REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

MERCURY CASUALTY COMPANY

NAIC #11908

AS OF

DECEMBER 31, 2012

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Department of Insurance
State of Arizona
Market Oversight Division
Examinations Section
Telephone: (602) 364-4994
Fax: (602) 364-2505

JANICE K. BREWER
Governor

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
www.azinsurance.gov

GERMAINE L. MARKS
Director of Insurance

Honorable Germaine L. Marks
Director of Insurance
State of Arizona
2910 North 44th Street
Suite 210, Second Floor
Phoenix, Arizona 85108-7269

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, an examination has been made of the market conduct affairs of the:

MERCURY CASUALTY COMPANY
NAIC # 11908

The above examination was conducted by William Hobert, Examiner-in-Charge, and Market Conduct Examiner Laura Sloan-Cohen.

The examination covered the period of January 1, 2012 through December 31, 2012.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Helene I. Tomme

Helene I. Tomme, CPCU, CIE
Market Conduct Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

William P. Hobert being first duly sworn, states that I am a duly appointed Market Conduct Examinations Examiner-in-Charge for the Arizona Department of Insurance. That under my direction and with my participation and the participation of Market Conduct Examiner Laura Sloan-Cohen on the Examination of Mercury Casualty Company, hereinafter referred to as "the Company," was performed at the examiners' residences and the Company's claim office in Brea, CA. A teleconference meeting with appropriate Company officials was held to discuss this Report, but a copy was not provided to management as the Examination was incomplete and had not yet been finalized. The information contained in this Report, consists of the following pages, is true and correct to the best of my knowledge and belief and that any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

William P. Hobert

William P. Hobert, CPCU, CLU, CIE
Market Conduct Examiner-in-Charge
Market Oversight Division

Subscribed and sworn to before me this 22nd day of May, 2013.

Maribel C. Boydens
Notary Public

My Commission Expires March 1, 2014

MARIBEL C. BOYDENS
Notary Public - Arizona
Maricopa County
My Comm. Expires Mar 1, 2014

FOREWORD

This target market conduct examination report of Mercury Casualty Company (herein referred to as the "Company"), was prepared by employees of the Arizona Department of Insurance (Department) as well as independent examiners contracting with the Department. A target market conduct examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the state of Arizona. The examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158 and 20-159. The findings in this report, including all work product developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of the following Private Passenger Automobile (PPA) and Homeowner (HO) business operations:

1. Complaint Handling
2. Marketing and Sales
3. Producer Compliance
4. Underwriting and Rating
5. Declinations, Cancellations and Non-Renewals
6. Claims Processing

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The target market conduct examination of the Company covered the period of

January 1, 2012 through December 31, 2012 for business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws, and whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report and the results are reported beginning on page 7.

In accordance with Department procedures, the examiners completed a Preliminary Finding ("Finding") form on those policies, claims and complaints not in apparent compliance with Arizona law. The finding forms were submitted for review and comment to the Company representative designated by Company management to be knowledgeable about the files. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action.

The examiners utilized both examinations by test and examination by sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examinations by test and by sample were completed without the need to utilize computer software.

File sampling was based on a review of underwriting and claim files that were systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company. Samples are tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data will result in an exception ratio, which determines whether or not a standard is met. If the exception ratio found in the sample is, generally less than 5%, the standard will be considered as "met." The standard in the areas of procedures and forms use will not be met if any exception is identified.

HISTORY OF THE COMPANY

The Company is a wholly-owned subsidiary of Mercury General Corporation, a publicly-traded (symbol MCY) holding Company domiciled in the state of California. The Company was incorporated in California on January 6, 1961, by its founder Mr. George Joseph, who is still the Company's Chairman. The Company commenced writing business on April 6, 1962. The Company is licensed and domiciled in the state of California and markets its products exclusively through the independent agency system. The Company primarily underwrites all

risk classifications of PPA in California and selected other states. The Company began writing PPA in Arizona in 2004, and HO in 2009.

The Company owns Mercury Insurance Services LLC (MIS), a management services Company formed in 2000 to manage the business of the insurers in the holding Company system. In 2009, the Company acquired AIS Management, LLC, and its two wholly-owned insurance agencies, Auto Insurance Specialists, LLC, and PoliSeek AIS Insurance Solutions, Inc. (collectively "AIS"). The AIS subsidiaries are independently managed, and conduct business in multiple states.

