THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

Division of Insurance

Report on the Comprehensive Market Conduct Examination of

OneBeacon America Insurance Company

Canton, Massachusetts

For the Period January 1, 2006 through June 30, 2007

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NAIC COMPANY CODE: 20621

EMPLOYER'S ID NUMBER: 04-2475442

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October 24, 2008

Nonnie S. Burnes
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
One South Station
Boston, Massachusetts 02110-2208

Dear Commissioner Burnes:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4, a comprehensive examination has been made of the market conduct affairs of

ONEBEACON AMERICA INSURANCE COMPANY

at its home office located at:

One Beacon Lane
Canton, Massachusetts 02021

The following report thereon is respectfully submitted.

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SCOPE OF EXAMINATION

The Massachusetts Division of Insurance (the "Division") conducted a comprehensive market conduct examination of OneBeacon America Insurance Company ("the Company") for the period January 1, 2006 to June 30, 2007. The examination was called pursuant to authority in Massachusetts General Laws Chapter ("M.G.L. c.") 175, Section 4. The market conduct examination was conducted at the direction of, and under the overall management and control of, the market conduct examination staff of the Division. Representatives from the firm of Rudmose & Noller Advisors, LLC ("RNA") were engaged to complete certain agreed upon procedures.

EXAMINATION APPROACH

A tailored audit approach was developed to perform the examination of the Company using the guidance and standards of the 2006 *NAIC Market Regulation Handbook*, ("the Handbook") the market conduct examination standards of the Division, the Commonwealth of Massachusetts' insurance laws, regulations and bulletins and selected federal laws and regulations. All procedures were performed under the management and control and general supervision of the market conduct examination staff of the Division, including procedures more efficiently addressed by the concurrent Division financial examination of the Company. For those objectives, market conduct examination staff discussed, reviewed and used procedures performed by the Division's financial examination staff to the extent deemed necessary, appropriate and effective, to ensure that the objective was adequately addressed. The following describes the procedures performed and the findings for the workplan steps thereon.

The basic business areas that were reviewed in under this examination were:

I. Company Operations/Management
II. Complaint Handling
III. Marketing and Sales
IV. Producer Licensing
V. Policyholder Service
VI. Underwriting and Rating
VII. Claims

In addition to the processes' and procedures' guidance in the Handbook, the examination included an assessment of the Company's internal control environment. While the Handbook approach detects individual incidents of deficiencies through transaction testing, the internal control assessment provides an understanding of the key controls that Company management uses to run their business and to meet key business objectives, including complying with applicable laws and regulations related to market conduct activities.

The controls assessment process is comprised of three significant steps: (a) identifying controls; (b) determining if the control has been reasonably designed to accomplish its intended purpose in mitigating risk (i.e., a qualitative assessment of the controls); and (c) verifying that the control is functioning as intended (i.e., the actual testing of the controls). For areas in which controls reliance was established, sample sizes for transaction testing were accordingly adjusted. The form of this report is "Report by Test," as described in Chapter 15, Section A. of the Handbook.

EXECUTIVE SUMMARY

This summary of the comprehensive market conduct examination of the Company is intended to provide a high-level overview of the examination results. The body of the report provides details of the scope of the examination, tests conducted, findings and observations, recommendations and, if applicable, subsequent Company actions. Managerial or supervisory personnel from each functional area of the Company have been advised to review report results relating to their specific area.

The Division considers a substantive issue as one in which corrective action by the Company is deemed advisable, or one in which a "finding," or violation of Massachusetts insurance laws, regulations or bulletins was found to have occurred. It also is recommended that Company management evaluate any substantive issues or "findings" for applicability to potential occurrence in other jurisdictions. When applicable, corrective action should be taken for all jurisdictions, and a report of any such corrective action(s) taken should be provided to the Division.

The following is a summary of all substantive issues found, along with related recommendations and, if applicable, subsequent Company actions made, as part of the comprehensive market conduct examination of the Company. All Massachusetts laws, regulations and bulletins cited in this report may be viewed on the Division's website at www.mass.gov/doi.

The comprehensive market conduct examination resulted in no findings or negative observations with regard to company operations/management. Examination results showed that the Company is in compliance with all tested Company policies, procedures and statutory requirements addressed in these sections.

SECTION II – COMPLAINT HANDLING

STANDARD II-2

Findings: None.

