

REPORT OF MARKET CONDUCT EXAMINATION

**Safeco Ins. Group
Group # 163**

**Safeco Ins. Co. of America,
NAIC # 24740; FEIN # 91-0742148**

**First National Ins. Co. of America
NAIC # 24724; FEIN # 91-0742144**

**General Ins. Co. of America
NAIC # 24732; FEIN # 91-0231910**

**Safeco Ins. Co. of IL
NAIC #39012; FEIN # 91-1115311**

**Safeco Plaza
4333 Brooklyn Ave NE
Seattle WA 98185-1016**

AS OF

June 30, 2005

BY

**KANSAS INSURANCE DEPARTMENT
ETS# KS057- M4 & M5**

TABLE OF CONTENTS

<u>SUBJECT</u>	<u>PAGE NO.</u>
TABLE OF CONTENTS	2
SALUTATION	3
PURPOSE AND SCOPE OF REVIEW	4
EXECUTIVE SUMMARY	6
DESK EXAMINATION/ON SITE EXAMINATION	7
COMPANY OVERVIEW	7
COMPLAINT HANDLING	9
UNDERWRITING AND RATING	11
CLAIM HANDLING	15
SUMMARIZATION	19
CONCLUSION	19
TABLE 1	
APPENDIX 1	

Honorable Sandy Praeger
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612

Dear Commissioner Praeger:

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:

Safeco Ins. Co. of America,

First National Ins. Co. of America

General Ins. Co. of America

Safeco Ins. Co. of IL

Safeco Plaza
4333 Brooklyn Ave NE
Seattle WA 98185-1016

hereafter referred to as “Safeco” or “the Company”, and the following report of such examination is respectfully submitted,

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

PURPOSE AND SCOPE OF REVIEW

A targeted market conduct examination of Safeco was conducted pursuant to, but not limited to, K.S.A. 40-222. The exam team reviewed underwriting files, claims and complaints to determine if the Company was in compliance with applicable statutes, regulations and bulletins of the State of Kansas.

The audit was conducted according to the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2006 (Handbook). The exam team utilized the standards and tests recommended in the Handbook. An acceptable tolerance standard per the Handbook of 7% was used for claim procedures and 10% was used for all other categories. The examination report is a report written by test rather than a report written by exception. This means all standard tests are described and results indicated.

The testing and file review for the Company's underwriting, rating and claims practices consisted of several samplings from the Company's corporate headquarters in Seattle, WA.

The examination included a review of the Company's underwriting, complaint and settled claim files from January 1, 2004 to June 30, 2006.

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

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

COMPANY OVERVIEW

- History and Profile
- Prior Market Conduct Examination Reports
- Fines and/or Penalties
- Company Operations and Management
- Certificates of Authority
- Internal Audit Procedures

COMPLAINT HANDLING

- Record Keeping
- Timely Response

UNDERWRITING & RATING

- Proper Rating
- Underwriting Acceptance/Termination
- Use of Appropriate Forms
- Promptness of Policy Issuance
- Proper Maintenance of Underwriting Files

CLAIMS

Claim Processing
Timeliness and Accuracy of Claim Payment
Proper Maintenance of Claim Files

EXECUTIVE SUMMARY

The Kansas Insurance Department (KID) performed a market conduct examination of Safeco. The period of examination was January 1, 2004 through June 30, 2006.

The examiners reviewed the Company underwriting, claims, and rating manuals. The exam team reviewed underwriting, claim, and complaint files in the Company's administrative office in Seattle, WA. A series of meetings were held with the Safeco staff that focused on their current operations. To supplement and verify the understanding of how the Company does business, a series of samples were selected for review to verify their procedures and practices in claims, underwriting and rating.

The Company passed most tests; and in terms of delivering good service to its insureds, the examiners were impressed with the overall positive and very professional performance by the Safeco staff and management to their policyholders. The exam team has made recommendations on several issues.

LIST OF RECOMMENDATIONS

Underwriting and Rating Recommendations

1. Safeco needs to review their termination procedures and how it relates to cancelled agents. The Company must report to KID within 30 days of the final order adopting this exam regarding how they are going to be in compliance with K.S.A. 40-276a,(a)(6).

