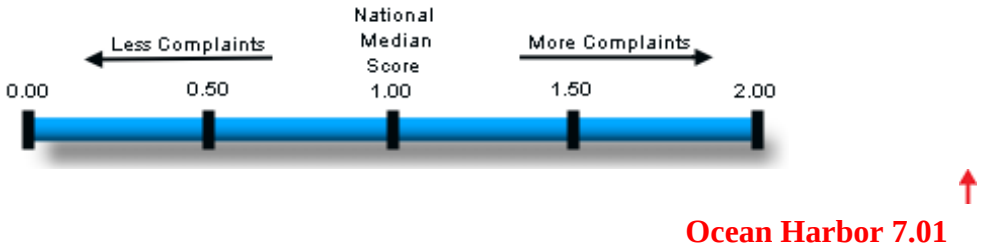
Complaint Comparison Ocean Harbor vs.
standard and non-standard of comparable written premium

Year	Company Name	Premium	Complaint Count
2015	Standard Fire Insurance Company (The)	$150,862,834	5
	Ocean Harbor Casualty Insurance Company	**$135,170,963**	**258**
	Infinity Indemnity Insurance Company	$134,985,096	75
2016	United Automobile Insurance Company	$178,583,748	121
	Hartford Underwriters Insurance Company	$160,791,870	34
	Ocean Harbor Casualty Insurance Company	**$160,478,033**	**309**
2017	***Ocean Harbor Casualty Insurance Company***	**$204,612,113**	**397**
	Direct General Insurance Company	$199,892,000	162
	Allstate Property Casualty Insurance Company	$191,631,676	24

Another source of complaint information, shown as follows, is the NAIC Complaint Ratio Report. This report provides information relating to complaints and is available at the NAIC website. Please note that "Total Complaints" include only those complaints in which the final resolution by Florida DFS upheld the consumer's complaint position. Additional information about how the report is developed is available online at https://eapps.naic.org/cis/help.do#complaints_state.

Complaint Ratios for Year 2017	Score
National Median Complaint Ratio	1.00
Ocean Harbor Cas Ins Co Complaint Ratio	**7.01**

The Complaint Ratio Score for Ocean Harbor has been calculated to be **7.01** for the policy type Private Passenger for the year 2017. In the graph below, this score is shown as a red arrow in relation to the National Median Complaint Ratio Score for Private Passenger for the year 2017, and signals that the Company's ratio greatly exceeds that of the National Median.



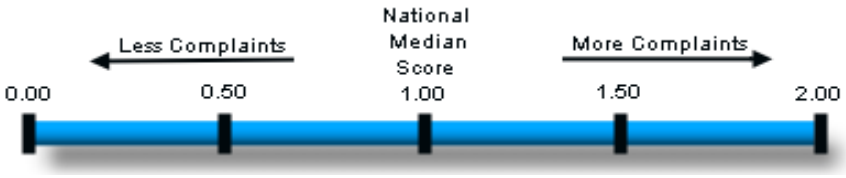
Complaint Ratios for Year 2016	Score
National Median Complaint Ratio	1.00
Ocean Harbor Cas Ins Co Complaint Ratio	**7.00**

The Complaint Ratio Score for Ocean Harbor has been calculated to be **7.00** for the policy type Private Passenger for the year 2016. In the graph below, this score is shown as a red arrow in relation to the National Median Complaint Ratio Score for Private Passenger for the year 2016, and signals that the Company's ratio greatly exceeds that of the National Median.

Ocean Harbor 7.00

Complaint Ratios for Year 2015	Score
National Median Complaint Ratio	1.00
Ocean Harbor Cas Ins Co Complaint Ratio	**17.79**

The Complaint Ratio Score for Ocean Harbor has been calculated to be **17.79** for the policy type Private Passenger for the year 2015. In the graph, this score is shown in red in relation to the National Median Complaint Ratio Score for Private Passenger for the year 2015, and signals that the Company's ratio greatly exceeds that of the National Median.



