

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF MARKET CONDUCT EXAMINATION

OF

**COUNTRY CASUALTY INSURANCE COMPANY
BLOOMINGTON, ILLINOIS**

NAIC COMPANY CODE 20982

AS OF

JUNE 30, 1998

TABLE OF CONTENTS

SCOPE OF EXAMINATION	4
COMPANY DESCRIPTION	4
MANAGEMENT AND CONTROL	5
COMPLAINT HANDLING	6
<i>Findings</i>	8
UNDERWRITING	11
<i>Findings</i>	13
<i>Additional Findings and Procedures</i>	17
<i>Credit Reports</i>	17
CLAIMS HANDLING PRACTICES	17
<i>Findings</i>	19
COMPLIANCE WITH PRIOR RECOMMENDATIONS	27
CONCLUSIONS	27
MANAGEMENT AFFIRMATION	29
ACKNOWLEDGMENT	30
AFFIDAVIT	31
APPENDIX A	32
<i>Complaint Handling</i>	32
<i>Underwriting</i>	32
<i>Claims</i>	33

April 30, 1999

Honorable Michael Greenfield, Director
Department of Consumer and Business Services
State of Oregon
350 Winter Street NE, Room 440-4
Salem, Oregon 97310

Dear Director:

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

Country Casualty Insurance Company
1701 Towanda Avenue
Bloomington, Illinois 61710
NAIC Company Code 20982

hereinafter referred to as the "Company." The examination was conducted at the Northwest Regional Office located at 2150 Country Drive South, Salem, Oregon. The following report of examination is respectfully submitted.

SCOPE OF EXAMINATION

The market conduct examination of the Company was conducted as of June 30, 1998, covering the period of July 1, 1997 to June 30, 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 market conduct emphasis examination using a standard emphasis was performed. The examination of the Company was conducted pursuant to ORS 731.300 and in accordance with procedures and guidelines that are established by the Oregon Insurance Division 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 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	Underwriting
Claims Handling	

COMPANY DESCRIPTION

The origin of Country Companies dates back to the formation of The Country Mutual Fire Company in 1925 (originally incorporated under the title Farmers Mutual Reinsurance Company). Country Mutual Casualty Company (founded in 1926) and the Country Mutual Fire Company were merged in 1957 to form the Country Mutual Insurance Company. Both companies were organized under the sponsorship of the Illinois Agricultural Association. The Country Casualty Insurance Company was incorporated in 1964. It is a stock company. The Country Preferred Insurance Company (formerly Mid-America Preferred Insurance Company) was chartered in 1953 and joined this group in 1964. The Northwest Farm Bureau Insurance Company was acquired in 1986, and was voluntarily dissolved effective September 30, 1993. Country Preferred and Country Casualty are wholly owned subsidiaries of Country Mutual.

Company operations are geared toward personal lines and small “main street” commercial insurance products including agricultural coverages. Its marketing emphasis is on “standard” risk automobile, homeowners, and farmowners rate plans. A large majority of its total direct premium revenue comes from the state of Illinois. Oregon contributed 21.2% of the Company’s total premiums written in 1997.

Affiliates within the Country Companies Group of insurance companies expand the potential market for auto insurance to preferred and ultra-preferred risk buyers, and offer a variety of life and health insurance products. The group includes the following insurers:

- Country Mutual Insurance Company
- Country Preferred Insurance Company
- Country Life Insurance Company
- Country Investors Life Assurance Company

MANAGEMENT AND CONTROL

Directors serving as of June 30, 1998, were as follows:

<u>Name</u>	<u>Address</u>
David Gardner	Solon Mills, Illinois
Robert Phelps	Rockton, Illinois
Roger Kiddo	Joy, Illinois
Ralph Freebairn	Ottowa, Illinois
James Schillinger	Plainfield, Illinois
Stanley Blunier	Forrest, Illinois
Richard Bachman	Secor, Illinois
Wendell Shauman	Kirkwood, Illinois
Randy Sims	Liberty, Illinois
Paul Shuman	Sullivan, Illinois
David Downs	Sidell, Illinois
Donald E. Stephen	Martinsville, Illinois
William E. Klein	Flora, Illinois
P.G. Fiedler	Batchtown, Illinois
Glenn Meyer	Steeleville, Illinois
Bill Williams	Enfield, Illinois
Robert Thurston	Pulaski, Illinois
Rollie Moore	Oneida, Illinois
Ronald Warfield	Gibson City, Illinois
Andy Goleman	Divemon, Illinois

