STATE OF ARIZONA
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DEPT. OF INSURANCE

REPORT OF TARGET MARKET EXAMINATION

OF

PROGRESSIVE CASUALTY INSURANCE COMPANY

NAIC # 24260

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:

PROGRESSIVE CASUALTY INSURANCE COMPANY

NAIC # 24260

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

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)

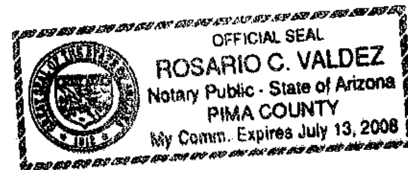
I, William P. Hobert, being first duly sworn state that I am a duly appointed Market Examinations Examiner-in-Charge for the Arizona Department of Insurance. That under my direction and with my participation and the participation of Market Examiners Laura Sloan-Cohen and Robert DeBerge, the Examination of Progressive Casualty Insurance Company, hereinafter referred to as the "Company" was performed at the Company's offices at 600 East Curry Road, Tempe, AZ 85281. 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
William P. Hobert, CPCU, CLU, CIE
Market Examinations Examiner-in-Charge

Subscribed and sworn to before me this 20th day of November, 2007.

Rosario C. Valdez
Notary Public

My Commission Expires 7/13/08



FOREWORD

This targeted market examination of Progressive Casualty Insurance 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 underwriting and claim files that were systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company's Representative, Patricia Kraven, Market Conduct Auditor III. 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 17 Department and five consumer complaints sent directly to the Company. Company responses were 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 a fraud warning on 32 claim forms and/or claim letters used during the examination period;

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

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

(d) advise on three 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 13 total losses;

(b) correctly calculate and fully pay total fees in the settlement of three total losses; and

(c) fully pay all settlement monies owed two claimants following a total loss.

The Company passed Claim Standard No. 7 with comment because the Company failed to return one insured's deductible following recovery from the adverse carrier.

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) 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 39 exceptions.

CLAIM FORMS

Failed to provide a fraud warning statement on 32 claim forms and/or claim letters in violation of A.R.S. § 20-466.03.

Population	Sample	# of Exceptions	Error Ratio*
N/A	N/A	32	N/A

***Any claim form violation does not meet the Standard; therefore, a recommendation is warranted.**

Finding No. 1

The Company failed Claim Standard No. 3 because the Company failed to provide a fraud warning statement on 32 claim forms and/or letters used in correspondence with parties associated with a claim. [PF 11]

Letter/Form #	Name of Letter or Form
L7	Statement letter for single client
L8	Statement letter for multiple clients
M5	Letter to treating physician for DX/TX plan

M8	Letter to attorney requesting update on treatment/prognosis
M9	Med pay 30-day contact letter
M10	IME letter to doctor
MP10	Subrogation to attorney or claimant carrier
R2	ROR quoting contract language
R4	ROR no policy found
S1	Subrogation notice to claimant carrier
S2	Subrogation demand to claimant
S3	Subrogation letter to claimant
S4	Subrogation letter to carrier
S5	Lien release request for total loss-owner retains salvage
S7	Lien release request for total loss-Progressive retains salvage
SIU3	Actual cash value
SIU3 Appraisal	Actual cash value letter with appraisal policy language
SIU4	Damage
SIU8	Lienholder
TL2	Authorization to pay
TL3	Odometer disclosure statement
X5	Agreement for submission to appraiser
X8	Lien release request
X19	Contact letter when we don't have a good phone number
X20	Request to witness for a statement along with form witness can complete
X21	Letter requesting vehicle to be moved to a storage-free facility
G2	BI transfer
G3	Chiropractor 10-day
G4	Chiropractic board
H1	Request to attorney for breakdown of bill
Hold Harmless	Hold harmless letter with signature block for attorney
Inquiry Form	Inquiry Form

Recommendation No. 1

Within 90 days of the filed date of this Report, provide documentation that these forms contain the required fraud warning statement, in 12-point type, in accordance with applicable state statute.

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; therefore, a recommendation is warranted.**

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 1]

1. Authorization to Release Employment Information

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 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).

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

***Any claim form violation does not meet the Standard; therefore, a recommendation is warranted.**

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]

1. Request for Verification of Information
2. Authorization to Release Employment Information

Recommendation No. 3

Within 90 days of the filed date of this Report, provide documentation that these forms specify 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 accordance with applicable state statute.

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

Population	Sample	# of Exceptions	Error Ratio*
N/A	N/A	3	N/A

***Any claim form violation does not meet the Standard; therefore, a recommendation is warranted.**

Finding No. 4

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

1. Request for Verification of Information
2. Authorization to Release Employment Information
3. Authorization for Disclosure of Medical Information

Recommendation No. 4

Within 90 days of the filed date of this Report, provide documentation that these forms provide an appropriate notice informing the individual or 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 a sample of 100 total losses paid from a population of 435 and found 18 exceptions.

TOTAL LOSSES PAID

Failed to correctly calculate and fully pay sales tax in the settlement of 13 total losses and failed to correctly calculate and fully pay title, registration, air quality and other fees payable in the settlement of three total losses 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
435	100	16	16.0%

A 16.0% 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 13 total losses and failed to correctly calculate and fully pay title, registration, air quality and other fees payable in the settlement of three total losses. [PF 5, 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. Provide documentation that amounts plus interest due claimants has been paid.

Subsequent Event

During the examination, the Company resettled all underpaid claims, resulting in total restitution of $1,387.93, which included $255.74 interest.

Failed to fully pay all settlement monies owed to two claimants following a total loss in violation of A.R.S. §§ 20-461(A)(6), 20-462(A) and A.A.C. R20-6-801(H)(1)(c).

Population	Sample	# of Exceptions	Error Ratio
435	100	2	2.0%

A 2.0% error ratio does meet the Standard.

Finding No. 6

The Company failed Claim Standard No. 5 because the Company failed to fully pay all settlement monies owed to two claimants following a total loss. [PF 9, 10]

Subsequent Event

During the examination, the Company resettled both underpaid claims, resulting in total restitution of $630.71, which included $105.12 interest.

CLAIM STANDARD 7

The following Claim Standard Passed with comment:

#	STANDARD	Regulatory Authority
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner.	A.R.S. §20-461(A)(6) A.R.S. § 20-462(A), A.A.C. R20-6-801(H)(4)

Procedures Performed

During the Phase I Examination, the examiners reviewed a sample of 50 subrogation claims from a population of 251 and found one exception.

SUBROGATED CLAIMS RECOVERED

Failed, after recovery, to return to one insured the proportionate share of their deductible in violation of A.R.S. §§ 20-461(A)(6), 20-462(A), and A.A.C. R20-6-801(H)(4).

Population	Sample	# of Exceptions	Error Ratio*
251	50	1	2.0%

***A 2.0% error ratio does meet the Standard; however, a comment is warranted since monies were returned.**

Finding No. 7

The Company passed Claim Standard No. 7 with comment because the Company failed, after recovery from the adverse carrier, to return to one insured the proportionate amount of their deductible. [PF 4]

Subsequent Event

During the examination, the Company resettled this underpaid claim, resulting in total restitution of $600.00, which included $100.00 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	