FLORIDA DEPARTMENT
OF
FINANCIAL SERVICES

OFFICE OF INSURANCE REGULATION
BUREAU OF MARKET CONDUCT

TARGET MARKET CONDUCT EXAMINATION

OF

UNITED AUTOMOBILE INSURANCE COMPANY

AS OF

December 22, 2003

NAIC COMPANY CODE: 35319
NAIC GROUP: UNITED AUTOMOBILE INSURANCE GROUP

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INTRODUCTION

United Automobile Insurance Company (Company) is a domestic property and casualty insurer licensed to conduct business in the State of Florida during the scope of this property and casualty market conduct examination. The scope of this examination was January 2001 through June 2003. The examination began June 24, 2002 and ended June 30, 2003. The last property and casualty market conduct examination of this insurer by the Office of Insurance Regulation of the Financial Services Commission within the Department of Financial Services, (hereinafter referred to as "the Office"), formerly known as Department of Insurance, concluded in January 2001.

The purpose of this examination was to review the issues leading to the volume of consumer complaints received by the Department of Financial Services, Division of Consumer Services. Based upon a review of the consumer complaints filed against the Company, the Office focused on claim handling delays and untimely return of unearned premiums due to cancellation or rating issues**.**

COMPANY OPERATIONS/MANAGEMENT

HISTORY/MANAGEMENT

The Company was incorporated in the State of Florida in March 1989. The Company was organized and funded by Safeway Insurance Company. The Company is licensed as a property and casualty insurer in Florida, Illinois, Louisiana, Oklahoma, South Carolina, Mississippi and Georgia. United Automobile Insurance Company is one of the companies in the United Automobile Insurance Group (UAIG). Other companies in the group are Argus Fire and Casualty Insurance Company, National Insurance Management Corporation, Safeway Premium Finance Company, Inc., 3iComp, Inc., Southwest Underwriters, Inc., and NIMC Services Texas.

The Company is a privately-owned company with its home office located at 3909 NE 163rd Street, North Miami, Florida 33160. The Company owns 100% of the Argus Fire and Casualty Insurance Company. Officers of the Company are: Richard P. Parrillo, Sr., President; Michael R. Parrillo, Executive Vice President; Charles J. Grimsley, Secretary; Jean-Guy O. Rivard, Treasurer and Chief Financial Officer; and Beau W. Parrillo, Executive Vice President. Directors/Trustees of the Company are Richard P. Parrillo, Sr., Richard P. Parrillo, Jr., Michael R. Parrillo, Jean-Guy O. Rivard and Patrick A. McCarthy. There has been no substantial change in the officers of the Company since the last examination.

COMPANY PROCESSES/STATISTICAL AFFILIATIONS

Computer System

The Company uses four AS400 systems to host the core business applications. The AS400-720 is used to run the insurance software. The AS400-170 runs the imaging software. The AS400-500 is the development system. The AS400-270 is used for email and Internet applications. The Fisery Specialty Insurance Service (SIS) software is used for database, business functions, navigation and presentation. All processes related to software enhancements and support are executed in the Miami, Florida office. The Company uses AT&T Frame Relay service to interconnect locations in Florida, Illinois, Louisiana and Mississippi.

Anti-Fraud Plan

The Company filed an Anti-Fraud Plan with the Florida Department of Financial Services, Division of Fraud.

The Company has a Special Investigations Unit that assists in the claims adjustment process.

Disaster Recovery Plan

The Company stated that they had developed a Disaster Recovery Plan for use with Florida business.

Internal Audit Procedures

The Company stated that they had developed Internal Audit Procedures for use in reviewing Florida business.

Privacy Plan

The Company has developed a Plan to meet the requirements of Rule 4-128.01, Florida Administrative Code. A copy of the privacy statement is attached to all new and renewal policies.

Statistical Affiliations

The Company is a member of the Insurance Services Office (ISO) and uses some ISO forms. The Company independently files rules and rates and some forms. The National Association of Independent Insurers acts as the Company's Statistical Agent.

Credit Reports

The Company does not use credit reports as an underwriting tool.