The Company's officers as of June 30, 1998, were as follows:

<u>Name</u>	<u>Title</u>
Ron Warfield	President
Rollie Moore	Vice President
Duane L. Miller	Chief Executive Officer
Barbara A. Bauer	Vice President and General Manager
Charles L. Jones	Sr. Vice President and CFO
John D. Blackburn	Sr. Vice President – Marketing
Shelly Prehoda	Vice President-Information Service
Deanna L. Frautschi	Vice President-Communication & HR
James R. Wenckus	Regional Vice President
Richard Beninati	Regional Vice President-Agency
J. Eric Smith	Regional Vice President-Agency
R. W. Weldon	Vice President-Finance & Treasurer
William J. Hanfland	Assistant Treasurer
Kenneth G. McMillan	Secretary
Elaine Thacker	Assistant Secretary
Steve Yoder	Assistant Secretary
Linda Hutchins	Assistant Secretary
Peter J Borowski	Corporate Controller
Matthew J Kopff	Associate Controller
Paul M. Harmon	General Counsel
Richard Bill	Actuary

COMPLAINT HANDLING

The Company's definition of a complaint is "any time a customer expresses their negative experience to our organization."

The Company identified three categories of complaints - telephone complaints from an insured, written complaints from an insured, and inquiries from the Insurance Division.

Telephone complaints received in the regional and home offices are recorded on a phone logging system and are coded with a "call type" indicating that the call involved a complaint. Complaint calls are prioritized with a goal of 24-hour turn around for resolution. If complete resolution cannot be accomplished within that time period, the client is to be contacted and advised of the status. The Company has a "Complaint Remedy Guidelines Manual" that includes suggested remedies for handling various types of complaints.

Written complaints received in the regional office are routed to a correspondence clerk for evaluation. The correspondence clerk reviews the complaint and then responds to the insured either in writing or by telephone. The Company's complaint procedures indicate a response is to be made within two to five business days depending on the amount of research involved.

Insurance Division inquiries are routed to the regional vice president's secretary, who logs the complaint, completes a summary form, sends the complaint and summary form to the appropriate division for response, reviews the response, and sends it to the Division.

Summaries of the reasons for the Insurance Division complaints and their dispositions are shown below:

<u>Reason</u>	<u>Number</u>	<u>% To Total</u>
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1 - Cancellation	1	50%
1 - Premiums and billing	<u>1</u>	<u>50</u>
Total	<u>2</u>	<u>100%</u>

Key: 1 = Underwriting; 2 = Advertising; 3 = Claims; 4 = Policyholder Service

Their disposition is as follows:

<u>Disposition</u>	<u>Number</u>	<u>% To Total</u>
Satisfactory explanation given	<u>2</u>	<u>100%</u>
Total	<u>2</u>	<u>100%</u>

Summaries of the reasons for the internal complaints and their dispositions are shown below:

<u>Reason</u>	<u>Number</u>	<u>% To Total</u>
4 - Error or incorrect information	1	33%
4 - Problem with billing	<u>2</u>	<u>67</u>
Total	<u>3</u>	<u>100%</u>

Key: 1 = Underwriting; 2 = Advertising; 3 = Claims; 4 = Policyholder Service

<u>Disposition</u>	<u>Number</u>	<u>% To Total</u>
Corrective action taken	2	67%
Not documented	<u>1</u>	<u>33</u>
Total	<u>3</u>	<u>100%</u>

Findings

Standards number one and two were reviewed on a global basis. Standards three and four were reviewed by testing the entire population of Insurance Division complaints (two files). The Company’s logs for complaints not involving the Insurance Division were used to develop the population of noninsurance division complaints. The total population of three such complaints for this examination period was reviewed.