Claim Handling Recommendations

1. The Company was within the tolerances for completing claim investigations within the 30 day period per K.A.R. 40-1-34, 7. However the three homeowners claims cited in Standard #2 were the result of a lack of activity on the Company's part until either the insured or the claims supervisor pursued the claim settlement issue. It appears that the Company should review their claims procedures to insure prompt handling by the front line claims adjuster.

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

History and Profile

History - Safeco

In 1923, insurance executive Hawthorne K. Dent startled the established business community with a radical approach to insurance. He organized a company to combine the financial stability and responsibility of an investor-owned stock company with the preferred-risk underwriting and lower prices of a mutual or policy-owned company. He based the company in Seattle, far from the recognized insurance centers of the metropolitan Northeast.

The first U.S. insurance company organized along those lines was General Insurance Company of America Corporation, or "The General" as it was known. Over the next several years, "The General" became known for its competitive prices and exemplary service.

In 1953, the company's innovative spirit sent it in pursuit of an emerging technology that offered independent agents the tools to compete with the direct insurance writers — computer-based automation. That quest produced the Selective Auto and Fire Insurance Company of America. The name Safeco was derived from the company's acronym.

The company entered the life insurance business in 1957. In 1968, the board of directors recognized Safeco's rapid growth and success by changing the parent corporation's name from General America Corporation to Safeco Corporation. Also in the late 1960s, Safeco further diversified its financial services by introducing mutual funds and a commercial credit company.

Always highly successful on the West Coast, Safeco took a major step in geographic and product diversification in 1997 with its acquisition of American States Financial Corporation. The combination doubled Safeco's independent agency distribution force, increased its presence east of the Rockies and, through its American States Business Insurance product line, the company became a leading writer of business insurance for small- to mid-sized businesses.

The company further increased its national presence in 1998, when it purchased the naming rights to the Seattle Mariner's ballpark.

The company continues to grow profitably and posted its best-ever net income result of \$562 million in 2004. Also in 2004, Safeco completed the sale of its life and investments operations, shifting the company's full attention to property and casualty insurance.

Today, Safeco focuses on the insurance needs of drivers, homeowners and small- and mid-sized businesses.

2004 Written Premium in Kansas:

	NAIC Code	Company Name	Domicile	Tot W/P
Private Passenger Auto In KS				
	24740	SAFECO INS CO OF AMER	WA	32,600,135
	24724	FIRST NATL INS CO OF AMER	WA	4,012,545
	24732	GENERAL INS CO OF AMER	WA	1,280,600
	39012	SAFECO INS CO OF IL	IL	72,635
TOT Auto W/P				\$37,965,915
Homeowners In KS				
	24740	SAFECO INS CO OF AMER	WA	17,162,472
Tot W/P Personal Lines				\$55,128,387

Company Agreements

There is a service agreement between Safeco and the individual Companies in the group that spells out the necessary business services that are provided to these individual companies by the parent corporation. This is a standard service contract and the allocation of expenses for such services as sales, claims, underwriting, Actuarial, data processing, legal, accounting and general management and administration.

The Safeco does not use an MGA.

Internal Audits

Safeco's Internal Audit Department periodically reviews business units following a pre-determined schedule. Findings are shared with department management and any necessary action plans are implemented.

Individual departments perform periodic self-assessments. Results are shared with department staff, and any necessary actions/corrections are taken.

Prior Market Conduct Examination Report(s)

Safeco provided the examiners with the market examination reports from the prior 3 years. There were no recommendations in these exams that required a follow up by the market conduct unit.

Fines and/or Penalties

The NAIC I-Site database was reviewed. There was nothing noted that warranted follow-up by this exam team.

Tests for Company Operations/Management

Standard 1

The company has an up-to-date, valid internal or external audit program.

See the comments noted on page 8 regarding internal audits.

Standard 7

Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. K.S.A. 40-222 (a)(b)(c)(g)

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

The Company passed Standard #7.

Standard 8

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

The Certificate of Authority was reviewed and found to be in order, and the Company was in compliance.

The Company passed Standard #8.

Standard 9

The company cooperates on a timely basis with examiners performing the examinations. K.S.A. 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.

The Company passed Standard #9.

COMPLAINT HANDLING

Policyholder Service and Complaints

Safeco’s defines a complaint as “a communication, written or verbal, primarily expressing a concern or grievance that is forwarded to Safeco from the Department of Insurance, Better Business Bureau, an individual, or some other source.”