Observations: It appears that the Company has adequate procedures in place to address complaints. The Company reported no complaints during the examination period. The Company is in the process of enhancing its complaint monitoring and trending capabilities.

Recommendations: The Company should complete the enhanced complaint monitoring and trending reporting process and timely implement its use.

SECTION III - MARKETING AND SALES

STANDARD III-1

Findings: None.

Observations: The results of RNA's testing showed that the Company's advertising and sales materials comply with Massachusetts M.G.L. c. 176D, § 3. The standard agency contract contains the requirement to obtain home office approval prior to use of agent-developed advertising material. The Company's website disclosure complies with the requirements of Division of Insurance Bulletin 2001-02. However, the Company has not retained internal approval of three advertising materials used during the examination period.

Recommendations: The Company should adopt a written policy and procedure, which requires that approvals from corporate communications, the legal department and the business line manager are obtained before marketing materials are published. Further, the written policy and procedures should require that this documentation be retained by the Company as long as the materials are in use.

Subsequent Actions: The Company has implemented the recommendations noted above.

SECTION IV - PRODUCER LICENSING

STANDARD IV-1

Findings: Based on the results of RNA's testing of six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, one policy was sold by a producer who was not licensed in Massachusetts on the sale date in violation of M.G.L c. 175, § 162I. The producer was licensed in Rhode Island on the sale date and is the process of becoming licensed in Massachusetts. All of the remaining producers who sold policies during the examination period were properly licensed. Further, all but three of the licensed producers were included on the Division's list of the Company's appointed agents when the policies were issued. The Company subsequently appointed the three producers as agents.

Observations: None.

Recommendations: The Company should implement a control procedure during underwriting to ensure that all producers are licensed and appointed as agents prior to selling business. Further, the Company and the Division shall complete a reconciliation of the Company's agent appointments at a mutually agreed upon date, to ensure that such appointment records are in agreement. Finally, internal audit, together with the producer appointment area, should conduct testing of underwriting controls designed to ensure that producers are licensed prior to selling business, to ensure that such controls are functioning properly

Subsequent Actions: The Company states that it is now appointing all licensed producers as agents within the required time frame.

SECTION V – POLICYHOLDER SERVICE

STANDARD V-2

Findings: None.

Observations: The insured-requested cancellations tested were processed timely according to the Company's policies and procedures. Based upon the results of testing, the Company's processing of insured-requested cancellations appears to be functioning in accordance with its policies, procedures, and statutory requirements. Computer system limitations required the cancellation of one commercial multi-peril policy and one workers' compensation policy, in order to change a producer code or a commission.

Recommendations: The Company should consider computer system enhancements to allow changes in producer codes and commissions without canceling and rewriting existing policies.

SECTION VI - UNDERWRITING AND RATING

STANDARD VI-8

Findings: None.

Observations: Based on the results of testing, the Company appears to comply with notice procedures for company-initiated cancellations and non-renewals. The homeowners' computer system cancellation report does not identify all company-initiated cancellations for underwriting reasons. The Company is changing its policy writing system, which will identify all company-initiated cancellations due to underwriting reasons.

Recommendations: The Company shall complete the conversion to the new policy writing system as soon as possible. The new system will allow the Company to enhance its tracking and monitoring of cancellations. In the interim, the Company shall devote resources and use all reasonable efforts to ensure that all company-initiated cancellations for underwriting reasons are tracked and monitored to comply with statutory requirements

STANDARD VI-26

Findings: None.

Observations: Based on the results of testing, it appears that the Company uses proper data coding procedures. The Massachusetts Workers' Compensation Rating and Inspection Bureau ("WCRIB") audit dated August 10, 2006 indicated that the Company generally uses proper workers' compensation statistical data related to premiums. However, numerous errors were noted in the 2005 CAR audit report of the Company's 2003 activity, and the 2007 CAR audit report of its 2005 activity. Some common errors were reported in both years. The Company states that it has made changes to its automobile premium statistical reporting methodology due to the issues identified during 2003, which were reflected in the 2005 CAR audit report; however, some of the results of such changes were not yet evident in 2005, as documented in the 2007 CAR audit report. Some of the errors noted included vehicle premium statistical errors related to age, class and VIN, and errors related to policies. The Company states that it has completed research to identify the root causes of the errors, modified computer system logic as necessary, developed a self-review process to address these errors and conducted training of commercial underwriters.

