

REPORT OF MARKET CONDUCT EXAMINATION

**GUIDEONE AMERICA INSURANCE COMPANY
GUIDEONE ELITE INSURANCE COMPANY
GUIDEONE MUTUAL INSURANCE COMPANY
GUIDEONE SPECIALTY MUTUAL INSURANCE COMPANY**

1111 ASHWORTH ROAD

DES MOINES, IOWA 50265

AS OF

DECEMBER 31, 2001

BY

KANSAS INSURANCE DEPARTMENT

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Honorable Kathleen Sebelius
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612

September 17, 2002

Dear Commissioner Sebelius:

In accordance with your respective authorization, and pursuant to K.S.A. 40-222, a market conduct examination has been conducted on the business affairs of:

GUIDEONE AMERICA INSURANCE COMPANY
GUIDEONE ELITE INSURANCE COMPANY
GUIDEONE MUTUAL INSURANCE COMPANY
GUIDEONE SPECIALTY MUTUAL INSURANCE COMPANY.

1111 ASHWORTH ROAD

DES MOINES, IOWA 50265

hereafter referred to as “the Group” or “the Companies”, and the following report as such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM
Market Conduct Supervisor
Examiner in Charge

SCOPE OF REVIEW

A Targeted market conduct examination of GuideOne Group's underwriting, claims and complaints was completed to determine compliance with applicable statutes, regulations and bulletins of the state of Kansas. The examination was conducted according to the guidelines and procedures recommended in the NAIC Market Conduct Examiners Handbook.

The examination included, but was **not limited to the following:**

COMPANY OVERVIEW

Certificates of Authority

COMPLAINT HANDLING

Record Keeping

Timely Response

UNDERWRITING & RATING

Proper Rating

Underwrite Acceptance/Termination

Use of Appropriate Forms

Promptness of Policy Issuance

Proper Maintenance of Underwriting Files

CLAIMS

Claim Processing

Use of Outside Pricing Entities

Timeliness and Accuracy of Claim Payment

Proper Maintenance of Claim Files

SUMMARY OF REVIEW

The market conduct examination focused on GuideOne Group. The testing and file review consisted of sampling from the Company's underwriting and processing center in Des Moines, Iowa.

The claim processing for the Company is also handled out of their office in Des Moines, Iowa. The examination included a review of the Company's underwriting and settled claim files from January 1, 2000 to December 31, 2001.

General topics were covered in Interrogatories submitted to the Companies for their written response. Subjects covered were Complaints, Underwriting and Claims. The response received adequately addressed the issues presented.

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

History

GuideOne America Insurance Company, GuideOne Elite Insurance Company, GuideOne Mutual Insurance Company, and GuideOne Specialty Mutual Insurance Company are all under a similar management. They market their products through one unified sales force. They also share the same underwriting and claims departments. All employees are employed by GuideOne Services, LLC, which is a subsidiary formed to provide insurance services to the group of companies through an employee leasing agreement. The 4 companies modified their names to their current title on April 4, 1999.

The company elected to phase out of the non-standard auto in September 2000. They notified the Kansas Insurance Department on March 16, 2001 that they were terminating that business.

Tests for Company Operations/Management

Standard 7

Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. KSA 40-222 a, b, c & g.

The company provided the exam team with the necessary records and documents in a timely fashion.

Standard 8

The company is licensed for the lines of business that are being written. KSA 40-216.

The Certificate of Authority was reviewed and found to be in order and the company was complying with it.

Standard 9

The company cooperates on a timely basis with examiners performing the examinations. KSA 40-222 c & g.

The company was very cooperative and provided the exam team with the items requested within the time frames established for this exam.

COMPLAINTS

Company Insurance Department Complaint Procedures

1. Jurisdiction

All complaints shall be directed to the Legal Department for initial review and assignment to the appropriate department. Copies of all responses shall be returned to the Legal Department for review. Closed complaint files shall be kept in the Legal Department. Any reply from the Insurance Department or any other party shall be forwarded to the Legal Department. Further activity may be assigned to the responding department, or may be retained by the Legal Department. When the Legal Department receives a complaint, it will be immediately logged in and a copy will be forwarded (preferably by fax) to the appropriate company and department.