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

The following standard passed without comment:

2	The Company has adequate complaint handling procedures in place and communicates such procedures to policyholders.	ORS 731.302(1)& ORS 746.240
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3	The Company furnished a response within 21 days of an inquiry from the Insurance Commissioner.	ORS 731.296 and OAR 836-080-0225(2)
4	The Company responds to Insurance Commissioner complaints adequately and conclusively.	OAR 836-080-0225(2)

The following exceptions were noted:

Complaint Handling Standard #1 – All complaints are recorded on the Company complaint register. Reference: ORS 731.302(1)

Findings

Failed. The two Insurance Division inquiries received during the examination period that involved a Country Casualty policy were listed in the Company’s complaint logs, but were identified as Country Mutual complaints. The Company lists complaints for Country Casualty and Country Mutual in the same log. Both of these complaints involved a Country Mutual policy as well as a Country Casualty policy. In their response to the Insurance Division, the Company indicated policies from both companies were involved. The Company did not want to list these complaints twice, so they chose to list them under the Country Mutual policy. Because of the way these complaints were logged, the initial review of the Company’s complaint log indicated that no Insurance Division inquiries had been received for Country Casualty during the examination period.

I recommend if a complaint involves both Country Casualty and Country Mutual, both companies be indicated in the complaint log in compliance with ORS 731.430.

The Company indicated it will comply.

The Company was able to produce a list of noninsurance division complaints made by telephone from their telephone logging system. However, written noninsurance division

complaints were generally not logged into this system. If the complaint involved a threat to contact the Insurance Division, the complaints were logged by the same person who logs complaints received from the Insurance Division; but no other tracking system for written complaints was in place during the examination period. The Company has now started logging those written complaints that are handled through customer service.

I recommend the Company implement a system for tracking all written complaints made to the Company in compliance with ORS 731.302(1) and ORS 746.240.

The Company is developing a tracking system.

Complaint Handling Standard #5 – The Company furnished a response within 30 days of an inquiry from an insured. Reference: OAR 836-080-225(3).

Findings

Failed – 33% compliance. Two files (67%) failed this standard. Both files involved situations in which the complainant had received correspondence from a collection agency. Both complaints were marked as resolved, but there was no documentation of a response regarding resolution in either file. In addition, in one case, the complaint was not resolved for 140 days.

I recommend the Company furnish a response within 30 days of an inquiry from an insured in accordance with OAR 836-080-225(3) and document that response in accordance with ORS 733.170.

The files that failed were relating to collections. The Company is in the process of

developing procedures to retain documentation in the policy file when a inquiry concerns collections.

<u>Number of Days to Response</u>	<u>Number</u>	<u>% To Total</u>
1 - 30	1	33%
31 - 45	0	0
Over 45	0	0
Undocumented	<u>2</u>	<u>67</u>
Total	<u>3</u>	<u>100%</u>

Complaint Handling Standard #6 – The Company response to an inquiry from an insured is adequate and answers the questions being raised. Reference: OAR 836-080-225(3).

Findings

Fail – 33% compliance. Two files (67%) failed this standard. Both files involved situations in which the complainant had received correspondence from a collection agency. Both situations were indicated to be resolved, but actual response to the complainant regarding resolution was not documented in either file.

I recommend the Company furnish a response to an inquiry that is adequate and answers the questions being raised in accordance with OAR 836-080-225(3) and document that in accordance with ORS 733.170.

The files that failed were relating to collections. The Company is developing a system to coordinate the collection complaints with all complaints.

UNDERWRITING

The Company markets personal lines property and casualty insurance policies for automobiles. Affiliated companies also offer homeowners, mobilehomes, farms, life and health insurance.

This examination was limited to a review of the Company's automobile underwriting procedures and practices. The Company's auto program is designed to insure private passenger vehicles, pickup and utility type vehicles, recreational and miscellaneous vehicle exposures, including such vehicles and trucks used in farm or ranch activities. The program is intended as a "standard" automobile plan. Prospective insured persons and vehicles are subject to selective qualification standards established to identify standard risks.

Agents are contracted to exclusively market the products of the affiliated Country Companies. Initially they are recruited as employees, and receive training through CC Services, Inc., a wholly-owned subsidiary. Experienced agents are self-employed, private contractors.