Ocean Harbor 17.79

The Company has established complaint handling procedures as required by Section 626.9541(1)(j), Florida Statutes. The Company recorded 456 consumer complaints from DFS, and 696 complaints received directly from consumers during the examination scope period. A random sample of 57 DFS complaints and 57 directly-received complaints were selected for review, for a total of 114 complaints. Complaints were reviewed to ensure that responses were timely, documentation was adequately maintained, the response addressed all issues raised, and the files were handled in compliance with the Florida Insurance Code.

Findings:

Review of the DFS complaints identified 16 violations.

1. In 13 instances, the Company failed to implement standards for the proper and prompt investigation of claims. This is a violation of Section 626.9541(1)(i)3.a, Florida Statutes, and Rule 69O-166.024, Florida Administrative Code. In ten instances, the Company failed to act quickly and efficiently in correctly processing claims. In three instances, claims were overpaid.

2. In one instance, the Company failed to maintain records as required in Section 627.318, Florida Statutes. The Company was unable to provide a copy of the application and Electronic Fund Transfer agreement.

3. In two instances, the Company failed to follow its filed rates and rules. This is a violation of Section 627.0651, Florida Statutes. In one instance, a Customer Service Representative (CSR) who reviewed and processed the application erroneously entered the city and ZIP code on the Motor Vehicle Report (MVR) request, resulting in an incorrect premium charge. In another instance, an agent received information on the insured's address change, but failed to process an endorsement, resulting in the insured not receiving cancellation notices.

Company Response: In response to the examiners' findings, the Company provided additional information relating to each of the instances reported, but was unable to support removal of the reported violation.

Recommendation: It is recommended the Company implement procedures to ensure claims are properly and timely investigated and resolved. Also, procedures should be established to ensure filed rates and rules are accurately assigned to policies and that accurate and complete records are maintained.

Review of the complaints received directly from consumers identified nine violations.

1. In nine instances, the Company failed to adopt and implement standards for the proper and prompt investigation of claims. This is a violation of Section 626.9541(1)(i)3.a., Florida Statutes, and Rule 69O-166.024, Florida Administrative Code.

Company Response: In response to the examiners' findings, the Company provided additional information relating to each of the instances reported, but was unable to support removal of the reported violations.

Recommendation: It is recommended the Company implement procedures to ensure claims are properly and timely investigated and resolved.

CLAIMS HANDLING

DFS summarized complaints received against Ocean Harbor during the past five years. A total of 1,230 complaints were listed, with 83% of the complaints involving a claims-related issue. Of the total, 64% were related specifically to Claims Handling Delay.

Claims were reviewed to verify compliance with the Florida Insurance Code and the Company's own claims-handling guidelines. Time studies were conducted during the claims review to measure the investigation and settlement times and to determine if the Company had adopted and implemented standards for the proper investigation of claims. A total of 50,961 claims was received during the scope of this examination. The examination included a review of eight different types of claims and did not include Bodily Injury Liability (45 claims) and Uninsured Motorist claims (1 claim) in the total population.

Examiners requested a copy of the Company's Private Passenger Auto Claims Settlement Manual, Claims Handling Procedures Manual, and Claims Handling Training Materials, as well as a summary of its supervisory review process to monitor claims processing practices.

The Company did not produce a formal claims handling manual and stated, "…*we have found that claims manuals are rigid and restrictive in that they cannot possibly cover all the different scenarios that arise in these claims."* The Company also did not produce any claims handling training materials and stated that the training is verbal and sometimes followed with an email.

PEARL handles claims functions for the Company under a claims service agreement between the Company and PEARL. PEARL provided a five-page document referenced as a Claims Manual and Handling Procedures Outline, ("Claims Handling Outline") a synopsis of its claims process. PEARL also provided a copy of the Claims Service Agreement between PEARL (formerly known as J.A.J. Holding Company, Inc.) and the Company, detailing the responsibilities and obligations of both parties. Both documents were reviewed relative to the Company's performance in handling claims. The Company's claims data was analyzed to determine the length of time (in number of days) from when a claim was opened to when it was closed.