PROCEDURES REVIEWED WITHOUT EXCEPTION

The examiners' review of the following Company departments[1] or functions indicates that they appear to be in compliance with Arizona statutes and rules:

Complaint Handling Marketing and Sales Producer Compliance

EXAMINATION REPORT SUMMARY

The examination revealed eight (8) compliance issues that resulted in forty-five (45) exceptions due to the Company's failure to comply with statutes and rules that govern all insurers operating in Arizona. These issues were found in three (3) of the six (6) sections of Company operations examined. The following is a summary of the examiners' findings:

Underwriting and Rating

In the area of Underwriting and Rating, one (1) compliance issue is addressed in this report as follows:

- The Company failed to notify twelve (12) PPA insureds that the reason for their policy's premium increase was an at-fault accident.

Declinations, Cancellations and Non-Renewals

In the area of Cancellations and Non-renewals, three (3) compliance issues are addressed in this report as follows:

[1] If a department name is listed there were no exceptions noted during the review.

- The Company failed to provide one (1) PPA insured their non-renewal notice at least forty-five (45) days before expiration.
- The Company failed to provide two (2) PPA insureds the specific facts that were the basis for their non-renewal.
- The Company failed to provide three (3) insureds whose policies were canceled after being in effect more than sixty (60) days and ten (10) insureds that received non-renewal notices the specific facts that were the basis for Company's action.

Claims Processing

In the area of Claims Processing, four (4) issues are addressed in this report as follows:

- The Company failed to accurately identify the state statute and/or Insurance Department in its claim correspondence with six (6) claimants.
- The Company failed on two (2) claim authorization forms to specify the length of time the authorization remains valid shall be no longer than the duration of the claim.
- The Company failed on two (2) claim authorization forms to advise the individual or a person authorized to act on behalf of the individual they are entitled to receive a copy of the authorization form.
- The Company failed to correctly calculate and fully pay the transaction privilege tax (TPT) on seven (7) first party real property losses.

FACTUAL FINDINGS

RESULTS OF PREVIOUS MARKET EXAMINATIONS

During the past three (3) years, Virginia conducted and finalized a market conduct examination of the Company.

FACTUAL FINDINGS

UNDERWRITING AND RATING

Private Passenger Automobile (PPA):

The examiners reviewed:

(1) 100 PPA new business and/or renewal policies from a population of 17,398; and

(2) fifty (50) PPA surcharged policies from a population of 3,881.

Homeowners (HO):

The examiners reviewed 100 HO new business and/or renewal policies from a population of 5,179.

The following Underwriting and Rating Standards were met:

#	STANDARD	Regulatory Authority
1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company Rating Plan.	A.R.S. §§ 20-341 through 20-385
3	All forms and endorsements forming a part of the contract should be filed with the director, if applicable.	A.R.S. § 20-398
4	All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations, including, but not limited to, the Notice of Insurance Information Practices and the Authorization for Release of Information.	A.R.S. §§ 20-2104, 20-2106, 20-2110, 20-2113
5	Policies and endorsements are issued or renewed accurately, timely and completely.	A.R.S. §§ 20-1120, 20-1121, 20-1632, 20-1654
6	Rescissions are not made for non-material misrepresentations.	A.R.S. §§ 20-463, 20-1109

The following Underwriting and Rating Standard failed:

#	STANDARD	Regulatory Authority
2	Disclosures to insureds concerning rates and coverage are accurate and timely.	A.R.S. §§ 20-259.01, 20-262, 20-263, 20-264, 20-266, 20-267, 20-2110

Preliminary Findings #2 – No At-Fault Accident Premium Increase Disclosure - The Company failed to notify twelve (12) insureds that the reason for their policy's premium increase was an at-fault accident. These represent twelve (12) violations of A.R.S. § 20-263.

PPA SURCHARGED POLICIES

Failed to notify insured policy premium increase due to an at-fault accident

Violation of A.R.S. § 20-263

Population	Sample	# of Exceptions	% to Sample
3,881	50	12	24%

A 24% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #1

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure policyholders are notified that the reason for their policy's premium increase is due to an at-fault accident, in accordance with applicable statutes.