Recommendations: The Company's internal audit function, together with the business information services department, shall conduct a review and evaluation of the new computer logic and procedures, to ensure that controls over coding and statistical reporting are effectively designed and properly implemented. The Company shall periodically update the Division, as requested, on these results of the audits.

STANDARD VI-27

Findings: None.

Observations: Based on the results of testing, it appears that policy files adequately supported the Company's decisions. However, RNA's review of the underwriting department's peer reviews indicated that, in several instances, individual commercial lines underwriters exceeded their authority limits during the underwriting process. As a result, the Company has provided training to all underwriters emphasizing adherence to authority limits.

Recommendations: The Company should enhance controls and procedures contemporaneous with the underwriting of risks, to ensure adherence to authority limits during the underwriting process. Such controls could include, for example, supervisory review of underwriters' work prior to the approval of new risks; information technology controls which prevent underwriters from approving risks that exceed their underwriting authorities; a risk underwriting assignment methodology that allows management to assess and monitor adherence to authority limits during the underwriting process, or other relevant effective controls.

SECTION VII – CLAIMS

STANDARD VII-5

Findings: None.

Observations: RNA noted that the files for tested claims were adequately documented. Based upon the results of testing, it appears that the Company's processes for documenting claim files are generally functioning in accordance with its policies and procedures. While not required by law or regulation, the Company has established a procedure to compile a list of bad faith claims for internal reporting to the Board of Directors. RNA noted one claim that was inadvertently excluded from the list of bad faith claims.

Recommendations: The Company should adopt a new control procedure to ensure that the list of bad faith claims is complete and accurate. The procedure should include periodic reconciliation of that list to similar data maintained in the claims department.

Subsequent Actions: The Company states that it has implemented the new control procedure and that the data is now reconciled monthly.

STANDARD VII-6

Findings: The Company did not give proper notice to the inspector of buildings for one homeowners claim over $5,000 and one commercial multi-peril claim over $1,000, in violation of M.G.L. c. 139, § 3B. The file for the same homeowners claim did not include a certificate a certificate of municipal liens from the city tax collector in violation of M.G.L. c. 175 § 97A. The Company's processes for handling claims in accordance with policy provisions, statutory and regulatory requirements are otherwise functioning in accordance with its policies and procedures.

Observations: RNA verified that when required, the Company responded to written requests for an insured's policy limits within 30 days, pursuant to M.G.L. c. 175, § 112C. When required, the Company properly verified that claim recipients were not subject to the intercept requirements in M.G.L. c. 175, §§ 24D, 24E and 24F, prior to making the claim payment.

RNA verified that the Company has procedures for providing claimants with a list of registered repair shops, as well as repair shops that qualify as a referral shop, as required by 211 CMR 123.00. Further, RNA noted that the Company performs re-inspections of repaired vehicles following completion of repairs, as required by 211 CMR 123.00.

Recommendations: The Company shall establish additional controls to ensure that claims are paid in accordance with statutory requirements including M.G.L. c. 139, § 3B and M.G.L. c. 175 § 97A. Further, internal audit, together with the claims department, shall review the newly established controls and periodically test and monitor claims handling policies, procedures and statutory requirements.

Subsequent Actions: The Company states that it has provided training to adjustors regarding statutory notice requirements.

STANDARD VII-9

Findings: None.

Observations: The Company could not locate the file for one homeowners claim filed in 1997 and closed in 2006. RNA otherwise noted that the files for the denied or closed without payment claims tested appeared complete, including correspondence and other documentation. Further, the Company's conclusions appeared reasonable. Based upon the results of testing, it appears that the Company's processes do not unreasonably deny or delay payment of claims.

Recommendations: The Company should implement new control procedures to ensure that all claim documentation can be located and easily tracked.

Subsequent Action: The Company states that it has revised its record retention process to ensure that claim documentation is available as necessary.

STANDARD VII-11

Findings: None.

Observations: Except as noted below, documentation for the selected claims involving litigation appeared complete, including correspondence and other documentation, and the Company's conclusions appeared reasonable. Based upon the results of testing, it appears that the Company's processes do not unreasonably deny claims or compel claimants to initiate litigation.

However, RNA noted one commercial automobile claim where the initial offers to settle appeared low when compared to the claim reserve, to claim file documentation regarding the initial planned offer, and to the settlement authority granted at the time of the initial offer and the final settlement value of the claim. The Company stated that the initial offers were made as part of a "strategy" to obtain a fair final settlement. While the claimant's attorney and the Company reached a final settlement, and the final settlement appeared reasonable, claim documentation was inconsistent, and it was unclear that the initial offers were fair and reasonable.

