

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF MARKET CONDUCT EXAMINATION

OF

**ALLSTATE INDEMNITY COMPANY
NORTHBROOK, ILLINOIS**

NAIC COMPANY CODE 19240

AS OF

DECEMBER 31, 1998

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January 5, 2000

Honorable Mary C. Neidig, Director
Department of Consumer and Business Services
State of Oregon
350 Winter Street NE, Room 440
Salem, Oregon 97301-3883

Dear Director:

In accordance with your instructions and pursuant to ORS 731.300, we have examined the business affairs of

ALLSTATE INDEMNITY COMPANY
2775 Sanders, Suite A4
Northbrook, Illinois 60062-6127

NAIC Company Code 19240

hereinafter referred to as the "Company." The following report of examination is respectfully submitted.

SCOPE OF EXAMINATION

The market conduct examination of the Company was conducted as of December 31, 1998, covering the period of January 1, 1998 through December 31, 1998, and included a review of material transactions or events which occurred subsequent to the examination cut-off date and were noted during the examination.

A target examination was performed focusing on personal lines automobile insurance. The examination of the Company was conducted pursuant to ORS 731.300 and in accordance with procedures and guidelines established by the Oregon Insurance Division's Market Conduct Program. The program generally follows the Market Conduct Examination Handbook as adopted by the National Association of Insurance Commissioners (NAIC) to the extent that it is consistent with Oregon law. The purpose was to determine the Company's ability to fulfill and manner of fulfillment of its obligations, the nature of its operations, whether it has given proper treatment to policyholders, and its compliance with the Oregon Insurance Code and Administrative Rules.

In order to determine the practices and procedures of the Company's operations, one or more of the following procedures was performed in each phase:

1. A sample of files was selected from listings provided by the Company. The examiner then reviewed each file.
2. The procedure manuals and/or memorandum were evaluated.
3. The Company responded to a series of questions regarding the phase being examined.

The examination was comprised of the following three phases:

- Complaint Handling Practices
- Underwriting
- Claims Handling Practices

COMPANY DESCRIPTION

Allstate Indemnity Company was incorporated on July 7, 1960, under the laws of Illinois and commenced business on December 12, 1960. Allstate Indemnity Company is a wholly owned subsidiary of Allstate Insurance Company. Until its name was changed on December 14, 1973, the Company was formally known as National Emblem Insurance Company.

Allstate Indemnity Company is a specialty carrier and primarily writes automobile insurance for drivers that are nonstandard risks. The Company is licensed in all states and the District of Columbia.

In Oregon, the Company is licensed to write the following lines of business:

Property and casualty (including workers' compensation)
Marine and transportation
Surety

MANAGEMENT AND CONTROL

The members of the Board of Directors serving as of December 31, 1998 were:

<u>Name</u>	<u>Principal Affiliation</u>	<u>Director Since</u>
Jerry D. Choate Barrington, IL	Director	July 5, 1989
Robert W. Gary Lake Forest, IL	Director	July 6, 1994
Steven L. Groot North Barrington, IL	Director	January 19, 1995
Edward M. Liddy Lake Forest, IL	Director	January 19, 1995
Louis G. Lower, II Winnetka, IL	Director	January 19, 1995
Casey J. Sylla Barrington, IL	Director	September 27, 1995
Thomas J. Wilson, II Chicago, IL	Director	July 1, 1995
Edward William Young Barrington, IL	Director	July 6, 1994

Operating management of the Company as of December 31, 1998, was under the direction of the following principal officers:

<u>Name</u>	<u>Office</u>
Jerry Dale Choate	Chairman of the Board
Steven Lambert Groot	President
Robert William Pike	Senior Vice-President, Secretary, and General Counsel
James Philip Zils	Senior Vice-President and Treasurer
Casey Joseph Sylla	Senior Vice-President and Chief Investment Officer
Samuel Henry Pilch	Vice President and Controller

COMPLAINT HANDLING PRACTICES

The Company uses the following definition of a complaint: “Any written or oral communication received by Allstate indicating any or all degrees of dissatisfaction.”

Complaints are classified by type based upon the general nature of concern:

Claim	Sales
Pricing	Underwriting
Operations	

Complaints may be received at various corporate locations, such as home offices in New York and Chicago, or regional offices, the operations center, or the payment center. They are recorded by “sequence number” using the corporate-wide “action line,” a computerized method of tracking complaint activity. This system maintains a continuous record for state insurance departments, measures complaint activity by region, and assists to identify training opportunities. Telephone complaints that can be resolved at the time of the initial call are not entered in the system, although the Company considers them no less important than written complaints. Company policy and procedure requires documentation to affirm that customers are contacted

within 24 hours after complaints are received, and that complaints are resolved by the close of business on the seventh calendar day.

When they are received at the regional office, complaints are directed to the customer care department, where they are logged into the system and redirected to the department considered most appropriate for handling based upon the general nature of the concern expressed. Primary handling is conducted at this level and when written responses are required, they are drafted and returned through the customer care department for review and approval. Insurance division complaints receive responses over the regional vice president's signature.

Findings

The standards used may be found in Appendix A immediately following the report.

The Company passed the following standards without comment:

<u>Standard</u>	<u>Regulatory Authority</u>
<u>Complaint Handling Standard #1</u> – All complaints are recorded on the Company complaint register.	ORS 731.302(1)
<u>Complaint Handling Standard #2</u> – The Company has adequate complaint handling procedures in place and communicates such procedures to policyholders.	ORS 731.302(1)
<u>Complaint Handling Standard #3</u> – The Company furnished a response within 21 days of an inquiry from the Insurance Commissioner.	ORS 731.296 and OAR 836-080-0225(2)
<u>Complaint Handling Standard #4</u> – The Company responds to Insurance Commissioner complaints adequately and conclusively.	OAR 836-080-0225(2)

The Company's complaint register for Insurance Division inquiries received during the examination period was used to develop the population review for Standards 3 and 4. A random sample of 50 (46.3%) complaints was selected for review from 108 recorded as Oregon Insurance Division complaints received. Summaries of the reasons for the inquiries and their dispositions are shown below:

<u>Reasons - Insurance Division Complaints</u>	<u>#</u>	<u>%</u>
Claims – delay in settlement	9	18.0%
Claims – settlement too low	7	14.0
Claims – failure to respond	6	12.0
Claims – denied	4	8.0
Claims – unsatisfactory repair	3	6.0
Claims – miscellaneous	3	6.0
Claims – inadequate explanation	2	4.0
Claims – unsatisfactory offer	1	2.0
Sales – inadequate explanation	3	6.0
Sales – agent failed service request	2	4.0
Sales – discourteous treatment or poor communication	2	4.0
Sales – different coverage issued	2	4.0
Sales – agent misquoted	1	2.0
Underwriting – company underwriting practice	3	6.0
Operations – endorsement incomplete	1	2.0
Operations – collections letter received	<u>1</u>	<u>2.0</u>
Total	<u>50</u>	<u>100.0%</u>

<u>Disposition - Insurance Division Complaints</u>	<u>#</u>	<u>%</u>
Satisfactory explanation	43	86.0%
Corrective action taken	6	12.0
No action required	<u>1</u>	<u>2.0</u>
Total	<u>50</u>	<u>100.0%</u>

<u>Days to Respond</u>	<u>#</u>	<u>%</u>
1 – 21	50	100%
22 – 45	0	0
Over 45	<u>0</u>	<u>0</u>
Total	<u>50</u>	<u>100%</u>

The following exceptions to the standards were noted:

The Company's complaint register for noninsurance division inquiries received during the examination period was used to develop the population reviewed for Standards 5 and 6. A random sample of 50 (24.2%) complaints was selected from 207 noninsurance division complaints listed on the Company's logs. Summaries of the reasons for the inquiries and their dispositions are shown below:

<u>Reasons - Noninsurance Division Complaints</u>	<u>#</u>	<u>%</u>
Operations - collections letter received	31	62.0%
Sales - agent failed service request	4	8.0
Claims - miscellaneous handling	3	6.0
Claims - failure to respond	2	4.0
Claims - settlement too low	2	4.0
Claims - unsatisfactory offer	2	4.0
Claims - unsatisfactory repair	1	2.0
Claims - delay in settlement	1	2.0
Sales - inadequate explanation	1	2.0
Sales - different coverage issued	1	2.0
Sales - request to change agent	1	2.0
Underwriting - company underwriting practice	<u>1</u>	<u>2.0</u>
Total	<u>50</u>	<u>100.0%</u>

<u>Disposition - Noninsurance Division Complaints</u>	<u>#</u>	<u>%</u>
Satisfactory explanation	32	64.0%
Corrective action taken	14	28.0
No action required	3	6.0
Undetermined	<u>1</u>	<u>2.0</u>
Total	<u>50</u>	<u>100.0%</u>

Complaint Handling Standard #5 - The company furnished a response within 30 days of an inquiry from an insured. Reference: OAR 836-080-0225(3).