FACTUAL FINDINGS

DECLINATIONS, CANCELLATIONS AND NON-RENEWALS

Private Passenger Automobile (PPA):

The examiners reviewed:

(1) fifty (50) PPA non-payment cancellations from a population of 824;
(2) both PPA non-renewals; and
(3) fifty (50) PPA underwriting cancellations from a population of 112.

Homeowner (HO):

The examiners reviewed:

(1) fifty (50) HO non-payment cancellations from a population of 429;
(2) all twenty-three (23) HO nonrenewals; and
(3) fifty (50) HO underwriting cancellations from a population of 285.

The following Declination, Cancellation and Non-Renewal Standard passed:

#	STANDARD	Regulatory Authority
1	Declinations, Cancellations and Non-Renewals shall comply with state laws and Company guidelines including the Summary of Rights to be given to the applicant and shall not be unfairly discriminatory.	A.R.S. §§ 20-448, 20-2108, 20-2109, 20-2110

The following Declination, Cancellation and Non-Renewal Standard failed:

#	STANDARD	Regulatory Authority
2	Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, and shall not be unfairly discriminatory.	A.R.S. §§ 20-191, 20-443, 20-448, 20-1631, 20-1632, 20-1632.01, 20-1651 through 20-1656

Preliminary Finding #4 – Late PPA Non-Renewal Notice - The Company failed to provide one (1) PPA policyholder their non-renewal notice at least forty-five (45) days before the expiration date. This represents one (1) violation of A.R.S. § 20-1632(A).

PPA NON-RENEWALS

Failed to provide non-renewal notice at least forty-five (45) days before expiration date
Violation of A.R.S. § 20-1632(A) and policy provisions

Population	Sample	# of Exceptions	% to Sample
2	2	1	50%

A 50% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #2

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure PPA insureds receive notices of non-renewal at least forty-five (45) days before the expiration date. in accordance with the applicable state statute.

Preliminary Finding #5 – Nonspecific PPA Non-Renewal Reason - The Company failed to provide both PPA insureds the specific facts that were the basis for the non-renewal due to underwriting reasons. These represent two (2) violations of A.R.S. § 20-1632(A)(1).

PPA NON-RENEWALS

Failed to provide specific reason for non-renewal

Violation of A.R.S. § 20-1632(A)(1)

Population	Sample	# of Exceptions	% to Sample
2	2	2	100%

A 100% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #3

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure the Company provides recipients of PPA non-renewals the specific reason for the Company's action, in accordance with the applicable state statutes.

Preliminary Findings #6 – Nonspecific HO Termination Reason - The Company failed to provide three (3) recipients of HO underwriting cancellation notices, after their policy was in effect more than sixty (60) days, and ten (10) HO insureds receiving non-renewal notices, the specific facts that were the basis for the Company's action. These represent thirteen (13) violations of A.R.S. § 20-1653.

HO MID-TERM CANCELLATIONS & NON-RENEWALS

Failed to provide specific reason for policy termination

Violation of A.R.S. § 20-1653

Population	Sample	# of Exceptions	% to Sample
301	66	13	19.7%

A 19.7% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Recommendation #4

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure underwriting cancellation notices for policies in force more than sixty (60) days from inception and non-renewal notices include the specific reason for the Company's action, in accordance with the applicable state statutes.

FACTUAL FINDINGS

CLAIM PROCESSING

Private Passenger Automobile (PPA):

The examiners reviewed:

(1) fifty (50) PPA claims closed without payment (CWP) from a population of 339;
(2) fifty (50) PPA paid claims from a population of 2,341;
(3) fifty (50) PPA paid total loss claims from a population of 128; and
(3) fifty (50) PPA subrogated claims from a population of 287.

Homeowner (HO):

The examiners reviewed:

(1) all fifty-seven (57) HO claims CWP;
(2) all seventy-nine (79) HO paid claims; and
(3) the only HO subrogated claim.