2. Logging Procedure

Each complaint received shall be entered into a logbook. The logbook shall be organized by states. The complaints entered for each state will be in chronological date order and numbered chronologically. Information required shall include the date received, name of complainant, state insurance department division file number, department to which the complaint is assigned for a response, name of the person responsible for the response, and due date for an answer. Other information that should be logged if available is the name of our insured, policy number, and claim number. A copy of the NAIC Complaint Record Format is attached for your review.

3. Complaint File

Each complaint shall have its own separate file jacket, which shall reflect the file number, state and company to which the complaint is directed. The file jacket shall also bear the date it is created, the person and department to which it is referred, and the due date. The contents shall include the complaint and the response, and copies of original documents from underwriting, claims, agency or other files, to the extent necessary to document the complaint and the response. Original documents shall not be removed from the original files.

4. Complaint Investigation

Each complaint shall be investigated by the department to which it is referred. The person listed in the Complaint Log may assign the file to any other person who is more familiar or knowledgeable about the subject matter of the complaint, and whose assistance is reasonable and necessary for a full and complete response. If a complaint is sent to you and needs to instead be addressed by an entirely different department, the Legal Department should be contacted immediately with a suggestion as to who should receive it. All documents necessary to properly respond to the complaint shall be located and copied for inclusion in the complaint file. Many complaints may be answered without the necessity of documentation. The department shall maintain its own diary system so that a timely response is sent.

5. Responses

The responding department shall prepare a written response to the Insurance Department, which shall fully answer the issues raised in the complaint, describe the action the company will take, or explain why no action will be taken, and will enclose any documents or materials

necessary for a full and complete understanding of the complaint and response. Sam Waters, an attorney in the Legal Department, will review the responses to all complaints before they are forwarded to the Insurance Department. The person responsible for responding to the complaint must email Liz Kaplan and Marcia Dykstra, Legal Assistant, their proposed response prior to the due date given by Legal. You may fax your response if email is not available to you. Liz will review the response and either make changes or approve it. The approved written response and any additional materials or documents attached should be mailed to the Insurance Department by the due date given by Legal. This date is normally three business days before the Insurance Department's due date. The approved written response and any additional materials or documents attached must be received in the Insurance Department no later than the Insurance Department due date. A response sent after this due date could result in a penalty and fine against the company. A copy will also be sent to the complainant, if requested. A copy of the final response should be forwarded to the Legal Department to keep in the complaint file.

The responding department shall be notified by the Legal Department if any follow up is suggested, and the nature and the reason for the follow up. A copy of any further response and copies of enclosures, if any, shall be sent to the Insurance Department. A copy shall also be sent to the complainant, if requested.

6. Closing the Complaint File

Upon receiving the response to the Insurance Department, the Legal Department shall close the complaint file, unless the nature of the complaint indicates that further action is reasonably contemplated. Claims files shall remain open until satisfactory resolution of the complaint. If no further activity is anticipated or received, the file will remain in storage in the Legal Department. Complaint files will be kept for at least three years in the Legal Department. Any further contact on a complaint shall be referred to the Legal Department, to be handled in the same manner as the original complaint. They are then sent to storage until destruction after another seven years.

Tests for Complaint Handling

Standard 1

All complaints are recorded in the required format on the company complaint register. KSA 40-2404 (10).

The complaint register was up to date and complete with the required columns from the Kansas statutes and the GuideOne complaint procedures.

However, the company complaint procedures call for the contents of each complaint file to contain copies of "original documents from underwriting, claims, agency or other files, to the extent necessary to document the complaint and the response." There were 13 files without these documents. The complaint history could not be followed by the examiner or anyone else using this file to investigate these complaints. Letters sent to policyholders, the Kansas Insurance Department, estimates from repair shops, adjuster reports, and a record of phone calls or other communications were not available in these files.

Standard 2

The company has adequate complaint handling procedures in place and communicates such procedures to policyholders. KAR 40-1-34 (5a) & (6).