OPERATIONS/MARKETING

Marketing

The Company writes non-standard automobile insurance providing minimum statutory limits. The Company offers a full coverage policy, as well as a limited policy providing Personal Injury Protection and Property Damage (PIP/PD) coverage only. Physical damage coverages can be added to the PIP/PD policies. The Company uses independent agents, as well as brokering agents. Its marketing efforts focus on South Florida, specifically Miami-Dade and Broward counties.

Agents/Agencies/MGA/Exchange of Business/Direct Response/Internet /Adjusters and Claims Handling

National Insurance Management Company (NIMC) operates as the Company's managing general agent (MGA). The Company did not appoint the MGA until September 12, 2002. Failure to appoint NIMC as MGA constitutes a violation of Section 626.7451, Florida Statutes. The Company implemented procedures to ensure timely renewal of the license and appointment.

The Company's in-house claims department handles all of the private passenger automobile claims. It is comprised of approximately 221 adjusters, support staff and management.

Lines of Business

The Company writes non-standard private passenger automobile liability, personal injury protection, private passenger automobile physical damage insurance, commercial automobile liability and commercial automobile physical damage insurance. Only private passenger automobile coverages were reviewed during this examination.

REVIEW OF POLICIES

PRIVATE PASSENGER AUTOMOBILE INSURANCE

Description of Product/Lines of Business

The Company's filed rating and underwriting rules cover non-standard private passenger automobile. Bodily injury rates are filed with limits of $10,000/20,000 and property damage limits of $10,000. They also write limits of $100,000/300,000 for leased vehicles with $50,000 property damage limits. Maximum liability for comprehensive and collision coverage is $45,000 actual cash value. Credit reports and/or credit scores are not used as underwriting criteria, and there are no rating tiers. The Company writes primarily in Miami-Dade and Broward Counties.

Premium and Policy Counts

Direct Premiums Written and in-force policy counts for the scope of the examination are as follows:

Year	DPW	Policy Count
2001	$ 88,893,211	105,290
2002	$194,686,438	142,560
2003*	$126,802,822	70,910

*** FIGURES FOR 2003 ARE AS OF 6/30/03**

According to the Company, the largest contributing factor to United Automobile Insurance Company's increase in writings has been the insolvency of competitors, as well as companies that have voluntarily changed underwriting criteria, which led to the companies leaving the non-standard marketplace.

Examination Findings

One hundred (100) policy files were examined. The policies were reviewed for compliance with rating and underwriting requirements.

No errors were found.

It was noted that the Company is accepting only new business and renewal applicants that meet filed underwriting guideline requirements.

CANCELLATIONS/NONRENEWALS REVIEW

DESCRIPTION OF CANCELLATION/NONRENEWAL PROCEDURES

Based upon a review of the sample files, the Company's cancellation/nonrenewal procedure allows the 45 days notice as required. A copy of the notice is provided to the insured and the agent. Cancellation by the insured is calculated at 90% of pro rata. Cancellation by the Company is calculated at pro rata.

CANCELLATION REVIEW

Eighty (80) cancelled policies were examined. The cancellations were reviewed for compliance with cancellation requirements.

Six (6) errors were found.

The errors are as follows:

1. One (1) error was due to failure to provide a specific reason for cancellation. This constitutes a violation of Section 627.4091, Florida Statutes. This error was due to the reason not being specific enough for the insured to understand why the policy was cancelled.

2. Two (2) errors were due to failure to maintain documentation of proof of mailing. This constitutes a violation of Section 627.318, Florida Statutes.

3. Three (3) errors were due to incorrect unearned premium refund amounts. This constitutes a violation of Section 627.7283, Florida Statutes. The method of calculating the refunds was incorrect resulting in smaller refunds than appropriate. Since the errors involved amount to less than $5.00, corrective action was not required.

NONRENEWAL REVIEW

Twenty (20) nonrenewed policies were examined. The nonrenewals were reviewed for compliance with nonrenewal requirements.

No errors were found.