Recommendations: The Company shall reinforce to claims adjustors its policy that all claim settlement offers be fair and reasonable. Further, file documentation of claim settlement offers, particularly in relation to the claim reserve, the settlement strategy and settlement authority, should fully support that each offer is fair and reasonable. Finally, internal audit shall test compliance with this policy and procedure as part of ongoing claims audit procedures.

Subsequent Actions: The Company states that it has provided training to adjustors on documentation of settlement evaluations and claim offers.

STANDARD VII-14

Findings: None.

Observations: The WCRIB audit dated August 10, 2006 indicated that the Company uses proper workers' compensation statistical data related to claims. RNA's review of property claims indicated three coding errors where coverage was improperly coded 431 (homeowners property) instead of coded 312 (commercial property). The Company states that these coding errors do not impact statistical data reporting to ISO or financial reporting, and only impact internal Company reporting.

Further, numerous errors were noted in the 2005 CAR audit report of the Company's 2003 activity, and the 2007 CAR audit report of its 2005 activity. Some common errors were reported in both years. The Company states that it made changes to its automobile loss statistical reporting methodology due to the issues identified during 2003, which were reflected in the 2005 CAR audit report; however, some of the results of such changes were not yet evident in 2005, as documented in the 2007 CAR audit report. Some of the errors noted included vehicle loss statistical errors related to loss type and accident location, and some errors related to policies. The Company has identified the root causes of the statistical errors, and will be developing computer logic changes to correct these errors.

Recommendations: The Company shall timely complete the development of the computer logic changes to correct statistical errors noted in the CAR audit reports. Further, the Company's internal audit function, together with the business information services department, shall review and evaluate the controls over coding and statistical reporting to ensure that they are effectively designed and properly implemented. Lastly, the Company shall periodically update the Division, as requested, on progress of the implementation efforts and on the results of the audits.

COMPANY BACKGROUND

The Company is a wholly-owned subsidiary of OneBeacon Insurance Company ("OneBeacon"), a Pennsylvania domestic insurance company. OneBeacon is a wholly-owned subsidiary of OneBeacon Insurance Group LLC ("OBLLC"), an insurance holding company domiciled in Delaware. OBLLC is an indirect wholly-owned subsidiary of OneBeacon Insurance Group, Ltd. ("OB"), a publicly traded insurance holding company domiciled in Bermuda. White Mountains Insurance Group, Ltd., also an insurance holding company domiciled in Bermuda, is the ultimate controlling entity indirectly owning 74.5% of the outstanding common shares of OB as of December 31, 2007, representing 96.7% of the voting power of a combined two-class common stock structure. The One Beacon Companies are rated "A" ("Excellent") by A.M. Best.

The Company offers homeowners, commercial automobile, commercial multi-peril and workers' compensation insurance in Massachusetts. Other lines of business including private passenger automobile coverage are sold through affiliated insurance companies within OB. The Company and OneBeacon contract with approximately 130 independent agencies in Massachusetts.

The Company had $1,057.0 million in admitted assets and $520.9 million in surplus as of December 31, 2006. For the year ended December 31, 2006, the Company's earned premium was $329.2 million and net income was $114.9 million. The Company does not directly employ any individuals. Rather, the Company reimburses OB for the Company's portion of shared services incurred by OB including staffing costs.

The key objectives of this examination were determined by the Division with emphasis on the following areas.

I. COMPANY OPERATIONS/MANAGEMENT

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures, (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard I-1. The regulated entity has an up-to-date, valid internal, or external, audit program.