The procedures written into company policy are adequate and provide control of the complaint and timelines by one department and one assigned person. Generally, these procedures work quite well.

Standard 3

The company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. KAR 40-1-34 (6).

There were five complaints involving agent issues. These issues included allegedly not sending application in a timely manner, not disclosing prior high risk coverage to company, not following through on vehicle being registered in another state, and giving incorrect information. In each case, a complaint was filed with the Kansas Insurance Department, an agent paid dollars from his own pocket or the company elected to cover the alleged errors.

There is one violation where the wrong vehicle was listed on the policy. Neither the agent nor the company verified the VIN number, which caused coverage to later be denied. A custom paint issue was involved and should have been noted on the application. It took one year to settle this claim.

Standard 4

The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations. KAR 40- 1-34 (6) & (8a&c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Complaints	50	1	98%

Fifty complaints filed with the Kansas Insurance Department were reviewed at GuideOne headquarters. Timelines required by Kansas Regulations were met with one exception. This response to the Kansas Insurance Department took 17 working days instead of the required 15 working days.

While one late complaint is not a critical issue, the dates used in responding to the complaint are an issue. Kansas uses the date the letter arrives at the company, not the date the Legal Department receives it, to start the timeline for each complaint. While the company has procedures in place to carefully monitor the required timelines, attention should be directed to the date of receipt at the company. It is noted that many times the two dates do coincide.

Recommendations:

1. Ensure that the contents of the company's complaint files contain copies of "original documents from underwriting, claims, agency or other files, to the extent necessary to document the complaint and the responds" per the company complaint procedures."
2. When there is a complaint regarding the performance of an agent, the company can use this as an agency management tool to educate their producer.

UNDERWRITING

The company's underwriting process is described below:

- Automobile & Homeowner Policies

Policies can be automatically underwritten using an Automatic Underwriting System (AUS). After policy service specialist enters all the information into the system, at night V4 will compare all the data submitted to a pre-determined set of criteria. These criteria are the same used by the underwriters, who if they were all satisfied, would accept the application.

Insurance Bureau Score (IBS) scores are ran on both automobile and homeowners applications.

On automobile policies a CLUE will be ordered automatically for those policies that were not rejected by the AUS system. These reports are received back the same night electronically and policy is again sent through the AUS system where it compares all the data received to a pre-determined set of criteria.

Three different products are generated after the AUS completes its calculations and these are to (1) accept the policy (2) reject it, or to (3) refer it to the underwriters. If the policy is accepted, the system prints out the "DEC" (policy and all together important information), which is received directly by the mailroom, which mails them for delivery to the agent/policyholder. If the policy is "rejected" or referred to the underwriters" a "DEC" is not prepared by the system and instead the underwriters must review the application prior to acceptance. A list is generated each day noting the status of each application.

Policy service specialist scans the file out to the underwriter's work bank where it remains until an underwriter retrieves the file for processing. The underwriter will extract the AUS results electronically from V4 enabling him/her to determine the reason why the application has not been accepted. (V4 tracks this information and upon request will show it to the underwriters).

The underwriters then determine if they should accept or reject the application. If the policy is accepted, the file is returned to policy service specialist who will make any changes that are needed and releases the application in the system, which allows it to complete the underwriting process.

If the application is denied coverage a letter or rejection notice and refund check (if applicable), is mailed to the policyholder. Handling an application that is denied coverage depends upon which state the policy was written since each state may have its own unique requirements. See 'Rejected policies' procedures below for additional documentation.

- Dwelling Fire & Personal Liability Policies

Unlike the automobile and homeowners' applications, dwelling fire and personal liability policies have to be manually underwritten and rated. Therefore, once policy service specialist completes their work, the files are scanned out to the underwriters' work bank where they remain until an underwriter has time to process the application. Underwriters will scan the files out to them and complete the underwriting process. The files are then stamped and dated noting their approval, then scanned out to the Policy service specialist (PSS) who had started the process. PSS completes the process by rating the application, loading the premium and then "releasing" the file from the system, which processes the information overnight and prints out the policy and all supporting documentation that will be mailed by the mailroom. The application and all other important data is sent to records for storage.

