STATE OF ARIZONA
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DEPT. OF INSURANCE

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

CALIFORNIA CASUALTY INDEMNITY EXCHANGE

NAIC #20117

AS OF

December 31, 2007

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Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street
Suite 210, Second Floor
Phoenix, Arizona 85108-7256

Dear Director Urias:

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

CALIFORNIA CASUALTY INDEMNITY EXCHANGE
NAIC #20117

The above examination was conducted by Helene I. Tomme, CPCU, CIE, Market Examinations Supervisor, Examiner-in Charge, and Linda L. Hofman, AIE, MCM, FLMI, AIRC, CCP, Market Conduct Senior Examiner and Christopher G. Hobert, CIE, MCM, FLMI, AIRC, CCP, Market Conduct Senior Examiner.

The examination covered the period of January 1, 2007 through December 31, 2007.

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

Sincerely yours,

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

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

Helene I. Tomme, CPCU, CIE being first duly sworn, states that I am a duly appointed Market Examinations Examiner-in-Charge for the Arizona Department of Insurance. That under my direction and with my participation and the participation of Linda L. Hofman, AIE, MCM, FLMI, AIRC, CCP, Market Conduct Senior Examiner and Christopher G. Hobert, CIE, MCM, FLMI, AIRC, CCP, Market Conduct Senior Examiner on the Examination of California Casualty Indemnity Exchange, hereinafter referred to as the "Company" was performed at the office of the Arizona Department. A teleconference meeting with appropriate Company officials in San Mateo, California, Colorado Springs, Colorado and Glendale, Arizona 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.

Helene J. Tomme

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

Subscribed and sworn to before me this 8th day of January, 2009.

Elizabeth L. Sickinger
Notary Public

My Commission Expires Jan. 17, 2009

OFFICIAL SEAL
ELIZABETH L. SICKINGER
NOTARY PUBLIC-STATE OF ARIZONA
MARICOPA COUNTY
My Comm. Expires Jan. 17, 2009

FOREWORD

This targeted market conduct examination report of California Casualty Indemnity Exchange (herein referred to as, "CCIE", or the "Company"), was prepared by employees of the Arizona Department of Insurance (Department) as well as independent examiners contracting with the Department. A 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 Personal Automobile (PPA) and Homeowners (HO) lines of business operations:

1. Complaint Handling
2. Marketing and Sales
3. Producer Compliance
4. Underwriting and Rating
5. 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 market examination of the Company covered the period of January 1, 2007 through December 31, 2007 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 9.

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, examination 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 form use will not be met if any exception is identified.

HISTORY OF THE COMPANY

(Provided by the Company)

California Casualty Indemnity (CCIE) is a California reciprocal interinsurance exchange. California Casualty Management Company (CCMC) has been attorney-in-fact of CCIE since 1917. In October of 1967, CCIE founded and purchased 100% of the issued and outstanding shares of common stock of California Casualty Insurance Company (CCIC). In July of 1973, CCIC founded and purchased 100% of the issued and outstanding shares of common stock of California Casualty & Fire Insurance Company (CCFIC). In September of 1977, CCIC founded and purchased 100% of the issued and outstanding shares of common stock of California Casualty General Insurance Company (CCGIC), a California domestic stock insurer. Effective February 7, 2005 this company re-domiciled to Oregon and changed its name to California Casualty General Insurance Company of Oregon. In October of 1990, CCIE founded and purchased 100% of the issued and outstanding shares of common stock of California Casualty Compensation Insurance Company (CCCIC). Collectively the five companies comprise the California Casualty Group (CCG), NAIC#33.

The business and affairs of CCIC, CCFIC, CCGIC and CCCIC are managed pursuant to management agreements with CCMC. CCIE, CCFIC, CCGIC and CCIC all market only Private Passenger Automobile (PPA) and Homeowners lines in the states in which they do business. Some of the companies wrote Workers' Compensation insurance in the past, but all Workers' Compensation writings ceased in 1998.

CCG's underwriting emphasis is on insuring preferred risk members of affinity groups, most of which are educator and public safety associations and credit unions. Production and operating facilities are provided by CCMC. Management facilities, sales, underwriting and claims personnel, as well as the principal and branch offices are provided by CCMC. In addition to the home office in San Mateo, California, CCMC maintains Service Centers in Colorado Springs, Colorado (CSC); Glendale, Arizona (ASC); and Leawood, Kansas (KSC).

Over the years, CCG has been successful in providing quality protection and service to an expanding number of group members. This success is evidenced by the long-term nature of the relationships with participating affinity groups in the education, law enforcement and public safety areas. For example, since 1982, the Arizona Teachers Association has sponsored California Casualty's personal lines insurance for its members.

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	Underwriting and Rating

EXAMINATION REPORT SUMMARY

The examination revealed two (2) compliance issues that resulted in 69 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 two (2) of the six (6) sections of Company operations examined. The following is a summary of the Examiners' findings:

Cancellation and Non Renewals

In the area of Cancellations and Non Renewals, one (1) compliance issue is addressed in this Report as follows:

- The Company failed to include adequate Summary of Rights language on three (3) PPA Non Renewals, 22 HO Cancellations for underwriting reasons and 34 HO Non Renewal notices for a total of 59 policyholders/insureds cancelled or non renewed for an adverse underwriting decision.