COMPLAINTS/INVESTIGATION REVIEW

A log of all the complaints received by the Company since the date of the last examination has been maintained as required by Section 626.9541(1)(j), Florida Statutes. Procedures for handling these complaints have been established by the Company. The complaints are separated into claims or underwriting issues and the individual in charge of each unit responds to the Department of Financial Services.

Consumer complaints received during the scope of examination were reviewed and the findings are as follows:

COMPLAINTS REFERRED BY CONSUMER SERVICES

Twenty-five (25) complaint files referred from Consumer Services were examined.

Twenty-one (21) errors were found.

The errors are as follows:

1. Twenty-one (21) errors were due to failure to disclose information. This constitutes a violation of Section 627.4137, Florida Statutes. The errors were due to failure to provide coverage information within the 30-day period required by statute. The Company has implemented procedures to correct this issue.

SAMPLE REVIEW - COMPLAINTS RECEIVED BY COMPANY FROM DFS AND COMPLAINTS RECEIVED BY COMPANY DIRECTLY FROM CONSUMERS

Sixty-eight (68) complaint files were examined.

Eleven (11) errors were found.

The errors from the sample review are as follows:

1. Five (5) errors were due to failure to properly adjust claims resulting in claims delay. This constitutes a violation of Section 626.877, Florida Statutes. These errors were due to failure to act promptly upon claims. The errors were random and insignificant. The Company's procedures were verified to be in compliance with Florida Statutes.

2. Two (2) errors were due to failure to tender payment timely. This constitutes a violation of Section 627.4265, Florida Statutes. These errors were due to the Company taking more than 20 days to issue the draft after settlement agreements were reached. The errors were random and insignificant. The Company's procedures were verified to be in compliance with Florida Statutes.

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3. Two (2) errors were due to failure to pay PIP timely. This constitutes a violation of Section 627.736, Florida Statutes. These errors were due to failure to pay bills within the 30-day requirement with no reasonable justification for the delay. The errors were random and insignificant. The Company's procedures were verified to be in compliance with Florida Statutes.

4. One (1) error was due to failure to comply with return of unearned premium requirements. This constitutes a violation of Section 627.7283, Florida Statutes. This error was due to failure to return unearned premium within the 30-day requirement after the cancellation date. The error was random and insignificant. The Company's procedures were verified to be in compliance with Florida Statutes.

5. One (1) error was due to failure to disclose information. This constitutes a violation of Section 627.4137, Florida Statutes. The error was due to failure to provide coverage information within the 30-day period required by statute. The Company has implemented procedures to correct this issue.

   Note: In view of the referral of twenty-one specific files from Consumer Services involving this same issue, discussions were held with the Company. The Company acknowledged that a staffing problem existed and that they were monitoring the problem. The Company pointed out that staff had been hired and would primarily address timely compliance and that additional staff would be hired to address this issue.

In addition to the above findings, the following issues were noted:

The number of consumer complaints continues to increase for this Company. From June 2002 through May 2003, the Company had 1,294 consumer complaints filed against it for an average of 108 complaints per month. The number of complaints filed for the month of June 2002 was 71. By the end of May 2003, the number of complaints had increased to 159. The average number of complaints related to claims for this period of time is 70 per month, or 65% of the monthly complaint average.

This represents an increase in complaint activity from the prior twelve month period. From June 2001 through May 2002, the Company had 458 consumer complaints filed against it for an average of 38 complaints per month. The number of complaints filed for the month of June 2001 was 17. By the end of May 2002, the number of complaints had increased to 67. The average number of complaints related to claims for this period of time is 24 per month, or 63% of the monthly complaint average.

While the number of complaints increased as indicated above, the Direct Premiums Written (DPW) also increased. The rate of increase in DPW was much greater than the rate of increase in complaints. From January 2001, through June 2003, DPW increased 700 percent while the average number of complaints received each month only increased 284 percent. Improvements in claims processing resulted in fewer complaints when considering premium growth.

CLAIMS REVIEW

Non-standard private passenger automobile insurance claims were reviewed, including claims for bodily injury, personal injury protection, property damage, comprehensive - fire and theft, as well as collision claims.