Various complaint reports and summaries reflecting response timeliness and other factors are reviewed quarterly by underwriting managers and compliance analysts/managers as part of the underwriting review process. Claims complaints reports are reviewed at least twice per year by claims compliance staff/management.

Tests for Complaint Handling

Standard 1

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

The Company provided the exam team with a copy of the complaint log. It was more detailed than the information required in K.S.A. 40-2404 (10).

The Company passed Standard #1.

Standard 2

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

The Company provided the exam team with a copy of Safeco’s complaint handling procedures manual. This document spells out the procedures one is to follow in handling a number of different types of complaints.

The Company passed Standard #2.

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. K.A.R. 40-1-34, 6.

The Company passed Standard #3.

Standard 4

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

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>% Pass</u>
Insurance Dept. Complaints	40	4	92%

- Three complaints did not have a response back to KID within 15 days per K.A.R. 40-34, 6(b).
- One complaint did not have a payment made within 15 days to the claimant after the arbitration panel ruled against Safeco. This is a violation of K.A.R. 40-1-34, 8(a).

The Company passed Standard #4.

UNDERWRITING AND RATING

Tests for Underwriting and Rating General Company Underwriting & Rating Standards

Standard 1: Rating Practices

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

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Auto New Business	50	1	98%
Homeowners New Business	50	0	100%

- One policy did not have liability coverage & the proper credits applied. This is a violation of K.S.A. 40-3404(a) & K.S.A. 40-955(a)(f).

The Company Passed Standard #1.

Standard 2: Rating Practices

All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations. K.S.A. 40-955

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

The Company passed Standard #2.

Standard 3: Rating Practices

Regulated entity does not permit illegal rebating, commission cutting or inducements. K.S.A. 40-953 & K S.A. 955

The exam team did not specifically test for this standard. In the normal review of the sample files, any indications of rebating, commission cutting or inducements would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 4: Underwriting Practices

The regulated entity underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulate entity guidelines in the selection of risks. K.S.A. 40-953 & K.A.R. 40-3-44

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

The Company passed Standard #4.

Standard 5: 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). K.S.A. 40-216

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

The Company passed Standard #5.

Standard 6: Underwriting Practices

Policies, riders and endorsements are issued or renewed accurately, timely and completely. K.S.A, 40-216

The exam team did not specifically test for this standard. In the normal review of the sample files, any policies, renewals or endorsements that were not processed timely and completely would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 7: Rejections/Declinations

Rejections and declinations are not unfairly discriminatory.

The Company does not reject or decline a new submission. Bound applications are issued and then cancelled if the client does not meet the new business criteria or accept an alternate rating plan.

Standard 8: Termination Practices

Cancellation/non-renewal, discontinuances and declination notices comply with policy provisions and state laws and regulated entity guidelines.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Cancellations - all	50	1	98%
Non-renewal - Underwriting	50	0	100%
Non-renewal – Canc. Agent	25	13	48%

- One policy was cancelled for underwriting reasons, and the company did not give the minimum number of days notice per the policy contract. This is a violation of K.S.A. 40-216(a).
- Thirteen policies were nonrenewed because the agent no longer represented the company. There was no offer to renew the policies. This is a violation of K.S.A. 40-276a,(a)(b).

The company passed the cancelled and nonrenewed for underwriting reasons portion of Standard #8, but failed the terminated agent portion.

Standard 9: Terminations

Recessions are not made for non-material misrepresentation.

Not Applicable

Specific Property & Casualty Underwriting & Rating Standards

Standard 1: Rating Practices

Credits and deviations are consistently applied on a non-discriminatory basis. K.S.A. 40-953

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

The Company passed Standard #1.

Standard 8: 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.

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

The Company passed Standard #8.

Standard 10: Underwriting Practices

The regulated entity underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks. K.S.A. 40-953, K.A.R. 40-3-44

There was no indication of any type of this activity in the files the exam team reviewed.

Standard 11: 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). K.S.A. 40-216

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

The Company passed Standard #11.

Standard 12: Underwriting Practices

Regulated entity verifies that VIN number submitted with application is valid and that the correct symbol is utilized. K.S.A. 40-953; K.S.A. 40-954

The company uses a software package purchased from an outside vendor to automatically assign VIN numbers as the car information is entered into their system.

