STATE OF ARIZONA
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DEPT. OF INSURANCE

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

AMERICAN SUMMIT INSURANCE COMPANY

NAIC #19623

AS OF

DECEMBER 31, 2011

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

Dear Director Marks:

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:

AMERICAN SUMMIT INSURANCE COMPANY
NAIC # 19623

The above examination was conducted by William Hobert, Examiner-in-Charge, and Market Conduct Examiner Robert DeBerge.

The examination covered the period of January 1, 2011 through December 31, 2011.

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 Robert DeBerge on the Examination of American Summit Insurance Company, hereinafter referred to as the "Company" was performed at the examiners' residences. 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 5th day of September, 2012.

Pamela Burleigh
Notary Public

My Commission Expires March 21, 2016

Pamela Burleigh
NOTARY PUBLIC - ARIZONA
MARICOPA COUNTY
My Commission Expires
March 21, 2016

FOREWORD

This target market conduct examination report of American Summit Insurance 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 Manufactured Home (MH), Homeowner (HO) and Residential Dwelling (DW) 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, 2011 through December 31, 2011 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.

On September 10, 2002, the Company entered into Consent Order, Docket No. 02A-158-INS, wherein the Company agreed to cease and desist from certain business practices found to have violated Arizona insurance laws.

HISTORY OF THE COMPANY

The Company was incorporated as a Minnesota corporation 12/15/55. The Company operated as Arrow Insurance Company until 9/25/70, when the title Summit Home Insurance Company was adopted. The present name of the Company was accepted January 1990. The Company was purchased by Guide One 4/1/99. During 2000, J.E. Murphy and C. Clifton Robinson formed NLASCO, Inc., a Delaware holding company for the purpose of acquiring both

the Company and National Lloyds. The acquisition was completed 12/31/00. In February 2007, Hilltop Holdings (formerly Affordable Residential Communities, Inc.) purchased all of the Company's and its affiliates' stock. Hilltop Holdings is publicly traded on the New York Stock Exchange under symbol HTH. NLASCO, INC., a Hilltop Holdings subsidiary, holds complete control of the Company. Company headquarters are in Waco, Texas.

The Company targets underserved markets that require underwriting expertise. The Company's largest line of business in Arizona is manufactured homeowners. Arizona admitted the Company as a property and casualty insurer 8/22/66. In addition, the Company is authorized to transact business in thirty-six (36) other states. However, the Company actively writes business in only thirteen (13) states and over ninety percent (90%) of that business is concentrated in three (3) states - Arizona, Louisiana and Nevada.

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 158 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 issues are addressed in this report as follows:

- The Company failed to accurately determine one (1) MH policy's premium.

Declinations, Cancellations and Non-Renewals

In the area of Declinations, Cancellations and Non-renewals, one (1) compliance issue is addressed in this report as follows:

- The Company failed to provide a Summary of Rights to all seventy-eight (78) recipients of an underwriting cancellation and all fifty (50) insureds receiving non-renewal notices.

Claims Processing

In the area of Claims Processing, six (6) compliance issues are addressed in this report as follows:

- The Company failed on three (3) claim forms to have a fraud warning statement.
- The Company failed to advise on one (1) claim authorization form that the authorization shall remain valid for no longer than the duration of the claim.
- The Company failed to advise on one (1) claim authorization form that the individual and persons authorized to act on behalf of the individual were entitled to receive a copy of the authorization form.
- The Company failed to return to seven (7) claimants the proportionate amount of their policy deductible after full or partial recovery.
- The Company failed to promptly return two (2) insureds' deductibles after recovery from at-fault parties.
- The Company failed to disclose to fifteen (15) first party claimants all pertinent benefits, coverages or other policy provisions when their claims were presented.

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

FACTUAL FINDINGS

RESULTS OF PREVIOUS MARKET EXAMINATIONS

During the past three (3) years, no jurisdiction conducted a market conduct examination of the Company.

FACTUAL FINDINGS

UNDERWRITING AND RATING

Manufactured Homes (MH):

The examiners reviewed 100 new and/or renewal policies from a population of 32,334.

Homeowners (HO):

The examiners reviewed fifty (50) renewal policies from a population of 809.

Residential Dwelling (DW):

The examiners reviewed fifty (50) new and/or renewal policies from a population of 3,577.

The following Underwriting and Rating Standards were met:

#	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
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
6	Rescissions are not made for non-material misrepresentations.	A.R.S. §§ 20-463, 20-1109

The following Underwriting and Rating Standard passed with comment:

#	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

Preliminary Finding #9 – Incorrect Premium Calculation - The Company failed to accurately determine the premium for one (1) MH policy. This represents one (1) violation of A.R.S. § 20-385.

NEW / RENEWAL POLICIES

Failed to accurately determine policy premium

Violation of A.R.S. § 20-385

Population	Sample	# of Exceptions	% to Sample
33,143	40	1	2.5%

A 2.5% error ratio does meet the Standard; therefore, a recommendation is not warranted.

Subsequent Event

The Company on 8/20/12 paid the policyholder restitution of $16.00, which included no interest.

FACTUAL FINDINGS

DECLINATIONS, CANCELLATIONS AND NON-RENEWALS

All Property Program Non-Payment Cancellations:

The examiners reviewed fifty (50) non-payment cancellations from a total population of 4,304.

All Property Program Non-Renewals:

The examiners reviewed fifty (50) non-renewals from a total population of 437.