Findings:

The Company's failure to adopt and implement formal procedures for the proper and prompt investigation of claims results in delayed payments that exceed industry averages and is a violation of Section 626.9541(1)(i)3.a., Florida Statutes, and Rule 69O-166.024, Florida Administrative Code. Additionally, the lack of formal claims handling procedures likely is the catalyst of many consumer complaints. Too frequently the Company takes an excessive amount of time to complete its claims investigations and clear coverage. While

the Company may utilize Examinations Under Oath and Independent Medical Examinations in claims-handling, the use of these processes appear overused and often unjustified. The Company should develop more efficient methods and standards for investigating claims.

Although the Company's Claims Service Agreement with PEARL requires periodic review of the claims handling procedures to identify problems and recommend corrective action, the documentation provided lacked standards for the proper investigation of claims.

Company Response: The Company reported it has revised procedures for obtaining police reports which it believes will reduce delays related to receipt of these reports.

Recommendation: It is recommended the Company adopt and implement formalized standards for the proper investigation of claims. The Company should also periodically review the practices and procedures used by PEARL.

First Party Paid Claims Review

There was a total of 8,471 first party paid claims during the scope of the examination and a random sample of 55 claims was reviewed.

Findings:

There were 15 violations found.

1. In seven instances, the Company failed to adopt and implement standards for the proper investigation of claims. The Company failed to process claims timely resulting in claims delays. This is a violation of Section 626.9541(1)(i)3.a., Florida Statutes.

   Company Response: In response to the examiners' findings, the Company agreed with two instances and disagreed with the remaining findings.

   Recommendation: It is recommended the Company implement procedures to ensure claims are properly and timely investigated and resolved.

2. In four instances, the Company failed to adopt and implement standards for the proper investigation of claims. The Claims Handling Outline indicates the Company is to inspect non-drivable vehicles within five days. In these four instances, the Company did not demonstrate sufficient claims standards or efforts were undertaken to perform inspections, in violation of Section 626.9541(1)(i)3.a., Florida Statutes.

   Company Response: In response to the examiners' findings, the Company stated, "*…vehicles were in storage facilities, therefore, had to be removed from the storage facility before inspection."*

   Recommendation: It is recommended the Company establish a methodology to ensure that procedures are fully implemented.

3. In two instances, the Company failed to pay claims within 20 days of settlement. This is a violation of Section 627.4265, Florida Statutes.

   Company Response: The Company agreed with the finding.

   Recommendation: It is recommended the Company implement procedures to ensure claims payments are made timely.

4. In two instances, the Company failed to clearly explain the nature of the requested information and the reasons why such information was necessary to the settlement of the claim. This is a violation of Section 626.9541(1)(i)3.h., Florida Statutes. In the files reviewed by examiners, the Company sent Theft Loss Questionnaires to insureds when the claims were the result of collisions with deer. The Company did not explain to the insured why this form was necessary when the losses were not caused by theft. The request for this questionnaire was not relevant to the claims.

   Company Response: In response to the examiners' findings, the Company stated, "*…sending this form did not delay the settlement or handling of this claim."*

   Recommendation: It is recommended the Company implement procedures to ensure claims are paid timely without requesting irrelevant forms or failing to explain the reason the information is necessary.

First Party Closed without Payment (CWP) Claims Review

There was a total of 10,425 first party CWP claims during the scope of the examination and a random sample of 54 claims was reviewed.

Findings:

There were ten violations found.

1. In ten instances, the Company failed to adopt and implement standards for the proper investigation of claims, and its adjuster failed to act quickly and efficiently in achieving a proper disposition of the claim. This is a violation of Section 626.9541(1)(i)3.a. and f., Florida Statutes, and Rule 69B-220.201, Florida Administrative Code. Rule 69B-220.201, Florida Administrative Code, provides a Code of Ethics, and requires adjusters to "…act with dispatch and due diligence in achieving the proper disposition of [a] claim." The Company closed claims without proper disposition or explanation provided to the insured. While the Company initially sent Reservation of Rights letters to the insureds, it did not timely complete its investigation nor did its adjuster act with dispatch and due diligence in achieving a proper disposition of the claim, failing to communicate its action or to follow-up with the insured for requested information following a period of inactivity. The Company did not document follow-up on attempts to obtain requested information before closing the files without notice.