Standard 13

The regulated entity does not engage in collusive or anti-competitive underwriting practices

There was no indication of any type of this activity in the files the exam team reviewed.

Standard 14 Underwriting Practices – Mass Market Auto

The regulated entity underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations in application of mass marketing plans.

Not Applicable

Standard 15: Underwriting Practices – Group Accounts

All group personal lines property and casualty policies and programs meet minimum requirements.

Not Applicable

Standard 16: 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.

See Standard #8 under General Underwriting & Rating Standards

Standard 17

All policies are correctly coded.

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

The Company passed Standard #17.

Standard 18

Application or enrollment forms are properly , accurately and fully completed, including any required signatures and file documentation adequately supports decisions made.

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

The Company passed Standard #18.

Underwriting and Rating Recommendations

1. Safeco needs to review their termination procedures and how it relates to cancelled agents. The Company must report to KID within 30 days of the final order adopting this exam regarding how they are going to be in compliance with K.S.A. 40-276a,(a)(6).

CLAIM HANDLING

Tests for Claims (See Appendix I for the wording of the appropriate statute or regulation)
General Company Claim Standards

Standard 1

The initial contact by the regulated entity with the claimant is within the required time frame. K.A.R. 40-1-34, 6(a)&(d)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Paid Auto Claims	100	0	100%
Paid Homeowners Claims	50	0	100%
No Pay Claims	50	0	100%

The Company passed Standard #1.

Standard 2

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

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Paid Auto Claims	100	2	98%
Paid Homeowners Claims	50	3	94%
No Pay Claims	50	0	100%

- Two auto claims were not settled within 30 days per K.A.R. 40-1-34, 7. No notice was sent to the claimant advising him that additional time was needed to complete the investigation per K.A.R. 40-1-34, 8(c).

- Three homeowners claims were not settled within 30 days per K.A.R. 40-1-34, 7. No notice was sent to the claimant advising him that additional time was needed to complete the investigation per K.A.R. 40-1-34, 8(c).

The Company passed Standard #2.

Standard 3

Claims are resolved in a timely manner. K.A.R. 40-1-34, 8(a)&(c)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Paid Auto Claims	100	4	96%
Paid Homeowners Claims	50	0	100%
No Pay Claims	50	0	100%

- Three auto claims were not paid in a timely fashion per K.A.R. 40-1-34, 8(a).
- One auto PIP claim was not paid per K.S.A. 40-3110(b) & K.A.R. 40-1-34, 8(c).

The Company passed Standard 3.

Standard 4

The regulated entity responds to claim correspondence in a timely manner. K.A.R. 40-1-34, 6(a)&(d)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Paid Auto Claims	100	0	100%
Paid Homeowners Claims	50	0	100%
No Pay Claims	50	0	100%

The Company passed Standard 4.

Standard 5

Claim files are adequately documented. K.A.R. 40-1-34, Sections 4, 6(a) & 8(b)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Paid Auto Claims	100	0	100%
Paid Homeowners Claims	50	0	100%
No Pay Claims	50	0	100%

The Company passed Standard #5.

Standard 6

Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations. K.A.R. 40-1-34, Sections 5(a), 8, & 9, K.S.A. 40-3110 & K.S.A. 40-2-126

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Paid Auto Claims	100	2	98%
Paid Homeowners Claims	50	0	100%
No Pay Claims	50	0	100%

- One auto claim did not have the comprehensive deductible taken out of the payment per K.S.A. 40-216 (a).
- One auto file lacked documentation on the salvage value per K.A.R. 40-1-34, 9(a)(c).

The Company passed Standard #6.

Standard 7

Regulated entity claim forms are appropriate for the type of product.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Paid Auto Claims	100	0	100%
Paid Homeowners Claims	50	0	100%
No Pay Claims	50	0	100%

The Company passed Standard #7.

Standard 8

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

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any reserving abnormalities would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 9

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

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Paid Auto Claims	100	1	99%
No Pay Claims	50	3	94%

- Three auto claims were denied because the damage was below the deductible, and there was no formal notification to the insured per K.A.R. 40-1-34, 8(a)(f).
- One paid claim consisted of the insured alleging additional damage as a result of the accident. After it was inspected, there was no additional damage and no

notification was sent to the insured that his additional claim was denied per K.A.R. 40-1-34, 8(a)(f).