All Property Program Underwriting Cancellations:

The examiners reviewed all eight-six (86) underwriting cancellations.

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

#	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

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

#	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 and 20-2110

Preliminary Finding #6 – No Summary of Rights - The Company failed to provide a Summary of Rights to seventy-eight (78) recipients of an underwriting cancellation and all fifty (50) insureds receiving a non-renewal. These represent 128 violations of A.R.S. § 20-2110.

UNDERWRITING CANCELLATIONS & NON-RENEWALS

Failed to provide a Summary of Rights to insureds receiving policy termination due to an adverse underwriting decision

Violation of A.R.S. § 20-2110

Population	Sample	# of Exceptions	% to Sample
523	128	128	100%

A 100% 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 a Summary of Rights is provided to all insureds, in accordance with the applicable statutes, when their policies are cancelled or non-renewed due to an adverse underwriting decision.

FACTUAL FINDINGS

CLAIM PROCESSING

All Property Claims Paid:

The examiners reviewed fifty (50) paid claims from a total population of 4,336.

All Property Claims Closed Without Payment (CWP):

The examiners reviewed fifty (50) claims closed without payment from a total population of 649.

All Property Claims Subrogated:

The examiners reviewed all thirteen (13) subrogated claims.

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
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
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
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
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 #1 – Fraud Warning Statement – The Company failed to provide a fraud warning statement in at least twelve (12) point type on three (3) claim forms. These represent three (3) violations of A.R.S. § 20-466.03. The following table summarizes the fraud warning statement findings.

	Specimen Form / Letter Description	Form #	Att. A #
1	Cause of Loss Questionnaire and Affidavit	None	V.C.3.
2	Schedule of Contents	None	V.C.3.
3	Burglary/Theft Loss Statement	None	V.C.3.

CLAIM FORMS

Failed to provide fraud warning statement in at least twelve (12) point type

Violation of A.R.S. § 20-466.03

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	3	N/A

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

Recommendation #2

Within ninety (90) days of the filed date of this report, provide documentation to the Department that the required fraud warning statement, in 12-point type, is included on each of the claim forms cited, in accordance with the applicable state statute.

Preliminary Finding #2 – Authorization Disclosure – On the Company's Authorization to Obtain Information form, the Company failed to advise:

(a) the authorization remains valid for no longer than the duration of the claim; and
(b) 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.

The form fails to comply with A.R.S. § 20-2106(8)(b) and (9) and represents two (2) violations of the statute.

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	1	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	1	N/A

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

Recommendation #3

Within ninety (90) days of the filed date of this report, provide documentation to the Department that this form advises:

(a) that the authorization remains valid for no longer than the duration of the claim; and

(b) that the individual or a person authorized to act on behalf of the individual that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form,

in accordance with the applicable state statute.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner.	A.R.S. §§ 20-461, 20-462

Preliminary Findings #4 & #5 – Proportionate Reimbursement after Recovery – The Company failed to:

(a) return the proportionate amount of seven (7) insureds' deductibles, and

(b) promptly reimburse the full amount of two (2) insureds' deductibles,

after full or partial recovery from at-fault parties. These represent nine (9) violations of A.R.S. §§ 20-220(A)(2), 20-462 and seven (7) violations of the prior Consent Order.

SUBROGATION RECOVERY

Failed to completely and/or promptly reimburse the proportionate amount of deductible after full or partial recovery

Violation of A.R.S. §§ 20-220(A)(2), 20-462 and prior Consent Order

Population	Sample	# of Exceptions	% to Sample
13	13	9	69.2%

A 69.9% error ratio not does meet the Standard; therefore a recommendation is warranted

Recommendation #4

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 fully and promptly reimburses insureds the proportionate share of their deductible after full or partial subrogation recovery, in accordance with applicable state statutes and regulations. In addition, The Company must provide the Department with documentation of restitution paid to the seven (7) claimants cited under PF#4. Documentation should include copies of all refund letters and checks (including interest) sent to these insureds and a summary worksheet.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
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.R.S. § 20-461, A.A.C. R20-6-801

Preliminary Finding #7 – Claim Benefit Explanation – The Company failed to fully disclose to fifteen (15) first party claimants all benefits, coverages or other provisions of their insurance policies when a claim was presented. These represent fifteen (15) violations of A.A.C. R20-6-801(D)(1).

PAID LOSSES

Failed to disclose all benefits, coverages or other provisions to first party claimants
Violation of A.A.C. R20-6-801(D)(1)

Population	Sample	# of Exceptions	% to Sample
4,336	50	15	30%

A 30% error ratio not does 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 explains all benefits, coverages and other provisions to first party claimants when their claims are presented, in accordance with applicable state statutes and regulations.

SUMMARY OF FAILED STANDARDS

EXCEPTION	Rec. No.	Page No.
DECLINATIONS, CANCELLATIONS & NON-RENEWALS		
Standard #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.	1	14
CLAIM PROCESSING		
Standard #3 The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations.	2 & 3	17 & 18
Standard #7 Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner.	4	18
Standard #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.	5	19

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	

#	STANDARD	PASS	FAIL
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	
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. §§ 20-157, 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 and 20-1121)	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, and shall not be unfairly discriminatory. (A.R.S. §§ 20-191, 20-443, 20-448, 20-1631, 20-1632, 20-1632.01)	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.R.S. § 20-461, 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	