   Company Response: In response to the examiners' findings, the Company stated, "…*the claim reserve status has nothing to do with the claim payment or investigation status. As*

mentioned under the Claims Administration Statute, we do not have to deny these claims. The Company is willing to still consider coverage if the information being sought is finally revealed. No need to deny at this point in time." Subsequently, the Company/PEARL provided an additional response stating, "*The Company never denied the claim, but did administratively close the file."*

Recommendation: It is recommended the Company implement procedures for the proper and timely investigation of claims, as well as proper disposition and communication prior to closing.

Third Party Paid Claims Review

There was a total of 7,944 third party paid claims during the scope of the examination and a random sample of 55 claims was reviewed.

Findings:

There were 13 violations found.

1. In 11 instances, the Company failed to adopt and implement standards for the proper investigation of claims and for its adjusters to act quickly and efficiently in completing investigations and resolving claims in a timely manner. These are violations of Section 626.9541(1)(i)3.a., Florida Statutes, and Rule 69B-220.201, Florida Administrative Code. The Company failed to have standards for the timely investigation and resolution of claims, resulting in claim delays.

2. In two instances, the Company failed to acknowledge and act promptly upon claim communications. This is a violation of Rule 69O-166.024, Florida Administrative Code.

Company Response: In response to the examiners' findings, the Company provided additional information relating to the instances reported, but was unable to support removal of the reported violation.

Recommendation: It is recommended the Company implement procedures for the proper investigation of claims and to ensure claims are investigated and processed timely, and to implement procedures to ensure claims communications are acknowledged in a timely manner.

Third Party CWP Claims Review

There was a total of 8,899 third party CWP claims during the scope of the examination and a random sample of 54 claims was reviewed.

Findings:

There were 21 violations found.

1. In 20 instances, the Company failed to adopt and implement standards for the proper investigation of claims and its adjuster failed to act quickly and efficiently in achieving a proper disposition of the claim. This is a violation of Section 626.9541(1)(i)3.f., Florida Statutes, and Rule 69B-220.201, Florida Administrative Code. The Company closed

claims without proper disposition or explanation provided to the insured or claimant. While the Company sometimes sent Reservation of Rights letters to the insureds, it did not timely complete its investigation nor did its adjuster act with dispatch and due diligence in achieving a proper disposition of the claim, failing to communicate its action or follow-up with the insured for requested information following a period of inactivity. The Company did not document follow-up attempts to obtain requested information following periods of inactivity before closing the files.

Company Response: In response to the examiners' findings, the Company stated, "…*the claim reserve status has nothing to do with the claim payment or investigation status. As mentioned, under the Claims Administration Statute, we do not have to deny these claims. The Company is willing to still consider coverage if the information being sought is finally revealed. No need to deny at this point in time."* Subsequently, the Company supplied additional commentary, disagreeing that the violations "characterized as business practice…."

The Office notes 37% of the sample reviewed exhibited the violation.

Recommendation: It is recommended the Company implement procedures for the proper and timely investigation of claims as well as proper disposition and communication prior to closing.

2. In one instance, the Company failed to acknowledge a communication and act promptly as to communications within 14 days. This is a violation of Rule 69O-166.024, Florida Administrative Code.

   Company Response: In response to the examiners' findings, the Company provided additional information relating to the instances reported, but was unable to support removal of the reported violation. The Company disagreed with the finding.

   Recommendation: It is recommended the Company implement procedures to ensure claims communications are acknowledged in a timely manner.