Findings

Passed with comment. 92% compliance. Four (8%) noninsurance division complaints were judged to fail this standard. One complaint file contained a letter draft, but the Company confirmed that no acknowledgement was sent prior to the final resolution letter dated more than 45 days after the complaint was received. In the other three cases, an initial response was made within the required 30 days, but the complainant had replied with additional correspondence, to which the Company did not respond. This indicated that the matter had not been concluded to the complainants' satisfaction, and that further response would have been appropriate.

The chart below provides a summary of the Company's response timeliness with regard to handling noninsurance division complaints:

<u>Days to Respond</u>	<u>#</u>	<u>%</u>
1 – 30	46	92%
31 – 45	0	0
Over 45	<u>4</u>	<u>8</u>
Total	<u>50</u>	<u>100%</u>

Although four complaints were not responded to within 30 days it appears the Company has a process in place for a timely response and acknowledge of all non commissioner complaints. **Therefore, no recommendation is warranted.**

Complaint Handling Standard #6 – The company response to an inquiry from an insured is adequate and answers the question being raised. Reference: OAR 836-080-0225(3).

Findings

Passed with comment. 92% compliance. Four (8%) of the noninsurance division complaints reviewed failed to meet this standard. Please refer to the explanation of findings shown for Standard 5 above. The Company did not send a final response to additional correspondence from the complainant in three cases. The Company explained that the failure to follow through with these three complaints was due to shared responsibility for processing complaints between the Bothell, Washington regional office and the Great Lakes Innovation Center (GLIC). The Company informed the examiner that this situation has now been corrected.

In the fourth case, the Company did not supply an adequate or timely response or explanation of its actions directly to the person who initiated the complaint for more than 45 days.

These situations do not appear to reflect the overall complaint handling practice of the Company. **Therefore, a recommendation is not warranted.**

Additional Findings and Procedures

Company Identification in Correspondence

During review, the examiner noted numerous complaint responses on Allstate Insurance Company letterhead showing the Company's Great Lakes Innovation Center corporate address. The letters did not reference the proper Company name, but each did refer to a policy number unique to the Company, rather than to its affiliate/parent company. These complaints were received at that corporate office

because they related to premium billings or collection letters that had originated from the same office.

Several inquiries from the examiner asked for an explanation of why the Company name was not correctly identified either on the letterhead or in the text of these complaint response letters. The examiner also sent a memo to the Company, listing 34 total complaints (68% of 50 reviewed) that did not properly identify the Company, including one from a local claims office and one from the insured's agency office.

The Company agreed with the examiner's findings and provided evidence that corrective action is being taken. The Company advised GLIC that all letters generated by that office must identify the actual name of the correct insuring company.

The Company has shown evidence of corrective action. Therefore, a recommendation for further action is not suggested.

UNDERWRITING AND RATING

The Company uses captive and independent agents to market its products in Oregon. Quotations are prepared by the agency force in their field offices.

Agents can prepare a quote from information provided by the applicant using the Company's ALSTAR system. The agent may also use PQB (prequalifying business) to assist in developing the customer information to prepare a quote.

PQB is a process that allows agents to develop a risk profile accurately by providing them with necessary information at the point of sale. When the PQB program is run,

that system automatically orders the MVR (motor vehicle report) on requested operators, LIS (Loss Information System) information, and DADS (Additional Drivers in the Household) information. The agent receives a PQB report that contains all of this information. The agent may run PQB in order to develop the information to provide an accurate quote without submitting an application. The PQB report helps the agent determine whether the applicant is eligible for coverage in the preferred market and calculates the correct premium.

An additional underwriting tool is IRMS (Integrated Risk Management System). IRMS performs an assessment of the risk based on the information gathered by the agent. It provides an indication of the underwriting acceptability of the risk. IRMS may be run before or after coverage is bound. Agents may request information through PQB first and then through IRMS, or they may run these programs simultaneously.

If the risk is acceptable to the Company, the agent may make a formal electronic submission of the application. The Company calls this process "slotting." The policy then may be automatically issued without manual underwriting intervention or may be referred to underwriting for SR22 filing or verification of proper classification.

In some instances, IRMS returns a "no decision" response. If so, the agent reviews for missing, incorrect, or inconclusive information and, if necessary, updates the information. The agent then may rerun IRMS to reevaluate the risk, or the information may be manually reviewed by an underwriter. At this point, the IRMS decision does not mean that coverage has been bound.

When IRMS indicates that the application would not meet the Company's underwriting criteria, the agent gives the applicant an opportunity to withdraw the request for coverage. If coverage was not bound and the applicant has chosen to withdraw the application, no action is required by the agent.

If coverage was bound and the application was not yet slotted, the customer still has the option to have the application withdrawn. The Company's definition of this process is "rescinding."

If the agent determines that there is duplicate coverage, the application will be "rescinded," with no coverage provided. Any payment received from the customer will be refunded in full, and the agent provides the customer with a letter confirming the customer's decision to withdraw the application.

If there was no duplicate coverage and the customer indicates that they still wish to withdraw the application, the Company will issue coverage on a temporary basis, in order to allow the customer time to obtain replacement coverage. The Company sends a letter to the customer confirming the customer's request and indicating the date and time coverage will cease. Any unearned premium is refunded to the customer.

If IRMS has indicated that the application does not meet the Company's underwriting criteria and the customer does not wish to withdraw their bound application, the bound application is slotted and referred to an underwriter for review. If the underwriter rejects the application, a letter is mailed to the applicant

indicating the date and time the coverage will cease and specifying the reason(s) for the adverse underwriting action.

Prior to the renewal date, the Company runs the IRMS renewal program to determine which policies are acceptable to renew and which cases should be referred to underwriting for renewal evaluation. IRMS screens each policy against established risk profiles and in some cases may order MVR reports to assist in the evaluation. Those which result in either a nonrenew or reengineer determination are reviewed by underwriting and are also presented to the agent. The agent has an opportunity to review each case prior to the renewal date and may agree with the decision or provide additional information to underwriting for consideration.

Findings

The underwriting review consists of eighteen standards. A list of all standards appears in Appendix A immediately following this report. Standards number 6 and 16 were waived, as they did not pertain to personal lines automobile insurance, which was the target of this examination.

The Company provided population runs of business issued, nonrenewed, canceled, new business issued with premium surcharge, and new business issued with mismatched bodily injury and uninsured motorist limits from which random samples were drawn. The chart below illustrates the size of the original population as well as the size of the sample drawn.

<u>Population Reviewed</u>	<u>Total Population</u>	<u>Initial Random Sample</u>	<u>Percentage to Total</u>	<u>Used to Review Standards</u>
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New business issued	13,032	100	0.77%	#1, #2, #7, #8, #9, #10, #11, #12, #13
Policies nonrenewed	20	20	100.00%	#15
Policies canceled	410	50	12.20%	#14, #15
New business issued with premium surcharge	9,491	50	0.53%	#3
New business issued with mismatched BI and UM limits	129	50	38.76%	#4

The following standards were deemed to pass without comment:

<u>Standard</u>	<u>Regulatory Authority</u>
<u>Underwriting Standard #2</u> - Disclosures to insureds concerning rates and coverage are accurate and timely.	ORS 737.205 and ORS 742.566
<u>Underwriting Standard #3</u> - An insured or applicant may not be assigned to a higher risk category than the person would normally be assigned because the person allowed a motor vehicle liability policy to lapse or had driving privileges suspended due to a nondriving offense.	ORS 742.449
<u>Underwriting Standard #8</u> - Employment driving record may not be used to determine if the file is issued renewed or in calculation of rates.	ORS 746.260 and ORS 746.265(1)
<u>Underwriting Standard #10</u> - All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the department of insurance.	ORS 742.003
<u>Underwriting Standard #11</u> - Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim.	ORS 731.302(1)
<u>Underwriting Standard #13</u> - The Company does not engage in collusive or anticompetitive underwriting practices.	ORS 731.302(1)

The following exceptions were noted:

Underwriting Standard #1 – The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan. Reference: ORS 737.205.

Findings

Failed. 89% compliance. Eleven files (11%) failed this standard for the following reasons:

<u>Reason</u>	<u>Number of Policies</u>
Rating error	7
Applicant qualified for Allstate Insurance Company policy but coverage was written in Allstate Indemnity Company	<u>4</u>
Total	<u>11</u>

I recommend the Company charge rates for policy coverage in accordance with the Company's filed rates and the Company's rating plan pursuant to ORS 737.205.

Underwriting Standard #4 – Written rejection for higher limits of uninsured and underinsured motorist coverage limits must be obtained. Reference: ORS 742.502(2)(a) and OAR 836-054-0000.

Findings

Failed. 84% compliance. Eight files (16%) failed this standard for the following reasons.