Examination Findings

One hundred seventy-five (175) claims were examined, along with claims related reports and processing procedures.

Fifteen (15) errors were found.

Six (6) errors resulted in underpayments totaling $22,667.

The errors are as follows:

1. Six (6) errors were due to failure to comply with PIP benefit requirements. This constitutes a violation of Section 627.736, Florida Statutes. These errors were due to failure to pay PIP benefits within the required 30 days without a reasonable justification for the delay. In one claim, there were nine (9) providers with bills totaling $9,352 in benefits due. This claim is now in litigation. Five of these errors resulted in underpayments totaling $13,315. The Company has paid only one of these claims in the amount of $2,163. See Pending Issues Section.

2. One (1) error was due to failure to comply with PIP benefit requirements. This constitutes a violation of Section 627.736, Florida Statutes. This error was due to failure to provide the policy application requested by an attorney for his client on four occasions. The Company has implemented procedures to correct this issue.

3. Eight (8) errors were due to failure to report suspected fraud to the Florida Department of Financial Services, Division of Fraud. This constitutes a violation of Section 626.989(6), Florida Statutes. The review found claim referrals to the SIU managers indicating suspected fraud and requesting assistance in the investigation process.

In addition to the above findings, the following issues were noted:

An analysis of claims processing was conducted for the period March 19, 2002 through December 13, 2002. The purpose of the analysis was to evaluate the Company's assertion that 95 percent of all of its PIP and theft claims are fraudulent. Because of this belief, the Company has implemented an aggressive claims adjustment process to combat the purported level of fraudulent claims. A result of this aggressive claims adjustment process is a corresponding delay in paying claims, some of which may or may not have fraudulent components.

The following chart, provided by the Company, describes the claims and related information:

Coverage	Claims Reported	SIU Referrals	Percent
PIP	9,608	513	5.3
Theft	645	301	46.7
Total	10,253	814	7.9

During this same period of time, the Company only reported sixteen (16) claims to the Department of Financial Services, Division of Fraud. Based upon the Company's assertion that 95 percent of its claims are fraudulent, 9,740 of the 10,253 claims reported should have been referred.

A further analysis of claims processing of PIP claims was made for the period 1996 through mid 2002. This analysis was to evaluate the impact of an aggressive investigation process in relation to the prompt payment of claims.

The following chart, provided by the Company, describes claims activities:

Year	New Claims Opened	Closed Without Payment	Currently Open	Paid *
1996	4,319	2,665	29	1,625
1997	3,326	2,038	66	1,222
1998	3,002	1,955	87	960
1999	2,622	1,579	131	912
2000	3,567	2,139	691	737
2001	6,089	3,117	2,617	355
2002	6,034	1,536	4,410	88

* Developed by the Office of Insurance Regulation

Based upon the results of the analysis, the high level of fraudulent claims is not documented, thus, the aggressive investigation of all claims may or may not be justified. We have been unable to reconcile the Company's assertion that 95 percent of its claims are fraudulent, with the SIU and Division of Fraud referrals noted above. Because concern for fraud serves as the grounds for some of the claim delays that prompted this examination, we would anticipate a much higher percentage of claims being referred to the appropriate entity for investigation. This is not the case, which raises concerns with the validity of the assertion and the attendant delays in paying claims.

The analysis noted above also demonstrates that the number of pending claims continues to grow. This growth in pending claims remains a catalyst for increased complaints by consumers/insureds causing a continual increase in the number of consumer complaints filed against the Company. Even though Florida Statutes do not require that property and casualty claims be settled within a certain timeframe, in order to reduce the catalyst for increasing complaints, claims investigation should be conducted in a timely manner resulting in the settlement of or denial of claims. Due to the increasing number of pending claims, it is apparent that this is an issue that needs to be addressed by the Company.

The claims review has documented that the Company's business practice is to follow established claims adjusting procedures despite random errors noted in the examination. The aggressive claims review, along with other related issues such as inadequate adjuster staffing, accounts for processing delays and the continuously increasing backlog of claims.