The Company passed Standard #9.

Standard 10

Canceled benefit checks and drafts reflect appropriate claim handling practices. K.A.R. 40-1-34, Sections 5(f), 8(a)&(c) & K.S.A. 40-3110

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Cancelled Checks	25	0	100%

The Company passed Standard #10.

Standard 11

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. K.S.A. 40-2404 (9) (f)&(g)

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any attempts to not settle a claim fair and promptly would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Specific Property & Casualty Claim Standards

Standard 1

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

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any claims where a reservation of rights or excess of loss letter would have been appropriate would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 2

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

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any subrogated claims would have been reviewed, and the examiner would have noted a deductible reimbursement. There were no issues with the files that were reviewed.

Claim Handling Recommendations

1. The Company was within the tolerances for completing claim investigations within the 30 day period per K.A.R. 40-1-34, 7. However the three homeowners claims cited in Standard #2 were the result of a lack of activity on the Company's part until either the insured or the claims supervisor pursued the claim settlement issue. It appears that the Company should review their claims procedures to insure prompt handling by the front line claims adjuster.

SUMMARIZATION

Underwriting and Rating Recommendations

1. The Company needs to review its termination procedures and how it relates to cancelled agents and report to KID within 30 days of the final order adopting this exam regarding how they are going to be in compliance with K.S.A. 40-276a,(a)(6).

Claim Handling Recommendations

1. The Company was within the tolerances for completing claim investigations within the 30 day period per K.A.R. 40-1-34, 7. However the three homeowners claims cited in Standard #2 were the result of a lack of activity on the Company's part until either the insured or the claims supervisor pursued the claim settlement issue. It appears that the Company should review their claims procedures to insure prompt handling by the front line claims adjuster.

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by Patty McCollum and the staff of the Safeco Insurance Group.