Claims Processing

In the area of Claims Processing, one (1) compliance issue is 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 include a fraud warning statement on nine (9) claim forms and the fraud warning statement in at least 12-point type on one (1) claim form for a total of 10 documents.

FACTUAL FINDINGS

RESULTS OF PREVIOUS MARKET CONDUCT EXAMINATIONS

During the past four (4) years, there were four (4) Market Conduct Examinations completed by the states of Arizona, California, Connecticut and Pennsylvania. There were no significant patterns of non-compliance noted.

CANCELLATIONS AND NON-RENEWALS

Private Passenger Automobile (PPA):

The Examiners reviewed seven (7) PPA cancellation files for non-pay/declinations (including 2 sample files) out of a population of seven (7), and three (3) PPA non renewal files (including 2 sample files) out of a population of three (3). This cancellation/non renewal review included a total sample size of 10 PPA files from a total population of 10.

Homeowners (HO):

The Examiners reviewed 54 HO cancellation/declination files for non-pay/declinations (including 4 sample files) and 22 HO cancellation files for underwriting reasons (including 1 sample files) out of a population of 198, and 34 HO non renewal files (including 1 sample file) out of a population of 34. This cancellation/non renewal review included a total sample size of 111 HO files from a total population of 232.

All cancellation and nonrenewal files were reviewed to ensure compliance with Arizona Statutes and Rules.

The following Cancellation and Non Renewal Standard was met:

#	STANDARD	Regulatory Authority
2	Cancellation 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

The following 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 policyholder and shall not be unfairly discriminatory.	A.R.S. §§ 20-448, 20-2108, 20-2109, 20-2110

Preliminary Finding 001 – Summary of Rights – The Company failed to provide policyholders with the required Summary of Rights, when terminating coverage for an adverse underwriting decision on three (3) PPA non renewals, 22 HO cancellations/declinations and 34 HO non renewals for a total of 59; in violation of A.R.S. §§ 20-2108, 20-2109 and 20-2110.

PRIVATE PASSENGER AUTOMOBILE NON RENEWALS

Failed to include Summary of Rights in the event of an adverse underwriting decision
A.R.S. §§ 20-2108, 20-2109 and 20-2110

Population	Sample	# of Exceptions	% to Sample
3	3	3	100%

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

HOMEOWNERS' CANCELLATIONS

Failed to include Summary of Rights in the event of an adverse underwriting decision
A.R.S. §§ 20-2108, 20-2109 and 20-2110

Population	Sample	# of Exceptions	% to Sample
22	22	22	100%

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

HOMEOWNERS' NON RENEWALS

Failed to include Summary of Rights in the event of an adverse underwriting decision
A.R.S. §§ 20-2108, 20-2109 and 20-2110

Population	Sample	# of Exceptions	% to Sample
34	34	34	100%

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

Recommendation #1

Within 90 days of the filed date of this report provide the Department with documentation that Company procedures are in place so that the required Summary of Rights is sent with all cancellation, non renewal or declination notices that involve an adverse underwriting decision by the Company. Also, re-submit cancellation and non renewal notices with the required language to the Department for approval.

Subsequent Events: During the course of the Phase I Examination, the Company agreed with the Examiner's findings and submitted cancellation and non renewal notices with the required Summary of Rights language.

CLAIMS PROCESSING

Private Passenger Automobile (PPA):

The Examiners reviewed 22 PPA claims closed without payment from a population of 28; six (6) PPA Bodily Injury claims closed without payment from a population of six (6); 50 PPA paid claims from a population of 70; 18 PPA paid Bodily Injury claims from a population of 18; 2 total loss PPA claims out of a population of 2 and 30 PPA subrogation claims out of a population of 30. This claim review included a total sample size of 128 PPA claims files from a total population of 154.

Homeowners (HO):

The Examiners reviewed 52 HO claims closed without payment (including 2 sample files) from a population of 129; 51 HO paid claims (including 1 sample file) from a population of 365 and 5 HO subrogation claims out of a population of 5. This claim review included a total sample size of 108 HO claims files from a total population of 499.

All claim files were reviewed to ensure compliance with Arizona Statutes and Rules.

The Following Claim 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, 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 insureds 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 claimants 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 Standards failed:

#	STANDARD	Regulatory Authority
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

Claims Processing Standard #3 failed

Preliminary Finding-006 – Fraud Warning Statement. . The Examiners reviewed a myriad of claims forms submitted by the Company via a USB Key (flash). The Company failed to include the Fraud Warning statement on nine (9) forms and failed to use at least twelve-point type on one (1) form that included the Fraud Warning Statement for a total of ten claim forms listed below, in violation of A.R.S. § 20-466.03.