Agents contact prospective applicants to verify their interest in receiving an auto insurance quotes. A credit bureau report (CBR) is obtained to determine whether or not the prospect is a desirable risk. Motor vehicle reports (MVR) and comprehensive loss underwriting exchange (CLUE) reports are requested to assure that an accurate quote can be given. Qualified prospects receive proposals based on their current coverages and recommended alternatives. If they find the quotes acceptable, an appointment is arranged to complete the application and bind coverage.

The Company uses an "expert system." The expert system matches applicants against a series of computer system edits. If all edits are met, the policy is automatically issued without the intervention or review of an underwriter. If all the edits are not met, the application is sent to the regional office for review by underwriting personnel.

A summary of the expert systems capabilities follows:

- Select and apply all applicable underwriting rules, criteria, and processing requirements relevant to the plan, state, agent, transaction, and effective date

- Define and consider differences related to state, company/plan, and effective dates
- Determine whether and when to order MVR and CLUE reports
- Calculate vehicle and driver ages
- Determine proper vehicle rate classes
- Match drivers and assigned vehicles
- Use Choice Point Standard Violation Codes and Equifax Standard Violation Codes to determine points for particular violations or accidents as applicable to each driver
- Calculate rates as necessary
- Respond to input, notifying agents of eligibility and rating concerns, and when application attachments are needed
- Determine when review is required and which departments need to be involved

Agents key information into the Company's electronic application system and forward signed applications, premium payments, and required attachments to the regional office. After application materials have been received, the underwriter determines acceptability from review of the electronic submission. Original paper applications are retained on microfiche as signature documents. Policies are system-generated, and mailed to the insured complete with declaration pages, endorsements, and billing notices for any premium still due. Unacceptable applicants are sent a letter of explanation noting the date coverage will end.

Unless a policy is cancelled during its term, or marked for nonrenewal, the renewal process begins automatically 35 days before the end of the present policy term. A new declaration page is sent to the insured with identification cards and a renewal billing that reflects any changes in premium. No underwriting review is required at renewal. A policy renews when required premiums are received. If not paid by the 5th day after it is due, a lapse notice is produced and mailed to the insured and all lienholders. If received within 17 days after the premium due date, the policy is normally reinstated with no lapse in coverage. If received between the 17th and 60th days after due, the policy is reinstated with a lapse in coverage.

Findings

The underwriting phase of this examination consisted of reviewing sample files selected from the following four categories:

<u>Population</u>	<u>Total Population</u>	<u>Sample Size</u>	<u>% To Total</u>
Auto new business issued	484	50	10.3%
Auto policies cancelled	33	33	100%
Auto policies nonrenewed	17	17	100%
Uninsured/underinsured motorist coverage mismatching bodily injury liability limits	2	2	100%

The Company's Oregon Personal Lines Manual was used as the primary source of information relating to products, risk selection, rating, and underwriting procedures. Regulatory compliance was measured using the standards presented below, which are based on Oregon Revised Statutes and Oregon Administrative Rules. The standards can be found in the appendix following the examination report. Since the fourth sample shown above was specifically selected to determine compliance with uninsured and underinsured motorist coverage requirements, standard #4 was applied exclusively to that sample.

Standard #18 was waived during this examination, as the Company did not have any policies to which this standard applied. Standards #6 and #16 do not apply personal lines auto and were waived.

The following standards were passed without comment:

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, 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 privilege suspended due to a non driving offense.	ORS 742.449

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.	ORS 746.015, ORS 746.018, OAR 836-081-0030
9	For the purpose of determining whether to issue or renew a policy and the calculation of rates an insurer may not use a driving record older than three year 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 (if applicable).	ORS 742.003
11	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(2)
12	File documentation adequately supports decisions made.	ORS 733.170
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. Cancellations must be made within the first 60 days of 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
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 non renewal and within 15 days of issuance to the Department of Transportation.	ORS 742.580

The following exceptions were noted:

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

Findings

Failed. 0% compliance. Both units included in this population failed this standard because the required consent/request form was not fully completed.

I recommend the Company assure that all policies are issued with

uninsured/underinsured motorist limits matching the bodily injury liability limits unless a completed and signed rejection form is presented with the application, as required by ORS 742.500 through 742.506 and OAR 836-054-0000.