- Personal Excess Liability policies

Processing a personal excess liability policy is the same as dwelling fire or personal liability except the V4 system does not have the ability to print out the "DEC". Instead, the policy is generated by a PC based system that prints the DEC, insuring agreement and any endorsements, in the new business process department. Policy service specialist, not the mailroom, will mail the policy directly to the agent/policyholder. A copy of all the information is put into the file, which is sent to records for storage.

- Application is "released"

Regardless if the application is approved and released by policy service specialist, underwriters, or automatically by V4 itself, once the approval is given V4 will perform a number of automatic journal entries. These entries record the fees and premium income earned, the expenses incurred, and the receivable or payable that have been calculated. Support team has already recorded the premium payment into a suspense account using the optical scanner so this balance must be eliminated and all the revenues, expenses and balance sheet items must be recorded.

- Ordering of MVR

Approximately 10 days after an automobile policy has gone to master, the system will automatically order an MVR on each driver age 17 or older unless all of the following apply:

Driver is at least age 30 and less than 69

CLS score is 575 or higher

Application shows no violations or accidents of any kind for that individual driver

Application shows a standard prior carrier

Application is for Elite, Ultra or Star tier

If the MVR comes back clear it is not printed and is therefore not included in the file. If the MVR comes back with any violations or accidents, assistant underwriter reviews it.

- Rejected Policies

On occasion, an application that was submitted will be denied. When an agent obtains a signed copy of the application and accepts the money, he has contractually bound GuideOne to provide coverage for a period of time. This time can vary between states but it is essential that GuideOne contact the policyholder as soon as possible.

When the underwriters have denied an application the following steps are implemented. The underwriters will start the process by entering a note in the diary, which will produce a pre-notifier that is mailed to the agent and an instruction sheet to the cancellation desk.

- The application is sent to the cancellation desk.
- The cancellation desk matches files with the instruction sheet.
- Following day, cancellation desk types any attachments required, cancels the policy using the appropriate number of days required per state guidelines and catches back the rejection notice.
- Third day, cancellation desk matches attachments to computer generated notice and mails proof-of-mailing. Processing Standard Lines renewals.

The process for renewals begins 120 days before renewal date. Once a month the system will generate frequency reports for automobile, homeowner and dwelling fire policies that meet certain loss criteria within the last six months. Assistant underwriter reviews losses and determines if any action is needed.

Tests for Underwriting and Rating

Standard 1: Rating Practices

The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan. KSA 40- 955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Business	50	0	100%

Standard 2: Rating Practices

Disclosures to insureds concerning rates and coverage are accurate and timely. KSA 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Bsns. Sub-Std. Auto	22	3	86.4%

There were 22 files out of the sample that were issued in GuideOne Specialty Mutual Insurance Co. This was their sub-standard auto program that they were writing in Kansas. The company has since withdrawn their sub-standard program in Kansas, and the exam team does not recommend any additional action at this time.

KAR 40-3-25 requires:

Each company issuing a fire and casualty insurance policy in this state with a premium rate that results from the insured's inability to obtain coverage in the normal market, shall include a statement on the application or policy form, signed by the applicant or named insured, that contains the following statement or one with similar wording:

(a) I am unable to obtain _____ insurance at normal rates and hereby request the issuance of this policy at rates in excess of normal rates.

(b) I have been unable to procure similar insurance at normal rates although my risk has been submitted to at least three other insurance companies authorized to transact insurance business in Kansas.

Standard 3: Rating Practices

Credits and deviations are consistently applied on a non-discriminatory basis. KSA 40-953 & KSA 40-954.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Business	50	3	94%

K.S.A. 40-955, Rate Filings; Disapproval of Filings, requires:

(a) Every insurer shall file with the commissioner, except as to inland marine risks where general custom of the industry is not to use manual rates or rating plans, every manual of classifications, rules and rates, every rating plan, policy form and every modification of any of the foregoing which it proposes to use.