<u>Reason</u>	<u># of Failures</u>
Company unable to provide copy of completed waiver form	4
Waiver form for incorrect company was used	<u>4</u>
Total	<u>8</u>

I recommend the Company obtain written rejection for higher limits of uninsured and underinsured motorist coverage in accordance with the provisions of ORS 742.502(2)(a) and OAR 836-054-0000.

Underwriting Standard #5 – Named exclusions are signed by all named insureds and comply with all rules and regulations. Reference: ORS 742.450(5).

Findings

Not applicable. The Company does not issue coverage with named exclusion endorsements.

Underwriting Standard #7 – The Company underwriting practices are not unfairly discriminatory. The Company adheres to applicable statutes, rules and regulations and Company guidelines in the selection of risks. Reference: ORS 746.015, ORS 746.018, OAR 836-081-0030.

Findings

Failed. 89% compliance. Eleven files (11%) failed this standard because the Company did not adhere to its underwriting guidelines when placing these policies in force. It appears that four of these applicants were eligible for coverage with Allstate Insurance Company and should not have been placed in this nonpreferred market.

Incorrect rates were charged on the other seven policies. Three of these policies were issued with discounts to which the applicants were not entitled. Two of the policies were issued to single males who were charged the married male rates. One policy should have been issued with a premium surcharge and the other policy was issued with a policy fee that should not have been charged.

I recommend the Company adhere to applicable statutes, rules and regulations and Company guidelines in the selection of risks in accordance with ORS 746.015, ORS 746.018, and OAR 836-081-0030.

Underwriting Standard #9 – For the purpose of determining whether or not to issue or renew a policy and the calculation of rates an insurer may not use a driving record older than three years immediately preceding the issuance or renewal. Reference: ORS 746.265(2).

Findings

Passed with comment. Agents do not make an independent selection to choose whether a three-year or five-year record is obtained. ALSTAR interfaces with an outside vendor with which the Company has contracted to obtain MVRs. The ALSTAR system requires the agent to input the class of business being written. For example, line 11 is commercial and line 10 is private passenger auto insurance. The ALSTAR system has been programmed to retrieve the correct three-year MVR record.

Underwriting Standard #12 – File documentation adequately supports decisions made. Reference: ORS 733.170.

Findings

Failed. 82% compliance. Eighteen files (18%) failed this standard. The reasons are shown in the chart below:

<u>Reason</u>	<u>Number of Failures</u>
Policy was written in Allstate Indemnity Company and risk qualified for preferred market. File documentation does not support this decision.	4
Policy was issued with premium discount to which the insured was not entitled. File documentation does not support this decision.	3
Insured is single male but policy was issued as though a married male is covered. File documentation does not support this decision.	2
Policy issued without surcharge that should have been included in premium. File documentation does not support this decision.	1

<u>Reason</u>	<u>Number of Failures</u>
Policy issued with policy fee that should not have been charged. File documentation does not support this action.	1
Incomplete application does not support Company's documentation regarding the risk.	2
Effective date of coverage was changed based on verbal agreement between agent and insured. File contains no supporting documentation.	1
Underwriting decision based upon applicant's inability to provide evidence of five years' experience. No file documentation regarding this issue.	3
Underwriting decision based upon applicant's inability to produce evidence of prior insurance with no lapse in coverage. No file documentation regarding this issue.	<u>1</u>
Total	<u>18</u>

I recommend the Company's documentation adequately support all decisions made by the underwriters and underwriting decisions made by agents in accordance with ORS 733.170.

Underwriting Standard #14 – Rejections and declinations are not unfairly discriminatory. Reference: ORS 746.015, ORS 746.018 and OAR 836-081-0030.

Findings

Failed. 88% compliance. The Company was unable to provide documentation regarding six (12%) of the 50 canceled policies selected for review.

The Company experienced problems with termination letter record retention as a result of a conversion to a new computer system. The Company indicated these problems were recognized in June of 1998. During the examination, the Company demonstrated to the examiners that this problem was corrected as of March 30, 1999.

It appears a recommendation is not warranted since the Company has identified and corrected the problem that caused these policies to fail this standard.

Underwriting Standard #15 – Cancellation/nonrenewal notices comply with policy provisions and state laws and company guidelines. Cancellation must be made within the first 60 days of the policy except for the exemption. Nonrenewal and changes in policy must be sent at least 30 days in advance of the renewal date. Reference: ORS 742.566 through ORS 742.572 and ORS 746.650.

Findings

Failed. 90% compliance. Seven files (10%) failed this standard.

<u>Population Reviewed</u>	<u># Files</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Canceled policies	50	43	7
Nonrenewed policies	<u>20</u>	<u>20</u>	<u>0</u>
Total	<u>70</u>	<u>63</u>	<u>7</u>

One cancellation notice did not include the expiration date of coverage.

The Company was unable to provide documentation regarding six of the canceled policies selected for review. The Company experienced problems with termination letter record retention as a result of a conversion to a new computer system. The Company indicated these problems were recognized in June of 1998. During the examination, the Company demonstrated to the examiners that this problem was corrected as of March 30, 1999.

It appears a recommendation is not warranted since the Company identified and corrected the problem that caused the majority of these policies to fail this standard.

Underwriting Standard #17 – The insurer reports the name address and VIN number of each vehicle covered by a motor vehicle liability policy whether the policy was bought, canceled or not renewed within 30 days of cancellation or nonrenewal and within 15 days of issuance to the Department of Transportation. Reference: ORS 742.580.

Findings

Passed with comment. The Company transmits the required information to the Department of Transportation electronically and has not developed a system

program to print the reports. The transmissions are sent from the Company's home office in Northbrook, Illinois, each Friday.

From the information provided, it appears the procedures the Company has established are in compliance with this standard.

Underwriting Standard #18 – Rescissions are not made for nonmaterial misrepresentations in accordance with the Company's established procedures.

Reference: ORS 746.240.

Findings

Failed. When evaluating the denied claims population, the examiner discovered a policy that had been rescinded during the examination period. The Company originally stated no policies were rescinded during 1998, but subsequently confirmed that this is the only policy rescinded during the examination period.

This policy was rescinded September 22, 1998. The Company referenced ORS 742.208 in the letter to the insured. ORS 742.208 specifically applies to fire insurance policies, not auto insurance. It appears Claims Standard 8 was not met since the Company represented ORS 742.208 as being applicable to this case when it is not.

ORS 742.013 states that misrepresentations, omissions, concealments of facts and incorrect statements shall not prevent a recovery under the policy unless the misrepresentations, omissions, concealments of fact and incorrect statements are contained in a written application for the insurance policy and a copy of the application is indorsed upon or attached to the insurance policy when issued.

ORS 742.016 states that when the contract is made pursuant to a written application therefor, if the insurer delivers a copy of such application with the policy to the insured, thereupon such application shall become a part of the insurance policy. Any application that is not so delivered to the insured shall not be a part of the insurance policy and the insurer shall be precluded from introducing such application as evidence in any action based upon or involving the policy. Any oral representations by the insured that are not included in an application shall not be a part of the insurance policy and the insurer shall be precluded from introducing such representations as evidence in any action based upon or involving the policy.

The Company's policy does allow for rescission if the policy was obtained or renewed through material misrepresentation. However, applications are not attached to and made a part of automobile policies issued.

Since the application was not attached to the policy, the Company is prohibited from using the responses on the application or oral representations as support for such action.

Additionally, the application completed by the insured does not indicate questions regarding the status of her driver's license or driving history were asked and answered. The Company informed the insured that the reason for rescinding coverage was her material misrepresentation of the status of her driver's license and her driving history.

Based on the facts related to this case, it appears the Company's procedures for rescinding coverage are not in compliance with the provisions of ORS 742.013 and ORS 742.016. The Company is reopening the claim and will contact the appropriate parties to consider payments due under this accident.

I recommend the Company rescind coverage only for material misrepresentation contained in a written application that is attached to and made a part of the policy at issue in accordance with the provisions of ORS 742.013, 742.016 and 746.240.

Additional Findings and Procedures

Dealership Referral Program (DRP)

The dealership referral program is a marketing tool the Company's agents use when a customer buys a car and needs insurance. This paragraph describes the Company's explanation of how the DRP should work. The dealership refers the customer to the agent and the customer calls the agent from the dealership. The agent obtains all necessary information from the applicant during this telephone conversation. The agent provides a quote and binds coverage. The customer leaves a premium down payment in the Company's lock box installed at the dealership. Premium payment must be made either by personal check or money order payable directly to the Company. The agent faxes a temporary binder to the insured at the dealership. The next business day, the agent retrieves the premium payment from the dealership and completes the policy issue process. If the applicant qualifies for coverage with Allstate Insurance Company, the policy is written in that Company instead of Allstate Indemnity Company.