Personal Injury Protection (PIP) Paid Claims Review

There was a total of 5,397 PIP paid claims during the scope of the examination and a random sample of 109 claims was reviewed.

Findings:

There were 544 violations found.

1. In 19 instances, the Company failed to adopt and implement standards for the proper investigation of claims. The Company failed to process claims timely resulting in claim delays. This is a violation of Section 626.9541(1)(i)3.a., Florida Statutes.

Company Response: In response to the examiners' findings, the Company disagreed with several instances. The Company provided additional information relating to the instances reported but was unable to support removal of the reported violation.

Recommendation: It is recommended the Company implement procedures for the proper investigation of claims and to ensure claims are processed timely.

2. In 516 instances, the Company failed to failed to pay claims timely. In 96 out of 109 claim files reviewed, the Company failed to pay 516 provider bills timely. The Company paid interest in all instances involving payment delays. There were 41 claims involving demand letters. These included 108 invoices (already counted in the 516 payment delays), with 76 being paid within 30 days of the demand letter and the remaining 32 being paid late (over 30 days). These are violations of Sections 627.736(4)(b), 626.9541(1)(i)3.i., 627.736(4)(g), and 627.736(10)(d), Florida Statutes.

   Company Response: In response to the examiners' findings, the Company disagreed with several instances. The Company provided additional information relating to the instances reported but was unable to support removal of the reported violation.

   Recommendation: It is recommended the Company implement procedures to ensure provider bills are paid timely.

3. In one instance, the Company failed to comply with the requirements relating to mental and physical examination of an injured person. This is a violation of Section 627.736(7)(a), Florida Statutes. No explanation was given as to why an independent medical examination (IME) was requested on February 25, 2016, when the insured had not had treatment since November 17, 2015. This IME appeared to be immaterial after so long a period of time had elapsed since the last treatment.

   Company Response: In response to the examiners' findings, the Company provided additional information relating to the instance reported, but was unable to support removal of the reported violation. The Company disagreed with the finding.

   Recommendation: It is recommended the Company implement procedures to only request IMEs for the mental or physical condition of an injured person when there are indications it is material to a claim.

4. In six instances, the Company paid interest on invoice payments when it was not due or required. These are violations of Section 627.736(4)(b), Florida Statutes.

   Company Response: In response to the examiners' findings, the Company provided additional information relating to each of the instances reported, but was unable to support removal of the reported violation.

   Recommendation: It is recommended the Company implement procedures to ensure interest is only paid on overdue invoices.

5. In two instances, the Company failed to acknowledge claims in a timely manner. These are violations of Rule 69O-166.024, Florida Administrative Code.

   Company Response: In response to the examiners' findings, the Company provided additional information relating to each of the instances reported but was unable to support removal of the reported violation.

   Recommendation: It is recommended the Company implement procedures to ensure claims are acknowledged in a timely manner.

   Finding:
   The Company should closely review the requirements relating to the payment of benefits under a claim in which an injured person fails to attend an IME. In several files examiners noted nonpayment of providers that rendered and billed for services prior to a missed IME.

PIP CWP Claims Review

There was a total of 9,778 PIP CWP claims during the scope of the examination and a random sample of 109 claims was reviewed.

Findings:
There were 13 violations found.

1. In 12 instances, the Company failed to adopt and implement standards for the proper investigation of claims, resulting in claim delays. The Company failed to process claims timely, a violation of Section 626.9541(1)(i)3.a., Florida Statutes.

   Company Response: In response to the examiners' findings, the Company provided additional information relating to the instances reported, but was unable to support removal of the reported violation. The Company disagreed with several of the findings.

   Recommendation: It is recommended the Company implement procedures for the proper investigation of claims including the timely completion of investigations and claims processing.

2. In one instance, the Company failed to adopt and implement standards for the proper investigation of claims. The Company failed to provide a denial letter. This is a violation of Section 626.9541(1)(i)3.a. and f., Florida Statutes.

   Company Response: In response to the examiners' findings, the Company provided additional information relating to each of the instances reported, but was unable to support removal of the reported violation.