The following Claim Processing Standards were met:

#	STANDARD	Regulatory Authority
1	The initial contact by the Company with the claimant is within the required time frame.	A.R.S. § 20-461, A.A.C. R20-6-801
2	Timely investigations are conducted.	A.R.S. § 20-461, A.A.C. R20-6-801
4	Claim files are adequately documented in order to be able to reconstruct the claim.	A.R.S. §§ 20-461, 20-463, 20-466.03, A.A.C. R20-6-801
6	The Company uses reservation of rights and excess of loss letters, when appropriate.	A.R.S. § 20-461, A.A.C. R20-6-801
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner.	A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801
8	The Company responds to claim correspondence in a timely manner.	A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801
9	Denied and closed without payment claims are handled in accordance with policy provisions and state law.	A.R.S. §§ 20-461, 20-462, 20-463, 20-466, 20-2110, A.A.C. R20-6-801
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented.	A.A.C. R20-6-801
11	Adjusters used in the settlement of claims are properly licensed.	A.R.S. §§ 20-321 through 20-321.02

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
3	The Company's claim forms are appropriate for the type of product and comply with statutes, rules and regulations..	A.R.S. §§ 20-461, 20-466.03, 20-2106, A.A.C. R20-6-801

Preliminary Finding #7 – Incorrect Statute / Insurance Department Reference – The Company failed to accurately identify the state statutes and/or Insurance Department in its correspondence with six (6) claimants. Each form contained a California fraud warning statement. Reference to an incorrect or conflicting statute or Insurance Department in correspondence is misleading and deceptive. These represent six (6) violations of A.R.S. § 20-461(A)(1).

The following table summarizes these findings:

	Form Title / Description	Form #
1	Affidavit of Loss	None
2	Property Inventory List	None
3	Additional Living Expense Worksheet	None
4	Affidavit of Loss	None
5	Property Inventory List	None
6	Schedule of Contents	None

CLAIM FORMS

Failed to correctly reference statutes or Insurance Department in correspondence with claimants
Violation of A.R.S. § 20-461(A)(1)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	6	N/A

Any error does not meet the Standard; therefore a recommendation is warranted.

Subsequent Event

The Company during the exam explained they had independently identified this problem early in the exam period and it was corrected at that time.

Preliminary Finding #8 – Authorization Disclosures – On two (2) claim authorization forms shown in the table below, the Company failed to:

(a) specify the authorization remains valid for no longer than the duration of the claim; and
(b) advise the individual or a person authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form.

These forms fail to comply with A.R.S. § 20-2106(8)(b) and (9) and represent four (4) violations of the statute. The following table summarizes these authorization form findings.

Form Description / Title	Form #	Statute Provision
Wage Authorization (4 pages including cover letter)	None	8(b) and 9
Authorization for Release and/or Disclosure of Medical Information	C7A	8(b) and 9

CLAIM FORMS

Failed to specify the authorization remains valid for no longer than the duration of the claim
Violation of A.R.S. § 20-2106(8)(b)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	2	N/A

Any form error does not meet the Standard; therefore a recommendation is warranted.

Failed to advise the individual or a person authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form
Violation of A.R.S. § 20-2106(9)

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	2	N/A

Any form error does not meet the Standard; therefore a recommendation is warranted.

Subsequent Event

The Company before the close of the exam provided examiners with corrected, conforming copies of both forms.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	A.R.S. §§ 20-268 20-461, 20-462, 20-468, 20-469, A.A.C. R20-6-801

Preliminary Findings #9 – Incorrect Transaction Privilege Tax (TPT) - The Company failed to accurately calculate and fully pay the correct transaction privilege tax (TPT) on seven (7) HO first party real property losses. These represent seven (7) violations of A.R.S. §§20-461(A)(6) and 44-1201.

HO PAID LOSSES

Failed to correctly calculate and pay TPT with real property losses
Violation of A.R.S. § 20-461(A)(6) and A.R.S. § 44-1201

Population	Sample	# of Exceptions	% to Sample
79	79	7	8.9%

An 8.9% error ratio does not meet the Standard; therefore a recommendation is warranted.

Recommendation #5

Within 90 days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company correctly calculates and fully pays any transaction privilege tax owed any first party claimant in the settlement of real property losses, in accordance with applicable state statutes and regulations.

Subsequent Event

The Company before the close of the exam paid restitution to all claimants that totaled $268.98, including $24.46 interest.