Findings

The Company indicated a total of 330 DRP policies were written during the examination period. From this population, an initial random sample of 50 (15%) policies was selected for review for compliance with the standards shown below.

Standard

Regulatory Authority

Dealership Referral Program Standard #1 – Coverage is bound by a properly licensed and appointed agent; not a representative of the dealership.

ORS 744.051

Dealership Referral Program Standard #2 – Policies are written in Allstate Insurance Company if they qualify according to Company underwriting standards.

ORS 746.015

The Company is unable to identify any DRP policies initially bound in Allstate Indemnity Company and ultimately issued as Allstate Insurance Company policies because its computer coding does not contain an identifier to locate these records.

The Company was asked to provide copies of the new business application, all underwriting information obtained, the policy declarations page, signed binder that was faxed to the dealership at point of sale and a copy of the check or money order used to pay the premium down payment for each of the 50 cases listed in the initial random sample. The Company was unable to produce records for five of the requested policies.

After reviewing the file documentation provided, the examiner learned that the original population of 330 policies was not valid. The correct number of DRP policies written in 1998 is 1,085. A computer programming change in April of 1998 caused the system to miss some of the records when the Company produced the first list of DRP policies. A new sample for review was not selected.

The Company does not require the customer to sign an application for policies written through the DRP.

There are 142 auto dealerships in the State of Oregon currently participating in the DRP. There were 95 Oregon agents authorized to participate in the DRP in 1998.

Only six of the 50 policies reviewed are still in force. Of the 44 terminated policies, the average number of days the policy remained in force was 136 (4.5 months).

The Company indicated the applicant knows coverage is in force and has evidence of such coverage with the temporary binder form that is faxed to the insured at the dealership. The agent instructions for this program state that if the agent does not have access to a fax machine, he/she must provide the customer with proof of insurance on the next business day. If this were the case, the customer would not have evidence of coverage when leaving the auto dealership.

The Company does not require its agents to obtain signed UM/UIM forms for DRP policies because the Company does not offer lower limits of this coverage through this program.

The following exceptions to the standards were noted:

Dealership Referral Program Standard #1 - Coverage is bound by a properly licensed and appointed agent; not a representative of the dealership. Reference: ORS 744.051.

Findings

Failed. 40% compliance. Thirty files (60%) failed this standard because the Company could not produce copies of the binders for the examiner's review.

ORS 744.024(3) states that a licensed insurance agent shall keep at the place of business of the licensee the usual and customary records pertaining to the business under the license. All such records as to any particular transactions shall be kept available and open to the inspection of the director of the Department of Consumer and Business Services during business hours. An agent shall keep records of insurance transacted by the agent under the license for three years following expiration of the policy.

ORS 733.170 requires the Company to keep its books, records, accounts and transaction source data in such manner that the director of the Department of Consumer and Business Services may readily verify its statements of financial condition and ascertain whether the insurer is unimpaired, has given proper treatment to policyholders and has complied with the Insurance Code.

The Company does not require agents to retain a copy of the binder for their records.

It appears retention of a copy of the temporary binder by the agent and by the Company would be required according to the statutes referenced above. Issuance of the temporary binder appears to be a particular insurance transaction for which the agent would be required to keep records according to ORS 744.024(3).

Without a copy of the binder, the examiner is unable to verify proper treatment was given to the policyholder and that the Company complied with the Insurance Code in accordance with ORS 733.170.

I recommend the Company keep its records in such a manner that the director of the Department of Consumer and Business Services may readily verify proper treatment has been given to policyholders and that the Company has complied with the Insurance Code in accordance with ORS 733.170.

Dealership Referral Program Standard #2 - Policies are written in Allstate Insurance Company if they qualify according to Company underwriting standards. Reference: ORS 746.015.

Findings

Failed. 84% compliance. Eight files (16%) failed this standard.

The Company was unable to explain why six of these cases were written in the indemnity company when it appears they may have qualified for coverage in Allstate Insurance Company. The Company was unable to provide documentation to support its action.

The other two cases failed because each of these applications was for a single car with one incident. According to the Company's underwriting guidelines, these applicants may have qualified for coverage with Allstate Insurance Company if their credit had been reviewed.

It appears these eight cases may have been placed in the nonstandard market solely because of the marketing method used to solicit this business.

A recommendation regarding compliance with ORS 746.015 appears under Underwriting Standard #7 above.

CLAIMS

Claims are reported to either the agent, the market claims office or the claims service center.

If the claim has been reported to the agent, the agent takes the loss facts, enters the data into a centralized computer system and forwards this “promise line” claim to the national claims service center. The agent also answers all questions the customer may have and verifies coverage.

If the claim is reported to the market claim office (MCO), the customer is transferred on-line to the national claims service center. The MCO stays on the line until they are certain the customer is connected with the loss report taker. Upon collection of all relevant loss facts from the customer, depending on the level of urgency of the claim, a commitment is made to the customer for a return call from the appropriate MCO.

Both the agent and the national claims service center, when gathering the loss facts from the customer, establish the formal claim record in the Company’s computer system and a claim number is assigned.

Either a claims adjuster or claims processor, depending on the nature of the claim, makes contact directly with the claimant, obtains the necessary documents and explains all applicable coverages and the claim process.

Reserves are established automatically for certain coverages, and by the claims adjuster for casualty coverage. Individual reserve amounts are revised upwards or downwards as needed to reflect the current value of the claim.

Once the investigation is complete, the claims adjuster pays the claim and the reserve is released.

Denial letters that are not based solely on liability are reviewed by the market claim manager (MCM) before mailing.

Claims involving unusual or complicated situations or large exposure may be submitted to the home office for recommendation on handling the case.

The Company maintains a claims manual outlining in detail its claim procedures.

Findings

The Company provided lists of claims paid, claims closed without payment, subrogated claims, and total loss claims paid during the examination period. From these lists random samples were selected for review.

The Company was unable to produce a list of denied claims excluding those which were simply closed without payment. An alternative method was used to select the denied claims for review. The examiner produced an initial random sample of 400 claims closed without payment. Each record was checked to determine whether benefits had actually been denied. From this sample, only 39 true denials were identified. A second random sample of 400 records was generated in order to select the remaining 11 records to complete the sample of 50 claims. When reviewing the hard copy files along with the Company's electronic records, the examiner learned

that not all of the 50 items identified as true denials were denied claims. In fact, only 40 of the 50 files reviewed represented actual coverage denials.

<u>Type of Claim</u>	<u>Total Population</u>	<u>Initial Random Sample</u>	<u>Percentage to Total</u>
Claims paid	10,395	100	.96%
Total loss claims paid	554	50	9.02%
Subrogated claims	1,428	50	3.50%
Denied claims	Unknown	50	Unknown

The total loss claims were reviewed for compliance with Standards 5 and 17 only.

The subrogated claims were reviewed for compliance with Standard 19 only.

The items were tested for compliance with the following standards based on Oregon Revised Statutes or Oregon Administrative Rules.

The following standards were deemed to pass without comment:

<u>Standard</u>	<u>Regulatory Authority</u>
Claims Standard #10 – The Company did not attempt to settle a claim on the basis of an altered application without notice to or consent of the applicant.	ORS 746.230(1)(i)
Claims Standard #18 – Automobile claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	ORS 746.230(1)(i) and OAR 836-080-0240(2)(3)(5)(6)(7) and (8)

The following exceptions were noted:

Claims Standard #1 – The initial contact by the Company with the claimant is within 30 days. Reference: OAR 836-080-0225.

Findings

Passed with comment. 99% compliance to applicable files. One file (1%) failed this standard.

An attorney representing a third party claimant wrote to the Company requesting PIP (Personal Injury Protection) forms. The Company's file documentation does not indicate the Company ever responded to this request. The Company acknowledged this third party claimant was never contacted and confirmed the file was not handled or documented in accordance with Company standards.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	0	99	1
Claims denied	<u>50</u>	<u>10</u>	<u>40</u>	<u>0</u>
Subtotal	150	10	139	1
Less N/A files	<u>10</u>			
Total	<u>140</u>	<u>10</u>	<u>139</u>	<u>1</u>

<u>Days to Acknowledge</u>	<u>Number</u>	<u>Percentage to Total</u>
0-30	139	99%
31-45	0	0
Over 45	0	0
Unknown	<u>1</u>	<u>1</u>
Total	<u>140</u>	<u>100%</u>

A failure rate of 1% does not represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #2 - Investigations are conducted within 45 days. Reference: OAR 836-080-0230.

Findings

Passed with comment. 96% compliance to applicable files. Five files (4%) failed this standard.

The Company took 76 days to investigate one paid claim and cannot explain the reason for the delay in completing the investigation.

The Company confirmed another paid claim was handled improperly by the claim adjuster. This claim investigation lasted 274 days.

A denied claim investigation took 50 days to complete and the file documentation does not explain why the investigation could not have been concluded within 45 days.