   Recommendation: It is recommended the Company implement procedures for the proper investigation and disposition of claims and to ensure that explanations are provided for denials or the offer of compromise settlements.

Non PIP – Open >90 Days Claims Review

There was a total of 1,910 Non-PIP claims that were in open status over 90 days as of May 31, 2017. A random sample of 107 claims was reviewed to determine the causes for the claims still being open.

Findings:

There were 16 violations found.

1. In 14 instances, the Company failed to adopt and implement standards for the proper investigation of claims. The Company failed to process claims timely resulting in claim delays. This is a violation of Section 626.9541(1)(i)3.a., Florida Statutes.

   Company Response: In response to the examiners' findings, the Company provided additional information relating to the instances reported, but was unable to support removal of the reported violation. The Company disagreed with several of the findings.

   Recommendation: It is recommended the Company implement procedures for the proper investigation of claims including the timely completion of investigations and claims processing.

2. In two instances, the Company failed to adopt and implement standards for the proper investigation of claims. The Company failed to provide denial letters. These are violations of Section 626.9541(1)(i)3.a. and f., Florida Statutes.

   Company Response: In response to the examiners' findings, **t**he Company provided additional information relating to the instances reported, but was unable to support removal of the reported violation. The Company disagreed with the findings.

   Recommendation: It is recommended the Company implement procedures for the proper investigation and disposition of claims to ensure that explanations are provided for denials or the offer of compromise settlements.

Litigated Claims Review

The purpose of the review was to determine if civil suits were stimulated by specific Company actions. The Company was unable to provide a list of closed/settled suits, but was able to provide a list that contained all (closed and open) civil suits. There were approximately 2,700 suits in the list provided. Since the list did not indicate whether it was open or closed, the examiners manually verified in the system if the claim was still open or closed and then randomly selected suits in closed status for each month. A total of 29 suits were selected for review. No violations were found.

CANCELLATIONS, NONRENEWALS AND RESCISSIONS

Cancellations, nonrenewals and rescissions were reviewed to verify that proper notice was given, the refund of premiums paid was processed timely and accurately, the reasons for the action were

specific, and the actions were in compliance with the Florida Insurance Code and the Company's underwriting guidelines.

Premium refund checks are processed daily by the system, but printed and mailed only once a week. The Company indicated the process usually takes no more than seven days to return checks to the insured. The cancellations review showed that refunds were all mailed within 15 days as required by Section 627.7283(2), Florida Statutes, however, refunds generated from rescinded policies generally took longer (see rescinded policies findings below).

The Company provided listings of 73,255 terminated files (consisting of 69,221 policies cancelled; 3,532 nonrenewed; and 502 rescinded.) Examiners randomly selected 159 cancelled, 25 nonrenewed, and 113 rescinded files. Findings are listed by review area below.

Findings:
No violations were found in the review of the sample of cancelled policies.
No violations were found in the review of the sample of nonrenewed policies.

Review of the sample of rescinded polices identified 69 violations.

1. In 65 instances, the Company failed to timely mail refunds within 15 days of its action to rescind (ab initio cancel) a policy. This is a violation of Section 627.7283(2), Florida Statutes.

   Company Response: The Company responded to the finding and stated, *"There is no Statutory or Administrative Rule governing the timely refund of premium in regard to an ab initio cancellation."*

   Recommendation: It is recommended the Company establish procedures to ensure premium refunds are sent timely.

2. In four instances, the Company failed to follow its filed underwriting rules. This is a violation of Section 627.0651(13)(a), Florida Statutes. The Company rescinded policies following a claim in which the owner of the vehicle was not accurately listed on the policy. The Company's filed underwriting rules require the agent to submit a copy of the vehicle registration within five days of binding coverage. The Company failed to follow this underwriting rule in four instances resulting in it overlooking ownership of the vehicles, post-claim rescissions, and claim denials. Had it followed the filed rule, vehicle ownership would have been discovered at the time of application.