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

Market Conduct Division

Lyle Behrens
Supervisor

Mary Lou Maritt
Market Conduct Examiner

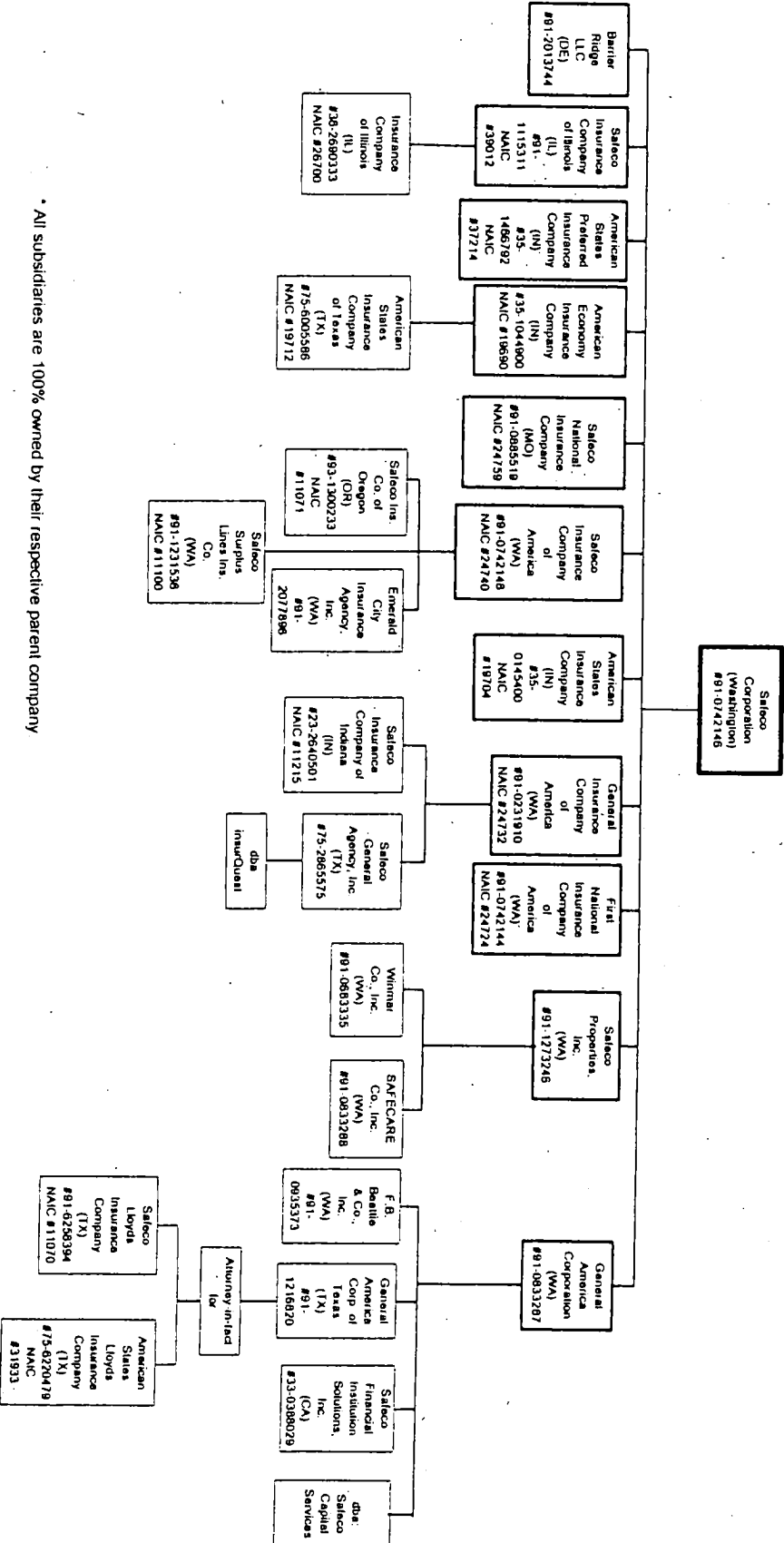
Tate Flott
Market Conduct Examiner

Respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM,
ARe

Table 1

SAFECO CORPORATION ORGANIZATIONAL AND ENTITY CHART



All subsidiaries are 100% owned by their respective parent company.

APPENDIX I

A. K.A.R. 40-1-34 - UNFAIR CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

Table of Contents

Section 1.	Authority
Section 2.	Scope
Section 3.	Definitions
Section 4.	File and Record Documentation
Section 5.	Misrepresentation of Policy Provisions.
Section 6.	Failure to Acknowledge Pertinent Communications.
Section 7.	Standards for Prompt Investigation of Claims.
Section 8.	Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers:
Section 9.	Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

Section 1. Authority

Section 1 is not adopted.

Section 2. Scope

This regulation applies to all persons and to all insurance policies and insurance contracts except policies of Workers' Compensation insurance. This regulation is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of K.S.A. 40-2404, and amendments thereto.

Section 3. Definitions

The definitions of "person" and of "insurance policy or insurance contract" contained in K.S.A. 40-2404, and amendments thereto shall apply to this regulation and, in addition, where used in this regulation:

- (a) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;
- (b) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;
- (c) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;
- (d) "Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract in this State;

(e) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

(f) "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(g) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer; and

(h) "Workers' Compensation" includes, but is not limited to, Longshoremen's and Harbor Workers' Compensation.

Section 4. File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

Section 5. Misrepresentation of Policy Provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(c) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(d) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(e) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

Section 6. Failure to Acknowledge Pertinent Communications

(a) Every insurer, upon receiving notification of a claim shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the

insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(b) Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within ten working days of notification of a claim shall constitute compliance with subsection (a) of this section.

Section 7. Standards for Prompt Investigation of Claim

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time.

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

(a) Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(b) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of this subsection. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(c) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(d) Section 8(d) is not adopted.

(e) An insurer shall not attempt to settle a loss with a first party claimant on the basis of a cash settlement which is less than the amount the insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

- (f) If a claim is denied for reasons other than those described in section 8(a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.
- (g) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.
- (h) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or a contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.
- (i) No insurer shall make statements which indicate the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

- (a) When the insurance policy provides, for the adjustment and settlement of automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:
 - (1) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the claimant, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.
 - (2) The insurer may elect to pay a cash settlement, based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost shall be determined by any source or method for determining statistically valid fair market value that meets both of the following criteria:
 - (A) The source or method's database, including nationally recognized automobile evaluation publications, shall provide values for at least eighty-five percent (85%) of all makes and models of private passenger vehicles for the last fifteen (15) model years taking into account the values for all major options for such vehicles; and
 - (B) The source, method, or publication shall provide fair market values for a comparable automobile based on current data available for the local market area as defined in subsection (j)(2).
 - (3) When an automobile total loss is settled on a basis which deviates from the methods and criteria described in subsection (a)(1) and (a)(2)(A) and (B) of this section, the deviation must be supported by documentation giving the

particulars of the automobile condition and the basis for the deviation. Any deviations from such cost, including deductions for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the claimant.