Another denied claim investigation was not completed until 97 days after notification of claim was received. From the information reviewed, it appears this delay was due to a miscommunication between Company employees.

The Company agreed a denied claim investigation that lasted 58 days did not meet this standard. The file documentation does not explain why there was a delay in reaching the police department to obtain necessary information regarding the claim.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	0	98	2
Claims denied	<u>50</u>	<u>10</u>	<u>37</u>	<u>3</u>
Subtotal	150	10	135	5
Less N/A files	<u>10</u>			
Total	<u>140</u>	<u>10</u>	<u>135</u>	<u>5</u>

A failure rate of 4% does not represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #3 – Claims are resolved in 30 days unless a delay letter (45 days) has been sent. Reference: OAR 836-080-0235(1) and (4).

Findings

Failed. 91% compliance to applicable files. Five files (9%) failed this standard. All five of these cases were PIP claims.

The Company received a medical bill for a PIP claim and did not process it because it was never entered into the Company's computer system.

A medical bill on another PIP claim was apparently overlooked and was not paid until the situation was brought to the Company's attention two years later.

The Company received a bill from an ambulance company February 2, 1998, and did not pay it until March 20, 1998, 46 days later. The file does not contain an explanation for the delay in processing this bill and no delay letter was sent to the insured.

Another medical bill was received May 22, 1998, and was not paid until June 23, 1998, 32 days later. The Company indicated this bill may have been originally mailed to an incorrect claims office. The file documentation does not explain the reason for the processing delay and does not indicate a delay notice was mailed to the insured.

One claim was received by the Company April 2, 1998 and denied May 5, 1998, 33 days later. A delay letter was not mailed to the insured.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	53	43	4
Claims denied	<u>50</u>	<u>40</u>	<u>9</u>	<u>1</u>
Subtotal	150	93	52	5
Less N/A files	<u>93</u>			
Total	<u><u>57</u></u>	<u><u>93</u></u>	<u><u>52</u></u>	<u><u>5</u></u>

Note: This standard applies to first party claims only. The N/A files represent third party claims and denied claims selected for review which were not true denials.

Although they respectfully disagree, the Company indicated it is taking steps to modify its processes to ensure that delay notices are sent to PIP claimants within the time frames outlined in OAR 836-080-0235 whenever the Company requires additional time to complete its investigation and make a payment decision.

I recommend the Company send delay letters in accordance with the provisions of OAR 836-080-0235(4) for all claims which are not resolved in 30 days.

I recommend the Company resolve within 30 days first party claims for which more time to determine whether the claim should be accepted or denied is not required in accordance with the provisions of OAR 836-080-0235(1).

Subsequent to the examination, the Company informed the examination team that they have revised their process to comply. The examiner did not perform a retest.

Claims Standard #4 – The Company responds to claim correspondence in 30 days.

Reference: OAR 836-080-0225 all subparts.

Findings

Failed. 82% compliance to applicable files. Ten files (18%) failed this standard.

The Company received a settlement demand from a claimant's attorney February 13, 1998, and did not respond to this correspondence until March 31, 1998, 47 days later.

The Company received another settlement demand from a claimant's attorney November 18, 1997, and did not respond to this correspondence until December 30, 1997, 43 days later.

The Company received a settlement demand from a claimant's attorney August 11, 1998, and did not respond to this correspondence until September 22, 1998, 43 days later.

Subrogation demands were received from a claimant's carrier March 4, 1998, March 13, 1998, May 4, 1998, June 4, 1998, September 11, 1998 and October 23, 1998. The claim was not paid until October 26, 1998. The Company acknowledged this claim was not handled properly.

An attorney for a PIP claimant wrote to the Company August 6, 1997, requesting PIP forms. The Company never responded to this request.

The Company received letters from an insured's attorney on August 8, 1997 and September 22, 1997, demanding arbitration for the unpaid PIP bills and asking the

Company to provide certain other information. The Company did not respond to this correspondence until November 7, 1997.

The Company received a subrogation demand from a claimant's carrier March 5, 1999 and never responded to that correspondence.

The Company received correspondence from a claimant's carrier January 26, 1998, to which it did not respond until March 11, 1998.

The Company received subrogation demands from two claimants' carrier on one case. One carrier's letters were received May 6, 1999 and March 25, 1999. The other carrier's demand was received November 18, 1998. The Company did not respond to any of this correspondence.

The Company received a letter from a claimant's attorney that was dated August 26, 1998. The Company's computer diary notes indicated that letter was received August 28, 1998, and the file was "routed for further handling." Another computer diary entry instructed an employee to respond to the attorney letter in file. The file documentation provided by the Company for the examiner's review did not contain a copy of the attorney's letter. The Company does not know what happened to this correspondence and it appears the Company did not respond to that letter until November 6, 1998, when the claim was denied.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	58	36	6
Claims denied	<u>50</u>	<u>37</u>	<u>9</u>	<u>4</u>
Subtotal	150	95	45	10

Less N/A files	<u>95</u>			
Total	<u>55</u>	<u>95</u>	<u>45</u>	<u>10</u>

Note: The N/A files are those without claim correspondence and denied files selected for review that were not true denials.

I recommend the Company respond to claim correspondence within 30 days in accordance with the provisions of OAR 836-080-0225.

Subsequent to the examination, the Company indicated that it has heightened awareness of this standard through training and will monitor compliance through internal reviews.

Claims Standard #5 - Claim files are adequately documented. Reference: OAR 836-080-0215 and ORS 733.170.

Findings

Failed. 92% compliance to applicable files. Sixteen files (8%) failed this standard for the following reasons:

<u>Reason</u>	<u># Files</u>
Documents misfiled or lost	6
Company file documentation does not explain reason for claim handling delays	5
Actual date PIP bill received entered incorrectly into Company's computer system	2
Letter mailed to insured was not dated	2
Documentation does not indicate when first offer to settle total loss claim was made	<u>1</u>
Total	<u>16</u>

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
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Claims paid	100	0	91	9
Claims denied	50	10	38	2
Total loss claims	<u>50</u>	<u>0</u>	<u>45</u>	<u>5</u>
Subtotal	200	10	174	16
Less N/A files	<u>10</u>			
Total	<u>190</u>	<u>10</u>	<u>174</u>	<u>16</u>

I recommend the Company maintain adequate claim file documentation in accordance with OAR 836-080-0215.

Claims Standard #6 - Claims are not denied without first conducting a reasonable investigation. Reference: ORS 746.230(1)(c) and (d).

Findings

Failed. 85% compliance to applicable files. Six files (15%) failed this standard.

The Company sent a denial letter to a claimant's carrier October 6, 1998. That same date the Company wrote to the claimant's attorney asking that the claimant be made available for a recorded statement and requesting an opportunity to inspect the claimant's vehicle. A follow up letter was mailed to the attorney October 29, 1998 which indicated the recorded statement was needed in order for the Company to complete its investigation.

The Company denied a PIP claim submitted and requested chart notes for review in the same letter to the provider that denied benefits. It appears the claim should have been pended rather than denied while the Company obtained the additional documentation necessary to make a claim determination.

The other four claims that failed this standard are PIP claims. In each of these cases, the Company denied the claim and requested information necessary to process the claim on the same EOB (explanation of benefits) that denied benefits. It appears the claims should have been pended rather than denied while the Company obtained the additional documentation necessary to make a claim determination. During this examination the Company changed the EOB text that prints out when additional documentation is required from a provider. The statement that now prints is “In compliance with ORS 742.528, reimbursement is suspended pending submission of the following.” (the missing information or documentation is identified in this space).

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims denied	50	10	34	6
Less N/A Files	<u>10</u>			
Total	<u>40</u>	<u>10</u>	<u>34</u>	<u>6</u>

The Company has corrected the situation with the PIP claims in that it now pends the claims when writing for additional documentation from a provider instead of denying at the same time this information is requested. A recommendation does not appear to be warranted. When the PIP claim failures are removed, the result is 97% compliance. As explained above, the examiner worked with a reduced population size due to difficulties encountered while attempting to develop a population of claims that were truly denied.

<u>Reason For Denial</u>	<u>#</u>	<u>% to Total</u>
Insured not negligent	28	56%
Not a true denial	10	20
Applied to deductible	1	2

Lack of insured's cooperation	2	4
No coverage for loss	1	2
Applied to deductible	1	2
Policy rescinded	1	2
Need medical information	5	10
Incomplete information received	<u>1</u>	<u>2</u>
Total	<u>50</u>	<u>100%</u>

Claims Standard #7 – The Company promptly and in good faith equitably settles claims in which liability has become reasonably clear. Reference: ORS 746.230(1)(f), (L), and (h).

Findings

Passed with comment. 98% compliance. Two paid claim files (2%) failed this standard.

The Company received a medical bill for an individual covered by PIP and did not process it. The Company cannot explain why this bill was never entered into its system.