Standard 4: Rating Practices

Schedule rating or individual risk premium modification plans, where permitted, are based on objective criteria with usage supported by appropriate documentation. KAR 40-3-32(d), KAR 40-3-12, KSA 40-953 & KSA 40-954.

This standard was not specifically tested for. However in our sample, there were no policies with either a limiting coverage endorsement, schedule rating or individual risk premium modification plan.

Standard 5: Underwriting Practices

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. KSA 40-953, KSA 40-954, KSA 40-955 & KAR 40-3-44.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Business	50	3	94%
Declines	50	0	100%

There were 3 files with a misapplied auto rate class and no documentation why that particular class was used.

K.S.A. 40-955, Rate Filings; Disapproval of Filings, requires:

(a) Every insurer shall file with the commissioner, except as to inland marine risks where general custom of the industry is not to use manual rates or rating plans, every manual of classifications, rules and rates, every rating plan, policy form and every modification of any of the foregoing which it proposes to use.

Standard 6: Underwriting Practices

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 (if applicable). KSA 40- 216.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Business	50	0	100%

Standard 7: Underwriting Practices

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. KSA 40-953.

This standard was not specifically tested for. However in our sample, there were no policies with either a limiting coverage endorsement, schedule rating or individual risk premium modification plan.

Standard 8: Underwriting Practices

File documentation adequately supports decisions made. KSA 40-953 & KSA 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Business	50	6	88%

The files showed a misclassification of vehicle use or annual mileage, and there was no documentation on how they arrived at that classification. This is a violation of KSA 40-953. "...One rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses."

Standard 9: Underwriting Practices

Policies and endorsements are issued or renewed accurately, timely and completely. KSA 40-216, KSA 40-953 & KSA 40-955.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
New Business	50	3	94%

The company had a display problem on their homeowners deck pages in 2000. This display problem did not affect the final premium charged and displayed on the policy or the forms and endorsements that were part of the contract. The company has since fixed the problem.

Standard 10: Underwriting Practices

Company verifies that VIN number submitted with application is valid and that the correct symbol is utilized. KSA 40-953 & KSA 40-954.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto	40	0	100%

Standard 11: Rejections/Declinations

Rejections and declinations are not unfairly discriminatory. KSA 40-954 (c) & KAR 40-3-40.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Declinations	50	0	100%

Standard 12: Termination Practices

Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract. KSA 40-276(a), KSA 40-277, KSA 40-278, KSA 40-2,111, KSA 40-2,112, KSA 40-2,120, KSA 40-2,121, KSA 40-2,122, KAR 40-3-23, KAR 40-3-28 & KAR 40-3-15.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Cancellations/Declines	50	5	90%

GuideOne’s policy is to send formal cancellation notice on all new business that is bound by their agents that does not qualify for their underwriting programs.

-3 policies did not have the proper number of days advance notice to the insured. This is a violation of KAR 40-3-15:

(a) Each policy or contract, that is issued by fire or casualty insurers within the state of Kansas, and that provides for cancellation at the option of the insurer, shall contain a provision within the policy, or at the discretion of the commissioner, within an amending rider, that the insured will be notified in writing at least 30 days in advance of the effective date of cancellation.

(b) Each fire or casualty insurer that cancels a policy or insurance contract in the state of Kansas, shall provide written notice of cancellation to the insured. Each cancellation notice shall specify the cancellation date and shall state in clear language that the policy is being cancelled. The following statement or one that is substantially the same shall be used: "You are hereby notified that your policy number _____ is cancelled effective _____."

-1 policy did not have the correct form attached. Therefore the insured was not advised that they may be eligible for the Kansas Insured Assigned Risk Plan per KSA 40-278:

When a policy of automobile liability insurance as defined in K.S.A. 40-276 is cancelled, or nonrenewed other than for nonpayment of premium by an insurance company, such insurer shall notify the named insured of his possible

eligibility for such coverage through the Kansas automobile insurance plan. Such notice shall accompany or be included in the notice of cancellation, or nonrenewal, given by the insurer and shall state that such notice of availability of the Kansas automobile insurance plan is given pursuant to the provisions of this act.