(b) Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's insurance policy or insurance contract.

(c) Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(e) If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.

(f) When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

(g) When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(h) Insurers shall include consideration of applicable taxes, license fees, and other fees incident to transfer of evidence of ownership in third party automobile total losses and shall have sufficient documentation relative to how the settlement was obtained in the claim file. A measure of damages shall be applied which will compensate third party claimants for the reasonable loss sustained as the proximate result of the insured's negligence.

(i) A claimant has the right of recourse if the claimant notifies the insurer, within thirty (30) days after the receipt of the claim draft, that claimant is unable to purchase a comparable automobile for the amount of the claim draft. Upon receipt of this notice, the insurer shall reopen its claim file within five (5) business days, and one of the following actions shall apply.

(1) the Insurer shall either pay the claimant the difference between the market value as determined by the insurer and the cost of the comparable vehicle of like kind and quality which the claimant has located, or negotiate and effect the purchase price of this vehicle for the claimant; or

(2) the insurer may elect to offer a replacement in accordance with provisions of subsection 9(a)(1).

(j) As used in this regulation the following terms shall have the following meanings:

(1) comparable automobile means a vehicle of the same make, model, year, style and condition, including all major options of the claimant vehicle;

(2) local market area means the fifty (50) mile area surrounding the place where the claimant vehicle was principally garaged.

B. KSA 40-2404. - Unfair methods of competition or unfair and deceptive acts or practices; disclosure of nonpublic personal information; rules and regulations

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

- (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- (b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- (c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- (d) refusing to pay claims without conducting a reasonable investigation based upon all available information;
- (e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;
- (f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;
- (g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;
- (h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;
- (i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;
- (j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;
- (k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

B. KSA 40-3110 - Payment of PIP benefits

(a) Except for benefits payable under any workmen's compensation law, which shall be credited against the personal injury protection benefits provided by subsection (f) of K.S.A. 40-3107, personal injury protection benefits due from an insurer or self-insurer under this act shall be primary and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued in compliance with this act. An insurer or self-insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the insurer's policy of motor vehicle liability insurance affords the coverage required by this act. No claim for personal injury protection benefits may be made after two (2) years from the date of the injury.

(b) Personal injury protection benefits payable under this act shall be overdue if not paid within thirty (30) days after the insurer or self-insurer is furnished written notice of the fact of a covered loss and of the amount of same, except that disability benefits payable under this act shall be paid not less than every two (2) weeks after such notice. If such written notice is not furnished as to the entire claim, any partial amounts supported by written notice is overdue if not paid within thirty (30) days after such written notice is furnished. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within thirty (30) days after such written notice is so furnished: Provided, That no such payment shall be deemed overdue where the insurer or self-insurer has reasonable proof to establish that it is not responsible for the payment, notwithstanding that written notice has been furnished. For the purpose of calculating the extent to which any personal injury protection benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of eighteen percent (18%) per annum.

C. KSA 40-2,126. - Interest Due On Insurance Settlements,

Except as otherwise provided by K.S.A. 40-447, 40-3110 and 44-512a, and amendments thereto, each insurance company, fraternal benefit society and any reciprocal or interinsurance exchange licensed to transact the business of insurance in this state which fails or refuses to pay any amount due under any contract of insurance within the time prescribed herein shall pay interest on the amount due. If payment is to be made to the claimant and the same is not paid within 30 calendar days after the amount of the payment is agreed to between the claimant and the insurer, interest at the rate of 18% per annum shall be payable from the date of such agreement. If payment is to be made to any other person for providing repair or other services to the claimant and the same is not paid within 30 calendar days following the date of completion of such services and receipt of the billing statement, interest at the rate of 18% per annum shall be payable on the amount agreed to between the claimant and the insurer from the date of receipt of the billing statement.

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