A claimant informed the Company of the cost to repair her property damage November 30, 1998. Company computer file notes indicate a field inspection was assigned to one of its employees, but this was never done. The Company paid this claim during this examination.

Population Reviewed	<u># Units</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	98	2

A failure rate of 2% does not appear to indicate a pattern. Therefore, no recommendation is warranted.

Claims Standard #8 – The Company did not misrepresent the facts or policy provisions while settling a claim. Reference: ORS 746.230(1)(a).

Findings

Failed. 91% compliance to applicable files. Four paid claim files (9%) failed this standard.

These files did not contain supporting documentation to indicate the applicable coverages were explained to the insureds.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	53	43	4

I recommend the Company not misrepresent the facts or policy provisions while settling a claim in accordance with ORS 746.230(1)(a).

Subsequent to the examination, the Company indicated it will conduct ongoing communication and training on proper documentation of the explanation of coverage and benefits.

Claims Standard #9 – Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy. Reference: ORS 746.230(1)(g).

Findings

Passed. 2,478 bodily injury claims were opened during the examination period. Of these, 11 (0.44%) were litigated claims. From the information provided, it appears the Company is in compliance with this standard.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>
Claims paid	100	0	100
Claims denied	<u>50</u>	<u>10</u>	<u>40</u>
Subtotal	150		
Less N/A files	<u>10</u>		
Total	<u>140</u>	<u>10</u>	<u>140</u>

Claims Standard #11 – The Company did not delay investigation or payment of claims by requiring a claimant to submit a preliminary claims report and then requiring subsequent submission of loss forms when both require essentially the same information. Reference: ORS 746.230(1)(k).

Findings

Passed with comment. 99% compliance. One file (1%) failed this standard.

The Company received an emergency room bill December 22, 1997. The Company received the emergency room chart notes from the hospital December 31, 1997. The Company denied the claim January 21, 1998, because the PIP application had not been received from the patient. The bill was paid July 20, 1998, and the file notes indicate the emergency room records in the file confirm the charges were related to the motor vehicle accident. The examiner asked the Company to explain what information it intended to obtain from the completed PIP application that it didn't

already have on file as of December 31, 1997. The Company informed the examiner that it could not explain the adjuster's train of thought. It is currently the adjuster's discretion to pay any medical bills such as emergency room treatment without the PIP forms. From the file information, it appears the claim could have been paid after the medical records were received in December of 1997 and without the PIP application since this is the action taken by the Company in July of 1998.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100		99	1
Claims denied	<u>50</u>	<u>24</u>	<u>26</u>	<u>0</u>
Subtotal	150	24	125	1
Less N/A files	<u>24</u>			
Total	<u>126</u>	<u>24</u>	<u>125</u>	<u>1</u>

A failure rate of 1% does not represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #12 – The Company uses the reservation of rights and excess of loss letters in accordance with the Company's established procedures. Reference: ORS 746.240.

Findings

Passed. 100% compliance to applicable files. Because of the low number of applicable files found in the sample, the examiner reviewed the Company's established procedures for use of reservation of rights and excess of loss letters. These procedures do appear to be in compliance with this standard.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
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Claims paid	100	99	1	0
Claims denied	<u>50</u>	<u>48</u>	<u>2</u>	<u>0</u>
Subtotal	150	147	3	0
Less N/A files	<u>147</u>			
Total	<u><u>3</u></u>	<u><u>147</u></u>	<u><u>3</u></u>	<u><u>0</u></u>

Note: The N/A files are those which did not require either a reservation of rights or excess of loss letter according to the Company's established procedures.

Claims Standard #13 – Claim files are reserved in accordance with the Company's established procedures. Reference: ORS 746.240.

Findings

Passed with comment. 98% compliance. Two files failed this standard.

The Company closed the reserve for a property damage claim when it had receipts for this unpaid property damage in its claim file at that time. There was no dispute regarding liability or the unpaid charges.

The Company closed the PIP reserves on a claim before the medical bills it had on file at the time had been processed. The reserves were closed in May of 1998 and the claim was paid in July of 1998.

<u>Population Reviewed</u>	<u># Units</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	98	2

A failure rate of 2% does not represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #14 – Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. Reference: OAR 836-080-0235(1) and ORS 746.230(1)(m).

Findings

Failed. 92% compliance to applicable files. Three files (8%) failed this standard.

The Company received a subrogation demand from a claimant’s carrier January 26, 1998. The Company’s adjuster called the claimant’s carrier March 11, 1998, indicating the Company may deny the claim. The Company determined the claim should be denied, but no denial letter was ever sent to the claimant or to the claimant’s carrier.

The Company received subrogation demands from two different claimants’ carriers on one claim and never sent denial letters to either of these carriers. These demands were received after the Company had determined the insured was not responsible for this accident.

Another claim’s computer file notes indicate the Company would “deny clmt unless there is evidence to support clmt’s version.” No denial letter was ever sent to the claimant.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims denied	50	10	37	3

I recommend the Company handle denied and closed-without-payment claims in accordance with policy provisions and state law pursuant to OAR 836-080-0235(1) and ORS 746.230(1)(m).

Claims Standard #15 – Canceled benefit checks and drafts reflect appropriate claim handling practices. Reference: ORS 746.240.

Findings

Passed.

The examiner visited the mailroom of an MCO where ten claim payments were selected for review. The examiner compared the date of the check to the mail date. All of the checks contained the same date as the mail date.

Claims Standard #16 – Personal injury protection claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. Reference: ORS 742.520 through ORS 742.544.

Findings

Failed. 78% compliance to applicable files. Four files (22%) failed this standard.

One claim contained a medical bill that the Company received and did not enter it into its system for processing.

Another PIP claim contained a medical bill that was received in October of 1996 but not paid until October of 1998 when the situation was brought to the Company's attention.

One file did not contain documentation indicating a copy of the denial was sent to the medical provider.

Another file did not contain documentation indicating a copy of the denial was sent to the patient.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	82	13	5

Note: The N/A files are those reviewed which were not personal injury protection claims.

The provisions of ORS 742.528 require the Company to provide written notice of the denial to the insured stating the reason for the denial and informing the insured of the method for contesting the denial. A copy of the denial is to be sent to the provider as well. During the examination period, it appears the Company did not maintain documentation in its hard copy file or electronically to prove that copies of EOBs sent to providers containing denial language were actually mailed to the insured.

Effective March 15, 1999, the Company implemented enhancements to its computer system so that the EOB forms include the name and address of each person to whom a copy of the EOB was mailed. The Company now has the capacity to recreate from its computer system exact replicas of the EOBs that were mailed. With the enhanced system, EOB copies are not required to be kept in the file because the Company can retrieve all EOBs as originally generated.

I recommend the Company properly handle personal injury protection claims in accordance with the provisions of ORS 742.520 through ORS 742.544.

Claims Standard #17 – Total loss settlements are handled in accordance with policy provisions and applicable statutes, rules and regulations. Reference: OAR 836-080-0240(1).

Findings

Failed. 90% compliance. Five files (10%) failed this standard.

One claim failed because the Company was unable to locate the file documentation for the examiner's review

The examiner was unable to verify that the actual cash value of another total loss vehicle was correct because the file documentation did not include a copy of the pre-damage appraisal describing the loss vehicle.

An insured was paid twice for new tires on his total loss due to an error made by the adjuster. This resulted in an overpayment of \$50.00.

One claimant received \$50.00 additional compensation during the examination period because the total loss vehicle's equipment was not correctly considered at the time the ACV was established.

The other claim failed this standard because the amount initially offered to settle the claim did not represent the loss vehicle as equipped.

<u>Population Reviewed</u>	<u># Units</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Total loss claims	50	45	5

<u>Disposition</u>	<u>Number</u>	<u>% to Total</u>
First offer accepted	34	68%
Negotiated ACV with claimant	15	30
Appraisal process used	0	0
Unknown	<u>1</u>	<u>2</u>
Total	<u>50</u>	<u>100%</u>

The Company does not require photographs of total loss vehicles and does use an outside vendor for assistance in establishing the actual cash value (ACV) of a loss vehicle.

I recommend the Company process total loss settlements in accordance with policy provisions and applicable rules and regulations pursuant to OAR 836-080-0240(1).

Subsequent to the examination, the Company indicated it is providing ongoing training to adjusters to ensure compliance with internal processes .

Claims Standard #19 – Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner. Reference: OAR 836-080-0240(4).

Findings

Failed. 80% compliance to applicable files. One file (20%) failed this standard.

The Company collected reimbursement from an uninsured motorist on one case and failed to return the \$200.00 deductible to the insured. The Company indicated this

was due to an oversight. This amount was paid to the insured during this examination.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Subrogated claims	50	45	4	1
Less N/A files	<u>45</u>			
Total	<u>5</u>	<u>45</u>	<u>4</u>	<u>1</u>

Note: The N/A files are those subrogated claim files reviewed which did not include recovery of the claimant's deductible.

