STATE OF ARIZONA
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DEPT. OF INSURANCE

REPORT OF TARGET MARKET EXAMINATION

OF

PACIFIC INDEMNITY COMPANY

NAIC # 20346

AS OF

DECEMBER 31, 2006

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CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
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, a targeted examination has been made of the market affairs of:

PACIFIC INDEMNITY COMPANY
NAIC # 20346

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

The examination covered the period of January 1, 2006 through December 31, 2006.

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

Sincerely yours,

Paul J. Hogan, FLMI, ALHC, CI, CIE
Market Oversight Administrator
Market Oversight Division

AFFIDAVIT

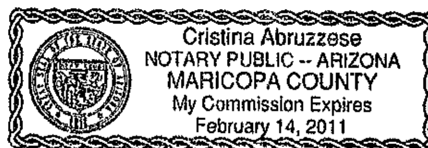
STATE OF ARIZONA)
) ss.
County of Maricopa)

I, William P. Hobert, being first duly sworn state 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 Market Examiner Laura Sloan-Cohen, the Examination of Pacific Indemnity Company, hereinafter referred to as the "Company" was performed at the Company's offices at 2155 West Pinnacle Peak Road, Phoenix, AZ 85027. A teleconference meeting with appropriate Company officials was held to discuss this Report, but a copy was not provided to management, as the Examination Report was not finalized. The information contained in this Report, consisting 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, CPCU, CLU, CIE
Market Examinations Examiner-in-Charge

Subscribed and sworn to before me this 29 day of April, 2008.

Notary Public



My Commission Expires 02/14/11

FOREWORD

This targeted market examination of Pacific Indemnity Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent examiners contracting with the Department. A targeted market 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 products developed in the production of this Report, are the sole property of the Department.

This examination consisted of a review of the Company's Private Passenger Automobile claim settlement practices. Examiners reviewed Private Passenger Automobile claim files to determine whether the Company was using claim methods and practices for acknowledging, investigating, settling and subrogating claims that were nondiscriminatory, equitable, thorough and compliant with policy provisions, state statutes and rules. Claim records were examined to determine if the objectivity and consistency of Company staff and practices in negotiating settlement amounts were reasonable and compliant.

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

This 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. This target market examination of the Company covered the period from January 1, 2006 through December 31, 2006 for the business reviewed. The purpose of the examination was to determine compliance with A.R.S. §§ 20-268, 20-461, 20-462, 20-463, 20-466, 20-466.03, 20-468, 20-469, 20-2106 and A.A.C R20-6-801.

In accordance with Department procedures, the examiners completed a Preliminary Finding ("Finding") 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 examination 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 claim files that were systematically selected from computer data files provided by the Company's Representative, Mary M. Leahy, Vice President, Manager of Claim Audit and Compliance. 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 error ratio found in the sample is, generally less than 5%, the standard will be considered as "met." The standard in the areas of procedures, forms and policy forms use will not be met if any exception is identified.

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during this examination is stated in this Report and the results are reported below.

The examiners reviewed no Department and one consumer complaint sent directly to the Company. The Company's response was complete, adequately documented and timely. The examiners found no trends or areas of concern.

The Company failed Claim Standard No. 3 because the Company failed to:

(a) provide the fraud warning statement, in twelve point type, and include the fraud warning statement with each of the claim forms and/or claim letters;

(b) advise on one authorization form the purpose for which the information is collected;

(c) specify on two authorization forms that the authorization remains valid for no longer than the duration of the claim when used for the purpose of collecting information in connection with a claim for benefits under an insurance policy; and

(d) advise on two authorization forms that persons authorized to act on behalf of the individual were entitled to receive a copy of the authorization form.

The Company failed Claim Standard No. 5 because the Company failed to:

(a) correctly calculate and fully pay sales tax in the settlement of five total losses; and

(b) correctly calculate and fully pay total fees in the settlement of one total loss.

The Company passed all other Complaint, Underwriting, Cancellation, Non-Renewal and Claim Standards.

FACTUAL FINDINGS

CLAIM STANDARD 3

The following Claim Standard 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. § 20-466.03 A.R.S. § 20-2106 (6), (8)(b), and (9)

Procedures Performed

The examiners reviewed the information provided by the Company in response to the Coordinator's Handbook, Attachments A and B, and follow-up requests that related to claim processing procedures. These documents and materials were reviewed without comment.

Phase I Examination – The Company provided electronic data in response to the Coordinator's Handbook, Attachment C. Attachment C requested private passenger automobile losses closed during the examination period. The examiners reviewed random samples of claim files from each of the following seven categories:

- 1st Party Total Losses Paid
- 1st Party Partial Losses Paid
- 1st Party Claims Closed Without Payment
- Subrogated Claims Against 3rd Parties
- 3rd Party Total Losses Paid
- 3rd Party Partial Losses Paid
- 3rd Party Claims Closed Without Payment

From a population of claim forms and claim letters provided by the Company in response to Attachment A, the examiners identified six exceptions.

CLAIM FORMS

Failed to provide a fraud warning statement with each of the claim forms and/or claim letters and failed to provide the fraud warning statement in twelve-point type in violation of A.R.S. § 20-466.03.