Form without Fraud warning statement:
HO Homeowner Loss Report PL-019 (9/00)
PA Release and Trust Agreement-(Uninsured Motorist Coverage) PL-203 (09/95)
PA Parents-Guardian Release PL-207 (03/98)
PA Release of All Claims PL-202 (03/95)
PA Release of All Claims PL-208 (10/92) Non-CA
PA Sworn Statement in Proof of Loss PL-003 (06/78)
PA Power of Attorney
PA Bill of Sale
PA Witness Statement Form PL-023 (11/72)

Forms with Fraud warning but require at least "12-pt type":
PA Receipt and Release Agreement-Underinsured Motorist Coverage PL-229 (06/01) (jb)

Recommendation #2

Within 90 days of the filed date of this report provide the Department with documentation that Company procedures are in place to include the Fraud Warning statement on nine (9) forms identified above and correct the Fraud Warning Statement font size to at least twelve-point type on the one (1) form identified above. Copies of these revisions should be submitted to the Department for approval.

Subsequent Events: During the course of the Phase I Examination, the Company disagreed with this finding stating:

Company Comments: A.R.S. § 20-466.03 requires that the forms provided by an insurer to an insured or any other person for filing a notice or making a claim in connection with a policy or contract issued by the insurer shall include in substance the following statement in at least twelve point type…"

This statute does not require that every form used in the claims process contain the fraud warning. Instead, the Legislature chose to mandate that this statement appear only on forms by which a claimant or insured first makes a claim. None of the forms listed in the Preliminary Findings is a notice of claim. Accordingly, the Company respectfully suggests that under A.R.S. section 20-466.03 no fraud notice is required on these forms. Due to this, the Company respectfully disagrees with this finding.

Examiner Response: The Examiners disagree with the Company's position. In general, any form letters, claim forms and/or other attachments used to gather information from insureds, claimants, agents, medical providers, attorneys, employers, witnesses, service providers, etc. that require an affirmative action to complete should include a fraud warning statement. Therefore, this Finding shall stand as written and will appear in the Report.

SUMMARY OF FAILED STANDARDS

EXCEPTIONS	Rec. No.	Page No.
CANCELLATIONS AND 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 policyholder and shall not be unfairly discriminatory.	1	14
CLAIMS PROCESSING		
Standard #3 The company claim forms are appropriate for the type of product and comply with statutes, rules and regulations.	2	19

SUMMARY OF PROPERTY AND CASUALTY STANDARDS

Complaint Handling

#	STANDARD	PAGE	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 and A.A.C. R20-6-801)	9	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 and A.A.C. R20-6-801)	9	X	

Marketing and Sales

#	STANDARD	PAGE	PASS	FAIL
1	All advertising and sales materials are in compliance with applicable statutes, rules and regulations. (A.R.S. § 20-442)	9	X	

Producer Compliance

#	STANDARD	PAGE	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 and 20-311 through 311.03)	9	X	
2	An insurer shall not pay any commission, fee, or other valuable consideration to unlicensed producers. (A.R.S. § 20-298)	9	X	

Underwriting and Rating

#	STANDARD	PAGE	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)	9	X	

#	STANDARD	PAGE	PASS	FAIL
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 and 20-2110)	9	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)	9	X	
4	File documentation adequately supports decisions made. (A.R.S. § 20-385)	9	X	
5	Policies and endorsements are issued or renewed accurately, timely and completely. (A.R.S. §§ 20-1120, 20-1121 and 20-1654)	9	X	
6	Rescissions are not made for non-material misrepresentations. (A.R.S. §§ 20-463 and 20-1109)	9	X	
7	Authorization for Release of Information forms used for underwriting purposes contain required disclosures (A.R.S. § 20-2106)	9	X	

Cancellation and Non-Renewals

#	STANDARD	PAGE	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 policyholder and shall not be unfairly discriminatory. (A.R.S. §§ 20-448, 20-2108, 20-2109 and 20-2110)	13		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, 20-448, 20-1631, 20-1632, 20-1632.01, 20-1651 through 20-1656.	13	X	

Claims Processing

#	STANDARD	PAGE	PASS	FAIL
1	The initial contact by the company with the claimant is within the required time frame. (A.R.S. § 20-461 and A.A.C. R20-6-801)	17	X	
2	Timely investigations are conducted. (A.R.S. § 20-461, and A.A.C. R20-6-801)	17	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, and A.A.C. R20-6-801)	18		X
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 and A.A.C. R20-6-801)	17	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 and A.A.C. R20-6-801)	17	X	
6	The company uses reservation of rights and excess of loss letters, when appropriate. (A.R.S. § 20-461 and A.A.C. R20-6-801)	17	X	
7	Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner. (A.R.S. §§ 20-461, 20-462 and A.A.C. R20-6-801)	17	X	
8	The company responds to claim correspondence in a timely manner. (A.R.S. § 20-461, 20-462 and A.A.C. R20-6-801)	17	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 and A.A.C. R20-6-801)	17	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)	18	X	
11	Adjusters used in the settlement of claims are properly licensed (A.R.S. §§ 20-321 through 20-321.02)	18	X	