I recommend the Company reimburse deductibles to insureds upon subrogation recovery in a timely and accurate manner in accordance with OAR 836-080-0240(4).

Subsequent to the examination, the Company indicated it is conducting training to address the concerns of the Insurance Division.

Additional Findings and Procedures

PIP Review

From the claims paid initial random sample, the examiner selected all claims that were identified as PIP cases. The examiner compared PIP claims billed amounts to the paid amounts. Eighteen claims were chosen for this PIP review. The examiner evaluated all paid medical bills for each claim, including all patients listed under the claim. The 18 claim files contained 165 separate medical bills. One hundred twenty-six of these were paid at 100% of the billed amount. The other 39 were paid at less than the billed amount for the following reasons:

<u>Reason</u>	<u>Number</u>
Amount billed exceeded the reasonable and customary amount	16
Duplicate charge	2
Coding errors or concerns	7
Not medically necessary	11
Applied to deductible	<u>3</u>
Total	<u>39</u>

Twenty-four percent of the bills reviewed were paid at less than the billed amount. Of these, 23 (14%) were for miscellaneous reasons listed above and 16 (10%) were above the reasonable and customary amount. The 10% billed above the reasonable and customary charge were submitted by seven providers from Bend, Oregon, Eugene, Oregon, Lake Oswego, Oregon and Boring, Oregon. The bills reviewed were received from 61 medical providers and one was for a prescription.

Comparative Negligence

The Company indicated that before any insured's claim is assigned 100% negligence, the case is reviewed by a manager for verification that the determination is correct. Of the 100 paid claims evaluated, eight (8%) were assigned comparative negligence. The chart below shows the market claim office (MCO) involved and the percentage assigned for each case. The first number represents the amount of negligence on behalf of the Company's insured and the second is the other party's assigned percentage of responsibility for the accident.

<u>Percentage</u>	<u>MCO</u>
55-45	Clackamas
90-10	Clackamas

80-20	Eugene
60-40	Eugene
85-15	Eugene
90-10	Eugene
51-49	Eugene
90-10	Clackamas

Subsequent to the examination, the Company has informed the examiners that it has modified its processes from a required review of all 100% negligence calls to review of 100% negligence calls at the manager's discretion.

Customer Service Money

The Company has a customer service authorization procedure that provides for limited amounts to be paid for the resolution of customer grievances which may arise in situations where the handling of the claim was technically correct, but failed to meet the Company's standards of fairness and customer service. The Company's procedures indicate the MCM has a maximum authority of \$500 per case without prior approval from the territorial claim manager (TCM). This authority may be extended to qualified managers, claim representatives and agents within the service area at the discretion of the MCM.

These customer service dollars are not be used to pay customers whose dissatisfaction is without merit, or used to supplement an already reasonable and fair course of action or offer of settlement.

Each MCO is required to maintain a register of customer service payments made. The Company's procedures establish the format to be used and specify that the register pages should be retained for a minimum of three years.

The examiner requested copies of the registers for the Oregon MCOs for payments made during the examination period. The Company found that not all of the MCOs retained registers or lists of payments made, but did furnish separate copies of the customer service authorization procedure pages with details regarding payments made. The Company's examination coordinator informed the examiner that not all claims with customer service money may have been included on the registers or other documentation provided. None of the cases reviewed in the total loss random sample which included customer service money were listed on the registers or other documentation provided.

A brief review of the customer service authorization register documentation for the examination period revealed customer service dollars paid for the reasons shown below. Please note that these amounts reflect combined totals for Allstate Insurance Company and Allstate Indemnity Company.

<u>Reason</u>	<u># Claims</u>	<u>Amount Paid</u>
Delay	42	8,630.28
Call not returned	1	250.00
Agent's negligence	1	200.00
Customer service/rapport	8	1,933.50
Long time customer	10	2,373.50
Rental car issues	6	1,684.70
Poor service from PRO shop	4	550.00
Unhappy with total loss offer	2	620.00
Management error	1	200.00
Confusion regarding coverage	7	958.91

<u>Reason</u>	<u># Claims</u>	<u>Amount Paid</u>
Failed to subrogate	2	500.00
Other misunderstanding	1	140.00
Loss item not covered	2	400.00
Other repair considerations	3	392.31
To retain customer	1	40.00
Loss of use	<u>1</u>	<u>282.81</u>
Total	<u>92</u>	<u>19,156.01</u>

It appears the Company's documentation of every claim does not adequately describe the reason for the use of customer service money. Some of the reasons stated such as "to retain customer" or "long time customer" may not have qualified for additional payment under the customer service authorization procedures.

It also appears the MCM has complete authority over this program for the MCO. The Company does not generate management reports regarding this issue and it appears no other mechanism to oversee appropriate use of the customer service money is in place.

Six (12%) of the total loss claims paid included customer service money. The amounts paid and reasons are shown in the chart below:

<u>Unit #</u>	<u>MCO</u>	<u>Amount Paid</u>	<u>Reason Shown in Company's Documentation</u>
9	6280	250.00	250.00 cust ser for communication
11	6280	500.00	I closed claim using mgr disc money of 500.00
13	6280	395.00	Called Ms Insd with new ACV, reach agreed, settled, ACV 2505.00 + 395.00 mgr disc We have had a lot of problems with this claim. ...The total came to 2090. I called insured and went over this he wanted 2100 to settle the claim so I added 100 M/D and we reached an agreed...
15	6280	110.00	I added 100 to completely satisfy our insured
18	6280	100.00	Although we had already given max \$500 customer service, due to circumstances of this loss agreed to have an additional check for \$250 sent directly to her – Examiner's note: the Company actually paid \$500 "customer service", \$130.00 "manager's discretion", plus the \$250.00 referenced above for a total of \$880.00.
34	4280	<u>880.00</u>	

Total 2,235.00

One of the claimants received additional money due to communication problems and another appears to have received additional funds due to multiple problems with this claim. However, the other four appear to have been paid customer service money because the Company and the claimant could not agree on the ACV of the loss vehicle. This action is contrary to the Company's instructions regarding use of these funds. The customer service dollars are not be used to supplement an already reasonable and fair course of action or offer of settlement.

The one payment that exceeded the \$500.00 limit does not appear to have been authorized by the TCM in accordance with the Company's established procedures.

Other Claim Issues

ORS 746.230(1)(e) requires the Company to affirm or deny coverage of claims within a reasonable time after completed proof of loss statements have been submitted. The Company received a property damage claim February 13, 1998, that included receipts for some of the replaced items and also mentioned invoices for signs to be replaced would be forthcoming. The Company did not pay the claim until November 20, 1998, after the receipts for the signs were received. The Company acknowledged that the undisputed amount should have been paid when the documentation was received in February of 1998.

The Company settled a claim with a minor's father in 1997. In 1998, the father called the Company to ask whether the prior settlement was valid because there was no court approval. The Company employee mistakenly believed the caller and reopened

the claim. Six months later the case was assigned to a different adjuster who discovered the prior settlement was valid.

The Company sent a letter to an insured informing him that the claim had been settled and the file was closed when in fact the claim had not yet been paid.

The Company received a telephone call from a claimant's carrier in October of 1998 indicating that insurer would cover the loss. The Company did not request reimbursement from that carrier until the examiner submitted an inquiry on this case. Due to the delay, the Company reimbursed the deductible to the insured during this examination.

The Company did not collect an insured's PIP deductible through subrogation according to established procedures. The Company was not aware that the deductible was paid directly to the insured as part of a settlement with the claimant's carrier until an inquiry was made by the examiner. It appears this claim was not handled in accordance with the Company's procedures.

In reviewing the subrogated claims, the examiner discovered a \$30.00 unpaid medical bill from July of 1998 which the Company processed during the examination.

An uninsured motorist retained legal counsel and filed a lawsuit against an insured in May of 1999. The Company received a courtesy copy of the summons and complaint. The Company never took any action regarding the lawsuit. September 7, 1999, the plaintiff's attorney filed a motion for default judgment. Because the suit was not answered within the prescribed time, the default judgment was granted. During the examination the Company sent a written explanation of the situation to

the insured. The Company will pay the judgment and any costs associated with it and did return the deductible to the insured.

COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

This was the first market conduct examination for this Company. Therefore, there were no prior recommendations.