Objective: This Standard addresses whether there is an audit program function that provides meaningful information to management.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company's statutory financial statements and OB's financial statements are audited annually by an independent accounting firm.
- OB's internal audit department reports to the OB Board of Directors' Audit Committee.
- OB's internal audit plan is based on priorities established by the Audit Committee, with input from senior management. The Audit Committee approves the plan for the following year prior to year end, and monitors plan progress and implementation results periodically throughout the year.
- OB's internal audit department conducts periodic audits of various operational areas to ensure compliance with OB and Company policies and procedures, and recommends enhancements to such policies and procedures.
- OB's claim department performs monthly branch self-audits, whereby claims processed are reviewed and evaluated for adherence to OB and Company policies and procedures. Further, OB's home office claims management conducts quality control audits to evaluate settlement practices by reviewing bodily injury settlements, liability claims and material damage claims.
- OB's underwriting department conducts quarterly peer reviews of each underwriter's business. In addition, the home office underwriting management conducts quality control audits every 18 months.
- OB conducts compliance audits of its producers regarding required maintenance of certain underwriting information that is retained by the producer.
- The Company is subject to periodic audits by Commonwealth Automobile Reinsurers ("CAR") for compliance with statutes and CAR Rules of Operation ("CAR Rules").
- The Massachusetts Workers' Compensation Rating and Inspection Bureau ("WCRIB") conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements, including those related to premiums and claims.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA reviewed various internal audit reports, claims department branch self-audits, underwriting department peer reviews and home office claims quality control audits to evaluate procedures performed and results obtained.

Transaction Testing Results:

Findings: None.

Observations: The internal audit reports, claims department branch self-audits, underwriting department peer reviews and home office claims quality control audits reviewed by RNA provided detailed information on the procedures performed, audit findings and recommendations for improvement. The review of these audits indicated that when recommendations for improvement were identified, the Company considered the recommendations and implemented those which management considered necessary.

Recommendations: None.

Standard I-2. The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

No work performed. All required activity for this Standard is included in the scope of the ongoing statutory financial examination of the Company.

Standard I-3. The regulated entity has anti-fraud initiatives in place that are reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts.

18 U.S.C. § 1033; Division of Insurance Bulletins 1998-11 and 2001-14.

Objective: This Standard addresses whether the Company has an anti-fraud plan that is adequate, up-to-date, in compliance with applicable statutes and is appropriately implemented.

Pursuant to 18 U.S.C. § 1033 of the Violent Crime Control and Law Enforcement Act of 1994 ("Act"), it is a criminal offense for anyone "engaged in the business of insurance" to willfully permit a "prohibited person" to conduct insurance activity without written consent of the primary insurance regulator. A "prohibited person" is an individual who has been convicted of any felony involving dishonesty or breach of trust or certain other offenses, who willfully engages in the business of insurance as defined in the Act. In accordance with Division of Insurance Bulletins 1998-11 and 2001-14, any entity conducting insurance activity in Massachusetts must notify the Division in writing of all employees and producers affected by this law. Individuals "prohibited" under the law may apply to the Commissioner for written consent, and must not engage or participate in the business of insurance unless and until they are granted such consent.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- OB and the Company have a written plan to address fraud throughout the organization.
- OB and the Company have a Special Investigative Unit ("SIU") within the claim department, which is dedicated to the prevention and handling of fraudulent activities.
- The SIU has written policies, guidelines and procedures to address claim fraud prevention.
- The SIU tracks and investigates potentially fraudulent activity with the assistance of other departments, and reports such activity to regulators as required.
- OB's and the Company's policy is to seek the Division's approval regarding the hiring of any "prohibited person" when it wishes to employ such a person.
- The Company does not directly employ any individuals, since it reimburses OB for its portion of shared services including staff. Beginning in 2000, OB began conducting criminal background checks on all new employees.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA reviewed the anti-fraud policies and procedures and the work of the SIU as part of various claims standards.

Transaction Testing Results:

Findings: None.

Observations: Based upon RNA's review of policies and procedures, it appears that anti-fraud initiatives are in place to detect, prosecute, and prevent fraudulent insurance acts.

Recommendation: None.

Standard I-4. The regulated entity has a valid disaster recovery plan.

No work performed. All required activity for this Standard is included in the scope of the ongoing statutory financial examination of the Company.

Standard I-5. Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, MGAs, GAs, TPAs and management agreements must comply with applicable licensing requirements, statutes, rules and regulations.

No work performed. OB and the Company do not utilize MGAs or TPAs; therefore this standard is not applicable to this examination.

Standard I-6. The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

No work performed. OB and the Company do not utilize MGAs or TPAs; therefore this standard is not applicable to this examination.

Standard I-7. Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Objective: This Standard addresses the organization, legibility and structure of files, as well as the determination of the Company's compliance with record retention requirements.

Controls Assessment: OB and the Company have established written record retention policies and procedures for each key function and department that note the length of time specific documents must be retained.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA reviewed OB's and the Company's record retention policies and evaluated them for reasonableness.