Or they could request the specific reason for the adverse underwriting decision per KSA 40-2,112.

(a) In the event of an adverse underwriting decision the insurance company, health maintenance organization or agent responsible for the decision shall either provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise such persons that upon written request they may receive the specific reason or reasons in writing.

-1 policy was cancelled without proper evidence from the insured to indicate that the policyholder requested termination. The policy allows for “the named insured shown in the Declarations may cancel by: a.) Returning this policy to us; or b.) Giving us advance written notice of the date cancellation is to take effect.”

Standard 13: Termination Practices

Unearned premiums are correctly calculated and returned to appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations. KSA 40-2,112 (d)(1).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Cancellation/Decline	50	1	98%

There was one policy where the service charge should have been waived because the policy was rewritten. It was not done. Per KSA 40-2,112 (d) (1).

(d) The company, health maintenance organization or the agent, whichever is in possession of the money, shall refund to the applicant or individual proposed for coverage, the difference between the payment and the earned premium, if any, in the event of a declination of insurance coverage, termination of insurance coverage, or any other adverse underwriting decision.

(1) If coverage is in effect, such refund shall accompany the notice of the adverse underwriting decision...

Standard 14: Terminations

Rescissions are not made for non-material misrepresentation.

This standard was not specifically tested for. In the regular file review, there were no rescissions taken in the 50 dailies reviewed.

Recommendations

1. While this was within the tolerances for error ratios per the NAIC Handbook, the examination team feels that a recommendation would apply for the company to insure that the proper rating rules be followed including credits and rating classification. KSA 40-3-953 & KSA 40-3-955.
2. Underwriting Files should be documented properly to support the rating classification. KSA 40-3-953.
3. While this was within the tolerances for error ratios per the NAIC Handbook, the examination team recommends that the company review its procedures to insure that the policy is issued correctly. When a systems problem is discovered, the programming to correct these errors should be done in a timely fashion. KSA 40-216, KSA 40-3-953 & KSA 40-3-955.
4. Cancellations for either cause or request of the insured are processed correctly with the proper notification to the insured or documentation from the client indicting when the policy is to be terminated. KAR 40-3-15, KSA 40-278 & KSA 40-1,112.

CLAIMS

Company claim processing procedures:

When claims are first received they are reported to central loss reporting unit. The Claim is established in claims system and electronically directed to appropriate branch office, immediately.

Within the branch office, the claim is assigned to a GuideOne adjuster. GuideOne adjuster handles investigation, negotiation and settlement of claims.

It is the policy of the GuideOne Claims Department to inform all policyholders of all applicable benefits and coverages for a particular loss.

Claim denials are communicated to the involved parties as soon as investigations are complete. A denial letter is sent as a follow up to a verbal denial. Copies of denial letters are to be provided to the agent and should be preceded by a call to the agent.

There is no formal appeals process for claim denials. As a practical matter, the GuideOne Claims Department organizational structure supports appeal to the next level of supervision. Both denials and complaints are handled accordingly.

GuideOne Insurance Company processes all claims in accordance with Kansas statutes and pays applicable interest when appropriate. GuideOne's internal standards require prompt payment of damages once agreement has been reached with our policyholder, claimant, or

repair provider. It would be rare for any agreed amount of damages to remain unpaid at 30 days. Should this occur, GuideOne will pay interest.

Tests for Claims (See Appendix I for the wording of the appropriate statute or regulation)

Standard 1

The initial contact by the company with the claimant is within the required time frame. KAR 40-1-34 (6a&d).

Passed

Standard 2

Timely investigations are conducted. KAR 40-1-34 (7) & (8c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Denied Property	52	3	94%
Paid Property	50	3	94%
Denied Auto	52	0	100%
Paid Auto	50	0	100%

Standard 3

Claims are resolved in a timely manner. KAR 401-34 (8a&c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Denied Property	52	0	100%
Paid Property	50	3	94%
Denied Auto	52	0	100%
Paid Auto	50	0	100%

Standard 4

The company responds to claim correspondence in a timely manner. KAR 40-1-34 (6a&d).