The Company is addressing this issue by corresponding with agents and reviewing internal procedures and training.

Underwriting and Rating Standard #5 – Named exclusions are signed by all named insureds and comply with all rules and regulations. Reference: ORS 742.450(6).

Findings

Passed with comment. The Company's rating plan allows coverage with a named driver exclusion for households in which there is a resident who does not qualify for coverage. A "Driver's Restriction Endorsement" policy form has received Insurance Division approval for use in such situations; however, no examples of its use were found among the sample units reviewed.

Underwriting and Rating Standard #8 – Employment driving records may not be used to determine if the file is issued, renewed or in the calculation of rates. Reference: ORS 746.260 and ORS 746.265(1).

Findings

Passed with comment. File information provided for sample review did not routinely include copies of driving records. Therefore, the Company was asked to provide evidence that employment driving records were not used in risk selection or calculation of rates. In response, the Company supplied information relating to its source of motor

vehicle reports, their cost, and an example of a monthly billing statement for this service, confirming that only nonemployment records are requested.

Underwriting and Rating Standard #13 – The Company does not engage in collusive or anti-competitive underwriting practices. Reference: ORS 731.302(2).

Findings

Passed with comment. The examiner was unable to find evidence of such underwriting practice either in information provided for each sample unit, or in any other documents or materials requested for review.

Additional Findings and Procedures

Credit Reports

The Company was asked to explain its use of credit reports in auto underwriting. The Company indicated agents use personal public records provided by a commercial vendor to screen prospective applicants. In addition to MVRs, and CLUE reports, CBRs are commonly requested for all applicants who do not currently have a policy in force with one of the affiliated companies. Applicants receive a standard Notice of Information Practices form. Agents do not receive the actual report, but a message called a “loss score,” which advises whether the report is excellent, good, average, poor, inconclusive, or not available. Loss scores can affect the eligibility of a prospect, and their proper use is described in a section of the underwriting manual. In general, prospects whose loss score is not excellent or good are subject to underwriting evaluation. The examiner found no evidence that the Company declined to issue or refused to renew any policy based solely upon an unfavorable credit bureau report.

CLAIMS HANDLING PRACTICES

All claims are centrally reported to the claims division. Each reported claim is assigned

a unique claim number. All claimed losses and damage that result from the same accident and are covered by the same policy are handled under the same claim number.

The claim is referred to the claims office for the location where the policyholder applied for insurance. The claims supervisor for that claims office then assigns the claim to an adjuster based upon the type and severity of the claim.

The assigned adjuster contacts the insured and/or claimants to obtain facts concerning the nature of the loss or damage and to verify whether the policy applies to such loss or damage. The adjuster conducts or directs additional investigation as needed to evaluate coverage, liability, and value.

The adjuster maintains the claim file to document the evidence supporting the Company's claims evaluations.

Pending claims are reviewed periodically by the claims supervisor.

If payment is made, the adjustment or settlement of the claim is handled by the adjuster to the extent of the adjuster's established authority limit. Claims exceeding the adjuster's dollar authority are reviewed by the level of senior claims staff required for approval of the recommended payments.

If denied, the denial is confirmed in writing with a brief explanation of the reason(s) for the Company's decision. All letters denying coverage are reviewed by a supervisor or claims attorney.

The personal injury protection (PIP) portion of a claim is handled in the Company's regional office in Salem, Oregon, rather than in the local claims offices.

The claims division conducts internal claim file audits of closed claims on a continuing basis. The claims division maintains a customer service center to respond to complaints and inquiries. The claims division participates in a policy reconstruction process available to extend coverage on claims when it is determined that coverage was not in force due to a preceding Company error.

Findings

Separate samples of denied, paid and total loss claims were selected for review. Although only one claim number is assigned to all lines of coverage under one policy that are in relation to one incident, the claim population reports provided by the Company list each type of coverage as a separate entry; so the terms “claim” and “file” in the following refer to one line of coverage under a claim number.

The Company identified a total population of 72 closed-without-payment claims, but not all of these claims were actually denied. The entire population of closed-without-payment claims were reviewed to determine which ones actually involved a claim denial. Twenty-four of the closed-without-payment claims were determined to be true denials and were, therefore, reviewed for compliance with Claims Standards 1, 2, 3, 4, 5, 6, 7, 8, 9, 12, and 14.