Transaction Testing Results:

Findings: None.

Observations: OB and the Company's record retention policies appear reasonable.

Recommendations: None.

Standard I-8. The regulated entity is licensed for the lines of business that are being written.

M.G.L. c. 175, §§ 32 and 47.

Objective: This Standard addresses whether the lines being written by a Company are in accordance with the authorized lines of business.

Pursuant to M.G.L. c. 175, § 32, domestic insurers must obtain a certificate authorizing it to issue policies or contracts. M.G.L. c. 175, § 47 sets forth the various lines of business for which an insurer may be licensed.

Controls Assessment: Due to the nature of this Standard, no controls assessment was performed.

Controls Reliance: Not applicable.

Transaction Testing Procedure: RNA reviewed the Company's Certificate of Authority and compared it to the lines of business which the Company writes in the Commonwealth.

Transaction Testing Results:

Findings: None.

Observations: The Company is licensed for the lines of business being written.

Recommendations: None.

Standard I-9. The regulated entity cooperates on a timely basis with examiners performing the examinations.

M.G.L. c. 175, § 4.

Objective: This Standard addresses the Company's cooperation during the course of the examination.

M.G.L. c. 175, § 4 sets forth the Commissioner's authority to conduct examinations of an insurer.

Controls Assessment: Due to the nature of this Standard, no controls assessment was performed.

Controls Reliance: Not applicable.

Transaction Testing Procedure: The Company's level of cooperation and responsiveness to examiner requests was assessed throughout the examination.

Transaction Testing Results:

Findings: None.

Observations: The Company's level of cooperation and responsiveness to examiner requests was acceptable.

Recommendations: None.

Standard I-10. The regulated entity has procedures for the collection, use and disclosure of information gathered in connection with insurance transactions to minimize any improper intrusion into the privacy of applicants and policyholders.

Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 Code of Federal Regulations ("CFR") Part 313.

Objective: This Standard addresses the Company's policies and procedures to ensure it minimizes improper intrusion into the privacy of consumers.

The Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313 set forth requirements for proper notice to consumers, and restrictions on a financial institution's ability to disclose non-public personal information about consumers to nonaffiliated third parties. Further, a financial institution must provide its customers with a written notice of its privacy policies and practices. In addition, a financial institution is prohibited from disclosing non-public personal consumer information to nonaffiliated third parties, unless the institution satisfies various disclosure and opt-out requirements and the consumer has not elected to opt out of such disclosure.

Controls Assessment: The following key observations were noted in conjunction with the review of Standards I-10 through I-17:

- The Company's practice is to provide the initial privacy notice on the policy application to individual applicants.
- The Company's privacy policy states that it collects certain types of non-public personal information from third parties or other sources, and gives examples of such third parties or other sources. The privacy policy further notes that the Company may disclose information as permitted by law, and that consumers have rights to access and to correct inaccuracies in this information.
- The Company's privacy policy states that it does not disclose any non-public personal information to any affiliate or non-affiliated third party for marketing purposes, and discloses non-public personal information only for the purpose of processing and evaluating consumers' insurance applications or claims.
- The Company annually provides the privacy policy to individual customers via mail upon renewal.
- The Company provides its privacy policy on its website.
- The Company annually conducts an information systems risk assessment to consider, document and review information security threats and controls. The risk assessment evaluations have resulted in continual improvements to information systems security.
- Company policy requires that its information technology security practices safeguard non-public personal and health information, and communicates these practices to all staff in training programs, compliance presentations and various memoranda as needed. Company policy also requires all staff to take annual privacy training, and to sign an acknowledgement that they have taken such training.
- Only individuals approved by Company management are granted access to the Company's electronic and operational areas where non-public personal and health information is located. Access is frequently and strictly monitored.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for privacy compliance, and reviewed documentation supporting its privacy policies and procedures.

Transaction Testing Results:

Findings: None.

Observations: It appears from RNA's review that the Company's privacy practices minimize any improper intrusion into individuals' privacy.

Recommendations: None.

Standard I-11. The regulated entity has developed and implemented written policies, standards and procedures for the management of insurance information.

Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313.

The objective of this Standard relates to privacy matters and is included in Standards I-10 and I-12 through I-17.

Standard I-12. The regulated entity has policies and procedures to protect the privacy of non-public personal information relating to its customers, former customers and consumers that are not customers.

Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313.