SUMMARY OF FAILED STANDARDS

EXCEPTION	Rec. No.	Page No.
UNDERWRITING & RATING		
Standard #2 Disclosures to insureds concerning rates and coverage are accurate and timely.	1	12
DECLINATIONS, CANCELLATIONS & NON-RENEWALS		
Standard #2 Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, and shall not be unfairly discriminatory.	2, 3, & 4	15
CLAIM PROCESSING		
Standard #5 Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	5	20

SUMMARY OF PROPERTY AND CASUALTY STANDARDS

A. Complaint Handling

#	STANDARD	PASS	FAIL
1	The Company takes adequate steps to finalize and dispose of the complaints in accordance with applicable statutes, rules, regulations and contract language. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	The time frame within which the Company responds to complaints is in accordance with applicable statutes, rules and regulations. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

B. Marketing and Sales

#	STANDARD	PASS	FAIL
1	All advertising and sales materials are in compliance with applicable statutes, rules and regulations. (A.R.S. §§ 20-442 and 20-443)	X	

C. Producer Compliance

#	STANDARD	PASS	FAIL
1	The producers are properly licensed in the jurisdiction where the application was taken. (A.R.S. §§ 20-282, 20-286, 20-287, 20-311 through 311.03)	X	
2	An insurer shall not pay any commission, fee, or other valuable consideration to unlicensed producers. (A.R.S. § 20-298)	X	

D. Underwriting and Rating

#	STANDARD	PASS	FAIL
1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company Rating Plan. (A.R.S. §§ 20-341 through 20-385)	X	
2	Disclosures to insureds concerning rates and coverage are accurate and timely. (A.R.S. §§ 20-259.01, 20-262, 20-263, 20-264, 20-266, 20-267, 20-2110)		X
3	All forms and endorsements forming a part of the contract should be filed with the director (if applicable). (A.R.S. § 20-398)	X	

#	STANDARD	PASS	FAIL
4	All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations, including, but not limited to, the Notice of Insurance Information Practices and the Authorization for Release of Information. (A.R.S. §§ 20-2104, 20-2106, 20-2110 and 20-2113)	X	
5	Policies and endorsements are issued or renewed accurately, timely and completely. (A.R.S. §§ 20-1120, 20-1121, 20-1632, 20-1654)	X	
6	Rescissions are not made for non-material misrepresentations. (A.R.S. §§ 20-463 and 20-1109)	X	

E. Declinations, Cancellations and Non-Renewals

#	STANDARD	PASS	FAIL
1	Declinations, Cancellations and Non-Renewals shall comply with state laws and Company guidelines including the Summary of Rights to be given to the applicant and shall not be unfairly discriminatory. (A.R.S. §§ 20-448, 20-2108, 20-2109 and 20-2110)	X	
2	Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, nonrenewal based on condition of premises, and shall not be unfairly discriminatory. (A.R.S. §§ 20-191, 20-443, 20-448, 20-1631, 20-1632, 20-1632.01, 20-1651 through 20-1656)		X

F. Claim Processing

#	STANDARD	PASS	FAIL
1	The initial contact by the Company with the claimant is within the required time frame. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	Timely investigations are conducted. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
3	The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations. (A.R.S. §§ 20-461, 20-466.03, 20-2106, A.A.C. R20-6-801)		X

#	STANDARD	PASS	FAIL
4	Claim files are adequately documented in order to be able to reconstruct the claim. (A.R.S. §§ 20-461, 20-463, 20-466.03, A.A.C. R20-6-801)	X	
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. (A.R.S. §§ 20-268, 20-461, 20-462, 20-468, 20-469, A.A.C. R20-6-801)		X
6	The Company uses reservation of rights and excess of loss letters, when appropriate. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	
8	The Company responds to claim correspondence in a timely manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	
9	Denied and closed without payment claims are handled in accordance with policy provisions and state law. (A.R.S. §§ 20-461, 20-462, 20-463, 20-466, 20-2110, A.A.C. R20-6-801)	X	
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented. (A.A.C. R20-6-801)	X	
11	Adjusters used in the settlement of claims are properly licensed. (A.R.S. §§ 20-321 through 20-321.02)	X	