   Company Response: In response to the examiners' findings, the Company stated, *"The guideline clearly indicates that the guidelines can be modified as the underwriter sees fit. Just because a guideline to require registrations is relaxed in an effort to accommodate the reduction of paperwork and ease of doing business does not mean an insured can misrepresent facts creating a material misrepresentation in the application process."*

Recommendation: It is recommended the Company establish procedures to ensure filed underwriting rules are followed.

UNDERWRITING AND RATING PRACTICES

Underwriting files were reviewed to verify compliance with the Florida Insurance Code and the Company's filed rates, rules and underwriting guidelines.

New and Renewal Business

There were 281,141 policies issued during the examination period. The population of policies issued was as follows:

New Business – 130,773
Renewals – 150,368

A random sample of 184 (92 new business and 92 renewals) policies was selected for review. Findings are shown by review area.

New Business

Findings:
There were 16 violations found.

1. In 14 instances, the Company failed to follow filed rules. This is a violation of Section 627.0651(1), Florida Statutes. The Company's filed rules require signed applications, motor vehicle records (MVR), and pre-inspections (Physical Damage Coverage). The Company relies on agents to maintain the signed applications, motor vehicle records (MVR) and pre-inspection forms. The Company was unable to provide one signed application, one MVR and 12 pre-inspections requested from the agents.

   Company Response: The Company agreed with the findings related to pre-inspection and stated: *The agents are required to fill out the pre-inspection forms in lieu of a bill of sale or title and window sticker. We recognize that these forms are not available in some instances. In order to combat that, we just rolled out an "Upload Docs" feature for our website. The agents are now able to upload the entire signed application, pictures, pre-inspection form, and any supporting documents. These uploaded documents get reviewed by the processing team in the underwriting department. We receive a daily report showing what is pending to be reviewed so that we can now follow-up and secure the necessary documents.*

   With respect to the MVR finding the Company stated: *When the agent is unable to pull the MVR due to the MVR record system being unavailable, we are automatically notified that the MVR has not been obtained and then, once available, we run the MVR and attach it to the file. In this instance, it appears this was an oversight. This was an isolated incident.*

In addition, regarding the missing application, the Company stated: *The entire signed application was not received from the agent's office. The reason the entire signed application, pictures & inspection are missing is because the electronic file was corrupted and the documents could not be retrieved.*

Recommendation: It is recommended the Company implement procedures to ensure that signed applications, MVR's, pre-inspection forms and other documents are retained. The Company should periodically audit agents to ensure such documents are being maintained.

2. In two instances, the Company failed to have the licensed 2-20 agent countersign an application that was instead signed by a 4-40 licensed customer representative, without documentation provided that written instructions were otherwise conveyed to the customer representative. This is a violation of Rule 69B-213.130(2), Florida Administrative Code.

   Company Response: The Company agreed with the findings.

   Recommendation: It is recommended the Company implement procedures to ensure all applications and binders initiated by a customer representative are co-signed by the designated supervising agent, unless otherwise delineated in the written instructions conveyed to the customer representative by the designated supervising agent.

Renewal Business

In a review of 92 renewal policies, no violations were found.