Population	Sample	# of Exceptions	Error Ratio*
N/A	N/A	1	N/A

***Any claim form violation does not meet the Standard.**

Finding No. 1

The Company failed Claim Standard No. 3 because the Company failed to provide a fraud warning statement with each of the claim forms and/or claim letters and failed to provide the fraud warning statement in twelve point type. [PF 1]

Form Description	Form #
One-Page Applicable Multi-State Fraud Warning Attachment	None

Recommendation No. 1

Within 90 days of the filed date of this Report, provide documentation that the required fraud warning statement, in 12-point type, is included with each of the claim forms and/or claim letters in accordance with the applicable state statute.

Subsequent Event

During the examination, the Company provided a corrected version of their multi-state fraud warning statement page, which includes the wording required by Arizona statute in twelve point type, and implemented procedures to have the page included with any form letters, claim forms and/or other attachments used to gather information and that require an affirmative action.

CLAIM AUTHORIZATION FORMS

Failed to specify the purpose for which the information is collected on one authorization form in violation of A.R.S. § 20-2106(6).

Population	Sample	# of Exceptions	Error Ratio*
N/A	N/A	1	N/A

***Any claim form violation does not meet the Standard.**

Finding No. 2

The Company failed Claim Standard No. 3 because the Company failed to specify the purpose for which the information is collected on one authorization form. [PF 2]

Form Description	Form #
Authorization for Medical Records	None

Recommendation No. 2

Within 90 days of the filed date of this Report, provide documentation that this form specifies the purpose for which the information is collected in accordance with the applicable state statute.

Failed to specify on two authorization forms that the authorization remains valid for no longer than the duration of the claim when used for the purpose of collecting information in connection with a claim for benefits under an insurance policy in violation of A.R.S. § 20-2106(8)(b).

Population	Sample	# of Exceptions	Error Ratio*
N/A	N/A	2	N/A

***Any claim form violation does not meet the Standard.**

Finding No. 3

The Company failed Claim Standard No. 3 because the Company failed to specify on two authorization forms that the authorization remains valid for no longer than the duration of the claim when used for the purpose of collecting information in connection with a claim for benefits under an insurance policy. [PF 2]

Form Description	Form #
Authorization for Medical Records	None
Authorization for the Release of Health Information	None

Recommendation No. 3

Within 90 days of the filed date of this Report, provide documentation that these forms specify the length of time that the authorization remains valid.

Failed to advise that the individual or person(s) authorized to act on behalf of the individual were entitled to receive a copy of the authorization form on two authorization forms in violation of A.R.S. § 20-2106(9).

Population	Sample	# of Exceptions	Error Ratio*
N/A	N/A	2	N/A

***Any claim form violation does not meet the Standard.**

Finding No. 4

The Company failed Claim Standard No. 3 because the Company failed to advise that the individual or person(s) authorized to act on behalf of the individual were entitled to receive a copy of the authorization form on two authorization forms. [PF 2]

Form Description	Form #
Authorization for Medical Records	None
Authorization for the Release of Health Information	None

Recommendation No. 4

Within 90 days of the filed date of this Report, provide documentation that these forms provide an appropriate notice informing persons authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form in accordance with applicable state statute.

Subsequent Event

During the examination, the Company provided corrected versions of their authorization forms specifying the purpose for which the information is obtained, the duration the

authorization remains valid and informing persons authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form in accordance with applicable state statute.

CLAIM STANDARD 5

The following Claim Standard Failed:

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

Procedures Performed

During the Phase I Examination, the examiners reviewed all 30 first party total losses and all 24 third party total losses from a population of 54 total losses and found six exceptions.

TOTAL LOSSES PAID

Failed to correctly calculate and fully pay sales tax in the settlement of five total losses and failed to correctly calculate and fully pay title, registration, air quality and other fees payable in the settlement of one total loss in violation of A.R.S. §§ 20-461(A)(6), 20-462(A) and A.A.C. R20-6-801(H)(1)(b).

Population	Sample	# of Exceptions	Error Ratio
54	54	6	11.1%

An 11.1% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Finding No. 5

The Company failed Claim Standard No. 5 because the Company failed to correctly calculate and fully pay sales tax in the settlement of five total losses and failed to correctly calculate and fully pay title, registration, air quality and other fees payable in the settlement of one total loss. [PF 4, 5, and 6]

Recommendation No. 5

Within 90 days of the filed date of this Report, provide documentation that procedures and controls are in place to ensure the Company correctly calculates and pays any taxes and/or title, registration or other fees owed any claimant in the settlement of a total loss in accordance with applicable state statutes and rules.

Subsequent Event

During the examination, the Company resettled all underpaid claims, resulting in total restitution of $189.59, which included $31.02 interest.

SUMMARY OF STANDARDS

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	

Underwriting

#	STANDARD	PASS	FAIL
1	Rescissions are not made for non-material misrepresentations. (A.R.S. §§ 20-463, 20-1109)	X	

Cancellations and Non-Renewals

#	STANDARD	PASS	FAIL
1	Declinations shall comply with state laws and company guidelines including the Summary of Rights to be given to the applicant and are not unfairly discriminatory. (A.R.S. §§ 20-448, 20-2108, 20-2109, 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, 20-448, 20- 1631, 20-1632, 20-1632.01)	X	

Claims 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, 20-462, 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
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

#	STANDARD	PASS	FAIL
6	The Company uses reservation of rights and excess of loss letters, when appropriate. [A.R.S. § 20-461(A)(1), A.A.C. R20-6-801(D)(1)]	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, 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	Claim handling practices do not compel 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 the insureds. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	