From a total population of 152 paid claims identified by the Company, a random sample of 50 (32.9%) was selected for review. The sample was reviewed for compliance with Claims Standards 1, 2, 3, 4, 5, 7, 8, 9, 11, 12, 13, 16, 18 and 19.

The Company identified a total population of only ten total loss claims, so the entire population was reviewed. One of these claims was eliminated from the sample because it was determined to be a third party loss and the total loss requirements of Standard

#17 were not applicable. The remaining nine claims were reviewed for compliance with Claims Standards #5 and #17.

The reasons recorded for claim denials are summarized in the following chart:

<u>Reasons for Denial</u>	<u>Number</u>	<u>% To Total</u>
Damage less than deductible	1	4%
Disability continued for less than 14 days	1	4
Insured determined not to be liable	10	42
Other carrier handled claim	2	8
Policy did not include collision coverage	1	4
Policy terminated prior to accident	5	21
Vehicle involved not covered under policy	<u>4</u>	<u>17</u>
Total	<u>24</u>	<u>100%</u>

Each item was tested for compliance with those of the following standards that applied based on Oregon Revised Statutes and Oregon Administrative Rules. All standards can be found in the appendix following the report.

The following standards were passed without comment:

1	The initial contact by the Company is within 30 days.	OAR 836-080-225(1)
6	Claims are not denied without first conducting a reasonable investigation.	ORS 746.230(1)(c) and (d)
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 731.302(1)
13	Claim files are reserved in accordance with the Company's established procedures.	ORS 746.240

19	Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.	OAR 836-080-0240(4)
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The following exceptions were noted:

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

Findings

Passed with comment – 97% compliance. This standard applied to all 74 of the files reviewed for this standard. Two files (3%), failed this standard. In one file, requested chart notes were not reviewed for over a month after they were received, at which time additional information was requested. In the other file a follow-up request was not sent for over four months after receiving part, but not all, of the requested information. These two files do not represent a pattern, and no recommendation is warranted.

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

Findings

Failed – 81% compliance. This standard only applies to first party claims. Therefore, only 47 of the 74 files were reviewed for this standard. Nine files (19%) failed this standard. Seven files involved PIP claims for medical expense, which included bills that were not paid or, in one case, denied within the 60 days allowed for payment or denial of PIP claims. On four of these files, no letters were sent explaining the delay. In another file, a delay notice was sent, but not until almost four months after the claim had been

received. On two files, delay notices were sent on some bills, but not others; and follow-up delay notices were not sent within 45 days of the initial notice on some bills. The other two files involved claims for collision coverage that were not paid within 30 days. On one of these claims, the Company was waiting for mechanical receipts from the insured that were never received; but no notice of the reason for the delay was sent. On the other collision claim, the Company was waiting for information and paperwork from the lienholder. The insured was notified of the initial reason for the delay, but no follow-up notices were sent after 45 days regarding the continued delay.

I recommend the Company resolve PIP claims within 60 days and resolve other claims within 30 days unless letters notifying the insured of the reason(s) for the delay are sent in accordance with OAR 836-080-0235(1) and (4).

The Company has indicated it now sends letters to all insured explaining the reason for delaying the claim.

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

Reference: OAR 836-080-0225(3).

Findings

Failed – 68% compliance. This standard applied to 31 of the 74 files reviewed for this standard. Ten files (32%) failed this standard. Correspondence in regard to two denied claims and eight paid claims did not receive a response within 30 days.

I recommend the Company respond to claim correspondence within 30 days

as required by OAR 836-080-0225(3).

The Company has indicated it is in agreement with the recommendation.

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

Findings

Fail – 94% compliance. This standard applied to 83 of the 84 files reviewed for this standard. Five files (6%) failed this standard due to inadequate documentation necessary to reconstruct the pertinent events of the claim.

I recommend the Company adequately document claim files in compliance with ORS 733.170 and OAR 836-080-0215.

The Company has indicated it is in agreement with the recommendation.