EXAMINATION FINAL REPORT SUBMISSION

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

APPENDIX A
Table of Violations

Statute / Rule	Description	Files Reviewed	Number of Violations
626.9541(1)(i)3.a., F.S. and 69O-166.024, F.A.C.	Complaints – Department of Financial Services (DFS) - Company failed to adopt and implement standards for the proper and prompt investigation of claims. The Company failed to correctly process claims timely in ten (10) instances and (3) claims were overpaid. Complaints justified.	57	13
627.318, F.S.	Complaints – DFS - Company failed to maintain records.	57	1
627.0651, F.S.	Complaints – DFS - Company failed to follow filed rates and rules.	57	2
626.9541(1)(i)3.a., F.S. and 69O-166.024, F.A.C.	Complaints – Directly Received - Company failed to adopt and implement standards for the proper investigation of claims. The Company failed to process claims timely. Complaints justified.	57	9
626.9541(1)(i)3.a., F.S.	Claims – First Party Paid - Company failed to adopt and implement standards for the proper investigation of claims. The Company failed to process claims timely resulting in claim delays.	55	7
626.9541(1)(i)3.a., F.S.	Claims – First Party Paid - Company failed to adopt and implement standards for the proper investigation of claims. The Company failed to inspect non-drivable vehicles within 5 days per its claims procedures.	55	4
627.4265, F.S.	Claims – First Party Paid - Company failed to pay claims within 20 days of settlement.	55	2
626.9541(1)(i)3.h., F.S.	Claims - First Party Paid Claims Review – Company failed to clearly explain the nature of the requested information and the reasons why such information is necessary.	55	2
626.9541(1)(i)3.a..and f., F.S. and 69B-220.201, F.A.C.	Claims – First Party CWP - Company failed to adopt and implement standards for the proper investigation of claims and adjuster failed to act with dispatch and due diligence in achieving a proper disposition of the claim.	54	10
626.9541(1)(i)3.a., F.S. and 69B-220.201, F.A.C.	Claims – Third Party Paid - Company failed to adopt and implement standards for the proper investigation of claims. The Company failed to investigate and settle claims timely.	55	11
69O-166.024, F.A.C.	Claims – Third Party Paid - Company failed to acknowledge and act promptly upon claim communications.	55	2
626.9541(1)(i)3.f., F.S. and 69B-220.201, F.A.C.	Claims – Third Party CWP - Company failed to adopt and implement standards for the proper investigation of claims and adjuster failed to act with dispatch and due diligence in achieving a proper disposition of the claim.	54	20
69O-166.024, F.A.C.	Claims – Third Party CWP - Company failed to acknowledge communications and act promptly as to communications within 14 days.	54	1
626.9541(1)(i)3.a., F.S.	Claims – Personal Injury Protection (PIP) Paid – Company failed to adopt and implement standards for the proper investigation of claims - Failure to investigate and settle claims timely.	109	19

APPENDIX A
Table of Violations

Statute / Rule	Description	Files Reviewed	Number of Violations
627.736(4)(b), 626.9541(1)(i)3.i, 627.736.(4)(g) and 627.736(10)(d), F.S.	Claims – PIP Paid – Company failed to pay claims timely.	109	516
627.736(7)(a), F.S.	Claims – PIP Paid – Company failed to comply with mental and physical examination requirements of an injured person.	109	1
627.736(4)(b), F.S.	Claims – PIP Paid – Company paid interest on payments when no interest was due.	109	6
69O-166.024, F.A.C.	Claims – PIP Paid – Company failed to acknowledge and act promptly upon claim communications.	109	2
626.9541(1)(i)3.a., F.S.	Claims – PIP Closed Without Payment (CWP) - Company failed to adopt and implement standards for the proper investigation of claims - Failure to investigate and settle claims timely.	109	12
626.9541(1)(i)3.a. and f., F.S.	Claims – PIP CWP - Company failed to adopt and implement standards for the proper investigation of claims - Failure to provide denial letter.	109	1
626.9541(1)(i)3.a., F.S.	Claims – Open > 90 Days – Company failed to adopt and implement standards for the proper investigation of claims - Failure to investigate and settle claims timely.	107	14
626.9541(1)(i)3.a.and f., F.S.	Claims – Open > 90 Days – Company failed to adopt and implement standards for the proper investigation of claims - Failure to provide denial letter.	107	2
627.7283(2), F.S.	Rescissions – Company failed to timely send refund.	113	65
627.0651(13)(a), F.S.	Rescissions – Company failed to follow filed underwriting rules.	113	4
627.0651(1), F.S.	Underwriting and Rating (New Business) – Company failed to follow filed rules.	92	14
69B-213.130(2), F.A.C.	Underwriting and Rating (New Business) – Company failed to have the 2-20 agent countersign an application that was signed by a 4-40 agent.	92	2