CONCLUSIONS

	<u>Recommendation</u>	<u>Page</u>
1	I recommend the Company charge rates for policy coverage in accordance with the Company's filed rates and the Company's rating plan pursuant to ORS 737.205.	17
2	I recommend the Company obtain written rejection for higher limits of uninsured and underinsured motorist coverage in accordance with the provisions of ORS 742.502(2)(a) and OAR 836-054-0000.	17
3	I recommend the Company adhere to applicable statutes, rules and regulations and Company guidelines in the selection of risks in accordance with ORS 746.015, ORS 746.018, and OAR 836-081-0030.	18
4	I recommend the Company's documentation adequately support all decisions made by the underwriters and underwriting decisions made by agents in accordance with ORS 733.170.	20
5	I recommend the Company rescind coverage only for material misrepresentation contained in a written application that is attached to and made a part of the policy at issue in accordance with the provisions of ORS 742.013, 742.016 and 746.240.	24
6	I recommend the Company keep its records in such a manner that the Director of the Department of Consumer and Business Services may readily verify proper treatment has been given to policyholders and that the Company has complied with the Insurance Code in accordance with ORS 733.170.	28
7	I recommend the Company send delay letters in accordance with the provisions of OAR 836-080-0235(4) for all claims which are not resolved in 30 days.	35

8 I recommend the Company resolve within 30 days first party claims for which more time to determine whether the claim should be accepted or denied is not required in accordance with the provisions of OAR 836-080-0235(1). 35

9 I recommend the Company respond to claim correspondence within 30 days in accordance with the provisions of OAR 836-080-0225. 38

Recommendation

Page

10 I recommend the Company maintain adequate claim file documentation in accordance with OAR 836-080-0215. 39

11 I recommend the Company not misrepresent the facts or policy provisions while settling a claim in accordance with ORS 746.230(1)(a). 42

12 I recommend the Company handle denied and closed-without-payment claims in accordance with policy provisions and state law pursuant to OAR 836-080-0235(1) and ORS 746.230(1)(m). 46

13 I recommend the Company properly handle personal injury protection claims in accordance with the provisions of ORS 742.520 through ORS 742.544. 48

14 I recommend the Company process total loss settlements in accordance with policy provisions and applicable rules and regulations pursuant to OAR 836-080-0240(1). 49

15 I recommend the Company reimburse deductibles to insureds upon subrogation recovery in a timely and accurate manner in accordance with OAR 836-080-0240(4). 50

MANAGEMENT AFFIRMATION

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

A special thanks is extended to the examination coordinators for their courtesy, assistance, and promptness in providing, correlating, or coordinating all requested documents and statistics necessary to ensure a smooth transition during the overall examination process. The responsibilities that were undertaken during this examination were in addition to the scope of their regular assigned duties.

In addition to the undersigned, market conduct examiner Thomas G. Moeller, AIE, RHU, CLU, participated in this examination.

Respectfully submitted,

Jann Goodpaster, CIE, CPCU
Chief Market Conduct Examiner
Market Conduct Section
Department of Consumer and Business Services
Insurance Division
State of Oregon

Gayle L. Woods, AIE
Market Conduct Examiner
Market Conduct Section
Department of Consumer and Business Services
Insurance Division
State of Oregon

AFFIDAVIT

STATE OF OREGON }
 } ss
County of Marion }

Jann Goodpaster and Gayle L. Woods, being duly sworn, depose and say that the foregoing market conduct report of examination as of December 31, 1998, of Allstate Indemnity Company, Northbrook, Illinois, subscribed by them is true to the best of their knowledge and belief.

Jann Goodpaster, CIE, CPCU
Chief Market Conduct Examiner
Market Conduct Section
Department of Consumer and Business Services
Insurance Division
State of Oregon

Gayle L. Woods, AIE
Market Conduct Examiner
Market Conduct Section
Department of Consumer and Business Services
Insurance Division
State of Oregon

Subscribed and sworn to before me on the _____ day of _____, 2001.

Notary Public for the State of Oregon
My commission expires: March 22, 2005

APPENDIX A
STANDARDS
ALLSTATE INDEMNITY COMPANY
MARKET CONDUCT EXAMINATION

Complaints

1	All complaints are recorded on the Company complaint register.	ORS 732.302(1)
2	The Company has adequate complaint handling procedures in place and communicates such procedures to policyholders.	ORS 732.302(1)
3	The Company furnished a response within 21 days of an inquiry from the Insurance Commissioner.	ORS 731.296, OAR 836-080-0225(2)
4	The Company responds to Insurance Commissioner complaints adequately and conclusively.	OAR 836-080-0225(2)
5	The Company furnished a response within 30 days of an inquiry from an insured.	OAR 836-080-0225(3)
6	The Company response to an inquiry from an insured is adequate and answers the questions being raised.	OAR 836-080-0225(3)

Underwriting and Rating

1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan.	ORS 737.205
2	Disclosures to insureds concerning rates and coverage are accurate and timely.	ORS 737.205 and ORS 742.566
3	An insured or applicant may not be assigned to a higher risk category than the person would normally be assigned because the person allowed a motor vehicle liability policy to lapse or had driving privileges suspended due to a nondriving offense.	ORS 742.449
4	Written rejection for higher limits of uninsured and underinsured motorist coverage limits must be obtained.	ORS 742.502(2)(a) and OAR 836-054-0000
5	Name exclusions are signed by all named insureds and comply with all rules and regulations.	ORS 742.450(5)
6	Individual Risk Package Modifiers (IRPM) are used in accordance with the instructions from the Oregon Insurance Division.	Bulletin 82-4
7	The company underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risk.	ORS 746.015, ORS 746.018, and OAR 836-081-0030
8	Employment driving record may not be used to determine if the file is issued renewed or in calculation of rates.	ORS 746.260 and ORS 746.265(1)

9	For the purpose of determining whether or not to issue or renew a policy and the calculation of rates an insurer may not use a driving record older than three years immediately preceding the issuance or renewal.	ORS 746.265(2)
10	All forms and endorsements forming a part of the contract are listed on the declarations page and should be filed with the department of insurance.	ORS 742.003
11	Underwriting, rating and classifications are based on adequate information developed at or near the inception of the coverage rather than near expiration, or following a claim.	ORS 746.240
12	File documentation adequately supports decisions made.	ORS 733.170
13	The company does not engage in collusive or anticompetitive underwriting practices.	ORS 746.240
14	Rejections and declinations are not unfairly discriminatory.	ORS 746.015, ORS 746.018 and OAR 836-081-0030
15	Cancellation/nonrenewal notices comply with policy provisions and state laws and company guidelines. Cancellation must be made within the first 60 days of the policy except for the exemption. Nonrenewal and changes in policy must be sent at least 30 days in advance of the renewal date.	ORS 742.566 through ORS 742.572 and ORS 746.650
16	Cancellation/nonrenewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.	ORS 742.224
17	The insurer reports the name, address, and VIN number of each vehicle covered by a motor vehicle liability policy whether the policy was bought, canceled, or not renewed within 30 days of cancellation or nonrenewal and within 15 days of issuance to the Department of Transportation.	ORS 742.580
18	Rescissions are not made for nonmaterial misrepresentations in accordance with the Company's established procedures.	ORS 746.240

Claims

1	The initial contact by the Company with the claimant is within 30 days.	OAR 836-080-0225
2	Investigations are conducted within 45 days.	OAR 836-080-0230
3	Claims are resolved in 30 days unless a delay letter (45 days) has been sent.	OAR 836-080-0235(1) and (4)
4	The Company responds to claim correspondence in 30 days.	OAR 836-080-0225 All Subparts
5	Claim files are adequately documented.	OAR 836-080-0215, ORS 733.170
6	Claims are not denied without first conducting a reasonable investigation.	ORS 746.230(1)(c) and (d)
7	The Company promptly and in good faith equitably settles claims in which liability has become reasonably clear.	ORS 746.230(1)(f), (L) and (h)

8	The Company did not misrepresent the facts or policy provisions while settling a claim.	ORS 746.230(1)(a)
9	Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.	ORS 746.230(1)(g)
10	The Company did not attempt to settle a claim on the basis of an altered application without notice to or consent of the applicant.	ORS 746.230(1)(i)
11	The Company did not delay investigation or payment of claims by requiring a claimant to submit a preliminary claims report and then requiring subsequent submission of loss forms when both require essentially the same information.	ORS 746.230(1)(k)
12	The Company uses the reservation of rights and excess of loss letters in accordance with the Company's established procedures.	ORS 746.240
13	Claim files are reserved in accordance with the Company's established procedures.	ORS 746.240
14	Denied and closed-without-payment claims are handled in accordance with policy provisions and state law.	OAR 836-080-0235(1), ORS 746.230(1)(m) and OAR 836-080-0235(1)
15	Canceled benefit checks and drafts reflect appropriate claim handling practices.	ORS 746.240
16	Personal Injury Protection claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	ORS 742.520 through ORS 742.544
17	Total loss settlements are handled in accordance with policy provisions and applicable statutes, rules and regulations.	OAR 836-080-0240(1)
18	Automobile claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	OAR 836-080-0240(2), (3), (5), (6) (7) and (8) and ORS 746.230(1)(i)
19	Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.	OAR 836-080-0240(4)