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 – 99% compliance. This standard applied to all 74 of the files reviewed for this standard. One file (1%) failed this standard. This file involved a PIP bill that wasn't paid for over two months after receiving the itemized bill even though no additional investigation was conducted nor other interim action taken. This one file does not represent a pattern, and 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

Passed with comment – 99% compliance. This standard applied to all 74 of the files reviewed for this standard. One file (1%) failed this standard. The Company told the insured that the “keeper” endorsement on the policy would probably pay “to repair” the car even if the repair costs exceeded the cash value. However, the Company did not explain that the endorsement would also pay the lesser of the cost of a new vehicle or the cost of repairs even if the claimant chose not to have it repaired. Insured decided not to have the car repaired and went through the other driver’s carrier to collect damages and the Company closed the claim without payment. Since the other carrier determined the car to be a total loss, they based payment on the vehicle's cash value rather than repair costs, which may have resulted in a lower payment than the insured would have been entitled to under her own policy’s “keeper” endorsement. This one file does not represent a pattern, and no recommendation is warranted.

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

Findings

Passed with comment – 96% compliance. This standard applied to all 24 of the files reviewed for this standard. One file (4%) failed this standard. This is the same file that failed Standard 8. The claim was closed-without-payment because the insured collected damages directly from the other driver’s carrier. The amount of the policy benefits provided under the terms of the “keeper” endorsement was not calculated for comparison to the amount payable by the other carrier. Since the “keeper” endorsement pays the lesser of repair costs or the cost of a new vehicle, this benefit may have been greater than the total loss cash value paid by the other carrier. This one file does not

represent a pattern, and no recommendation is warranted.

Claims Standard #15 – Canceled benefit checks and drafts reflect appropriate claim handling procedures. Reference ORS 731.302(1).

Findings

This standard was waived because benefit checks are not generated in any of the Company's Oregon offices. All checks issued by the Company are produced at the home office in Bloomington, Illinois.

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. 30% compliance. This standard applied to ten of the 50 files reviewed for this standard. Seven files (70%) failed this standard because they were paid or denied within 60 days.

I recommend the Company pay or deny personal injury protection claims within 60 days in compliance with ORS 742.525 and 742.528.

The Company has indicated it is in agreement with the recommendation.

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. 67% compliance. This standard applied to nine of the ten files reviewed. Three

files (33%) failed this standard. One file failed because title and transfer fees were not included in the benefit payment. The other two files failed because they did not include complete documentation in regard to the basis for the benefit calculation. In one of these files, the Company advised that the documentation had been misfiled. In the other, the Company advised that the benefit was based on a reinspection of the vehicle, but the file notes did not document the second inspection.

I recommend the Company handle total loss claims in accordance with OAR 836-080-0240(1), including paying title and transfer fees and adequately documenting the basis for the benefit calculation.

The Company indicated it has reviewed all claims in which title and transfer fees were not included in the benefits payment and issued payment where it was appropriate. The Company has also provided additional training to all persons handling total loss claims.

Claims Standard #18 – Automobile claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. Reference: ORS 746.230(1)(i) and OAR 836-080-0240(2), (3), (5), (6), (7) and (8).

Findings

Passed with comment – 96% compliance. This standard applied to all 50 of the files reviewed. Two files (4%) failed this standard. In one file, medical bills for services rendered prior to the date of the accident were paid under PIP. In the other file, the claimant's deductible was not included in the subrogation payment made to the other carrier. These two files do not represent a pattern, and no recommendation is

warranted.

COMPLIANCE WITH PRIOR RECOMMENDATIONS

This is the first examination performed on this Company. Therefore, there are no prior recommendations.