The continued failure to report fraudulent claims remains an issue. The Company had noted in a March 6, 2003 letter that it would begin referring every fraudulent claim. However, from March 6, 2003 through June 18, 2003, the Company had only referred 18 claims.

A Claims Customer Service Satisfaction Survey was conducted in an effort to gauge consumer reaction to the service provided by the Company in the claims adjustment process.

The following conclusions can be implied by the data:

- Claims were paid more often than not.
- More people were required to attend meetings with the Company than were not.
- Some claimants were dissatisfied with the claims process.

As indicated previously, the Company asserts that 95 percent of all PIP and automobile theft claims are fraudulent. The Division of Fraud for the Department of Financial Services has acknowledged that they believe at least 80 percent of these claims are fraudulent. Despite the Company not reporting suspected fraudulent claims as required, they have committed to working closer with the Division of Fraud in reporting when required by Florida Statutes.

Even though the Office acknowledges the effort by the Company to investigate and defend against fraudulent claims, Section 626.989(6), Florida Statutes, is definitive in addressing the reporting of <u>all</u> suspected fraudulent claims.

As stated by the Company and the Division of Fraud, the degree of fraudulent activity in claims makes it appear that the Company is failing to report a very significant number of suspected fraudulent claims. The Company asserts that this investigation of fraudulent claims is the reason for claims delays and the Office acknowledges this allegation. None the less, the failure to report the significant number of suspected fraudulent claims is of

extreme concern and will be the basis in developing administrative penalties as opposed to claims delays.

PENDING ISSUES

The following issues are pending:

1. Company Operations – The Company must develop an anti-fraud corrective action plan to ensure that all potential fraud claims are reported to the Department of Financial Services, Division of Fraud. See Subsequent Events Section.

2. Claims – The Company must pay past due bills as identified in the Claims Section totaling $11,152.55.

3. The Company must revise the letter to providers, rejecting requests for payment due to signature issues. Copies of the letter should be sent to the insured, claimant and representing attorney (if known).

4. Claims – The Company must develop a Claims Staffing Plan wherein the average number of claims assigned per adjuster is decreased in an effort to decrease claims delays associated with case overload.

The Company is requested to address all issues within ninety (90) days of receipt of the examination report, with written documentation to the Office that each item has been addressed.

CORRECTIVE ACTION PLAN

As indicated in the examination findings, the following issues exist:

- Claim delays resulting in a backlog of claims;
- Failure to report fraudulent claims to the Department of Financial Services, Division of Fraud.

In view of the delays in processing claims and failure to report fraudulent claims, United Automobile shall:

- Re-evaluate claims adjusting practices and develop methods to reduce processing time and eliminate the backlog of claims. This will include, for example, shifting the responsibility of obtaining police reports to clerical staff rather than having adjusters or claimants obtain the reports.
- Recruit and train additional claims adjusters and related claims staff sufficient to enable faster processing of claims, as well as reduce the backlog of claims.
- Devote staff to timely communication with claimants and other parties associated with claims to reduce the number of consumer complaints and/or improve processing time associated with consumer complaints filed against the Company. Staff size must be flexible to accommodate fluctuating demands.
- Continue to monitor the staff devoted to the timely release of policy information as required by Florida Statutes to ensure that the corrective action procedures implemented by the Company enables the Company to remain in compliance.
- Establish timeframes for acknowledging claims and communications with claimants and/or Department of Financial Services staff to meet the standards required by Florida Statutes and the Florida Administrative Code.
- Devote staff to report fraudulent claims to the Department of Financial Services, Division of Fraud. See Subsequent Events Section.

The Company and the Office will continue working together to provide actions necessary to facilitate compliance with Florida Statutes.

SUBSEQUENT EVENTS

Following the on-site review by the examiners, the Company has established procedures for identifying and reporting claims suspected of fraudulent activity. If the adjuster reviewing the file suspects fraud, the file is referred to the SIU Department. The SIU Department conducts an investigation and if fraud is suspected, a form is completed and sent to the Division of Fraud along with pertinent information related to the claim. A log of all claims referred to the Division of Fraud is maintained by the SIU Department.