Passed

Standard 5

Claim files are adequately documented. KAR 40-1-34 (4), (6a) & (8b).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Denied Property	52	0	100%
Paid Property	50	6	88%
Denied Auto	52	3	94%
Paid Auto	50	1	98%

Standard 6

Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. KAR 40-1-34 (5a), (8), & (9), KSA 40-3110 & KSA 40-2-126.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Denied Property	52	0	100%
Paid Property	50	4	92%
Denied Auto	52	0	100%
Paid Auto	50	2	96%

Standard 7

Company uses the reservation of rights and excess of loss letters, when appropriate.

This standard was not specifically tested for. In the normal review of the 50 paid auto claims, any activity would have been reviewed and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 8

Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner. KAR 40-1-34 (9d).

This standard was not specifically tested for. In the normal review of the 50 paid auto claims, any subrogation activity would have been reviewed and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 9

Company claim forms are appropriate for the type of product.

Passed

Standard 10

Claim files are reserved in accordance with the company’s established procedures.

Passed

Standard 11

Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. KAR 40- 1-34 (8a), (8b) & (8c).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Denied Auto	52	3	94%
Denied Property	52	3	94%

Standard 12

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. KSA 40-2404 (9f) & (9g).

Passed

Recommendations:

1. GuideOne shall complete its investigation of a claim within thirty days after notification of the claim, unless such investigation cannot reasonably be completed within such time. Per K.A.R. 40-1-34 (7).
2. If GuideOne needs more time to investigate the claim to determine if the claim should be accepted or denied, GuideOne shall notify the member within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, GuideOne shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such member a letter setting forth the reasons additional time is needed for the investigation. Per K.A.R. 40-1-34 (8c).
3. The claim files need to properly documented to insure that pertinent events and dates can be reconstructed. Per 40-1-34 (4).
4. The company needs to insure that all claims are properly handled in accordance with policy provisions and applicable statutes rules and regulations. Per KAR 40-1-34 (5).

GENERAL COMMENTS

Complaint Handling

1. Ensure that the contents of the company’s complaint files contain copies of “original documents from underwriting, claims, agency or other files, to the extent necessary to document the complaint and the response” per the company complaint procedures.”
2. When there is a complaint regarding the performance of an agent, the company can use this as an agency management tool to educate their producer.

Underwriting

1. While this was within the tolerances for error ratios per the NAIC Handbook, the examination team feels that a recommendation would apply for the company to insure that the proper rating rules be followed including credits and rating classification. KSA 40-3-953 & KSA 40-3-955.
2. Underwriting Files should be documented properly to support the rating classification. KSA 40-3-953.
3. While this was within the tolerances for error ratios per the NAIC Handbook, the examination team recommends that the company review its procedures to insure that

the policy is issued correctly. When a systems problem is discovered, the programming to correct these errors should be done in a timely fashion. KSA 40-216, KSA 40-3-953 & KSA 40-3-955.

4. Cancellations for either cause or request of the insured are processed correctly with the proper notification to the insured or documentation from the client indicating when the policy is to be terminated. KAR 40-3-15, KSA 40-278 & KSA 40-1,112.

Claims Handling

1. GuideOne shall complete its investigation of a claim within thirty days after notification of the claim, unless such investigation cannot reasonably be completed within such time. Per K.A.R. 40-1-34 Section (7).
2. If GuideOne needs more time to investigate the claim to determine if the claim should be accepted or denied, GuideOne shall notify the member within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, GuideOne shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such member a letter setting forth the reasons additional time is needed for the investigation. Per K.A.R. 40-1-34 (8)(c).
3. The claim files need to properly documented to insure that pertinent events and dates can be reconstructed. Per 40-1-34 (4).
4. The company needs to insure that all claims are properly handled in accordance with policy provisions and applicable statutes rules and regulations. Per KAR 40-1-34 (5).

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by the Assistant General Counsel and the staff of GuideOne Group.

The following examiners of the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

Market Conduct Division

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Respectfully submitted,

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