CONCLUSIONS

	<u>Recommendation</u>	<u>Page</u>
1	I recommend if a complaint involves both Country Casualty and Country Mutual, both companies be indicated in the complaint log in compliance with ORS 731.430.	9
2	I recommend the Company implement a system for tracking all written complaints made to the Company in compliance with ORS 731.302(2).	10
3	I recommend the Company furnish a response within 30 days of an inquiry from an insured in accordance with OAR 836-080-225(3) and document that response in accordance with ORS 733.170.	11
4	I recommend the Company furnish a response to an inquiry that is adequate and answers the questions being raised in accordance with OAR 836-080-225(3) and document that in accordance with ORS 733.170.	11

	<u>Recommendation</u>	<u>Page</u>
5	I recommend the Company implement procedures to assure that all policies are issued with uninsured/underinsured motorist limits matching the bodily injury liability limits unless a completed and signed rejection form is presented with the application, as required by ORS 742.500 through 742.506 and OAR 836-054-0000.	16
6	I recommend the Company resolve PIP claims within 60 days and resolve other claims within 30 days unless letters notifying the insured of the reason(s) for the delay are sent in accordance with OAR 836-080-0235(1) and (4).	22
7	I recommend the Company respond to claim correspondence within 30 days as required by OAR 836-080-0225(3).	23
8	I recommend the Company adequately document claim files as required by ORS 733.170 and OAR 836-080-0215.	23

9	I recommend the Company pay or deny personal injury protection claims within 60 days as required by ORS 742.525 and 742.528 and determine primary carrier in accordance with 742.526.	26
10	I recommend the Company handle total loss claims in accordance with OAR 836-080-0240(1) including paying title and transfer fees and adequately documenting the basis for the benefit calculation.	26

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, Thomas G. Moeller, AIE, RHU,CLU, and Kathi Kalk, insurance examiners for the State of Oregon, Department of Consumer and Business Services, Insurance Division, 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

AFFIDAVIT

STATE OF OREGON }
 }
County of Marion } ss

Jann Goodpaster, being duly sworn, deposes and says that the foregoing market conduct report of examination as of June 30, 1998, of Country Casualty Insurance Company, Bloomington, Illinois, subscribed by her is true to the best of her 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

Subscribed and sworn to before me on the ____ day of _____, 1999.

Linda J. Rothenberger
Notary Public for the State of Oregon
My Commission Expires: March 22, 2001

APPENDIX A
STANDARDS
COUNTRY CASUALTY INSURANCE COMPANY
MARKET CONDUCT EXAMINATION

Complaint Handling

#	Standard	Regulatory Authority
1	All complaints are recorded on the company complaint register.	ORS 731.302(1), ORS 746.240
2	The Company has adequate complaint handling procedures in place and communicates such procedures to policyholders.	ORS 731.302(1), ORS 746.240
3	The Company furnished a response within 21 days of an inquiry from the Insurance Commissioner.	ORS 743.296, OAR 836-80-225(2)
4	The Company responds to Insurance Commissioner complaints adequately and conclusively	OAR 836-80-225(2)
5	The Company furnished a response within 30 days of an inquiry from an insured.	OAR 836-80-225(3)
6	The Company response to an inquiry from an insured is adequate and answers the question being raised.	OAR 836-80-225(3)

Underwriting

#	Standard	Regulatory Authority
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 coverages 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 privilege suspended due to a non driving 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)
5	Named exclusions are signed by all named insureds and comply with all rules and regulations.	ORS 742.450(6)
6	Individual Risk Package Modifiers (IRPMs) 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 risks.	ORS 746.015, ORS 746.018 and OAR 836-081-0030

8	Employment driving records may not be used to determine if the file is issued, renewed or in the calculation of rates.	ORS 746.260 and ORS 746.265(1)
9	For the purpose of determining whether to issue or renew a policy and the calculation of rates an insurer may not use a driving record older than three year 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 (if applicable).	ORS 742.003
11	Underwriting, rating and classifications are based on adequate information developed at or near 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 anti-competitive 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 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
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 non renewal and within 15 days of issuance to the Department of Transportation.	ORS 742.580
18	Rescissions are not made for nonmaterial misrepresentation in accordance with the Company's established procedures.	ORS 746.240

Claims

#	Standard	Regulatory Authority
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 (3)

4	The Company responds to claim correspondence in 30 days.	OAR 836-080-0225
5	Claim files are adequately documented.	OAR 836-080-0215 and ORS 733.170.
6	Claims are not denied without first conducting a reasonable investigation.	See 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 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 companies 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) and ORS 746.230 (1) (m).
15	Canceled benefit checks and drafts reflect appropriate claim handling practices.	ORS 731.302(1)
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)(8), ORS 746.230(1)(i).
19	Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.	OAR 836-080-240(4)