Objective: This Standard addresses the Company's policies and procedures to ensure it protects the privacy of non-public personal information.

The Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313, set forth requirements for proper notice to consumers, and restrictions on a financial institution's ability to disclose non-public personal information about consumers to nonaffiliated third parties. Further, a financial institution must provide its customers with an annual notice of its privacy policies and practices. In addition, a financial institution is prohibited from disclosing non-public personal consumer information to nonaffiliated third parties, unless the institution satisfies various disclosure and opt-out requirements and the consumer has not elected to opt out of such disclosure.

Controls Assessment: See Standard I-10.

Controls Reliance: See Standard I-10.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for privacy compliance, and reviewed documentation supporting its privacy policies and procedures.

Transaction Testing Results:

Findings: None.

Observations: It appears from RNA's review that the Company's policies and procedures adequately protect consumers' non-public personal information.

Recommendations: None.

Standard I-13. The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of non-public personal financial information.

Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313.

Objective: This Standard addresses the Company's practice of providing privacy notices to customers and consumers.

The Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313, set forth requirements for proper notice to consumers, and restrictions on a financial institution's ability to disclose consumers' non-public personal information to nonaffiliated third parties. Further, a financial institution must provide its customers with an annual written notice of its privacy policies and practices. In addition, a financial institution is prohibited from disclosing consumers' non-public personal information to nonaffiliated third parties, unless the institution satisfies various disclosure and opt-out requirements and the consumer has not elected to opt out of such disclosure.

Controls Assessment: See Standard I-10.

Controls Reliance: See Standard I-10.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for privacy compliance, and reviewed documentation its supporting privacy policies and procedures.

Transaction Testing Results:

Findings: None.

Observations: Based upon RNA's review of the Company's privacy notice and its privacy practices, it appears that the Company has a process for providing a sufficient privacy notice to individual applicants and policyholders regarding its collection and disclosure of non-public personal financial information. The Company primarily writes commercial coverage and is not required by law to provide privacy notices to commercial customers.

Recommendations: None.

Standard I-14. If the regulated entity discloses information subject to an opt out right, the company has policies and procedures in place so that non-public personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the company provides opt out notices to its customers and other affected consumers.

Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313.

No work performed. The Company does not utilize opt out rights as it does not share information with others for marketing purposes; therefore, this standard is not applicable to this examination.

Standard I-15. The regulated entity's collection, use and disclosure of non-public personal financial information are in compliance with applicable statutes, rules and regulations.

Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313.

Objective: This Standard addresses the Company's policies and procedures regarding collection, use and disclosure of non-public personal financial information.

The Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313, set forth requirements for proper notice to consumers, and restrictions on a financial institution's ability to disclose consumers' non-public personal information to nonaffiliated third parties. Further, a financial institution must provide its customers with an annual written notice of its privacy policies and practices. In addition, a financial institution is prohibited from disclosing consumers' non-public personal information to nonaffiliated third parties, unless the institution satisfies various disclosure and opt-out requirements and the consumer has not elected to opt out of such disclosure.

Controls Assessment: See Standard I-10.

Controls Reliance: See Standard I-10.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for privacy compliance, and reviewed documentation supporting its privacy policies and procedures. During underwriting and claims testing procedures, RNA looked for any evidence that the Company improperly collected, used or disclosed non-public personal financial information.

Transaction Testing Results:

Findings: None.

Observations: It appears from RNA's review that the Company's policies and procedures provide reasonable assurance that the Company properly collects, uses and discloses non-public personal financial information.

Recommendations: None.

Standard I-16. In states promulgating the health information provisions of the NAIC model regulation, or providing equivalent protection through other substantially similar laws under the jurisdiction of the Department of Insurance, the regulated entity has policies and procedures in place so that non-public personal health information will not be disclosed except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.

Objective: This Standard addresses the Company's policies and procedures to ensure it maintains the privacy of non-public personal health information related to claims.

Controls Assessment: See Standard I-10.

Controls Reliance: See Standard I-10.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for privacy compliance, and reviewed documentation supporting its privacy policies and procedures related to claims. In conjunction with claims testing, RNA looked for evidence of improper use and maintenance of non-public personal health information.

Transaction Testing Results:

Findings: None.

Observations: Based upon RNA's review of the Company's policies, procedures and liability claims, it appears that such policies and procedures provide reasonable assurance that the Company maintains the privacy of non-public personal health information related to claims.

Recommendations: None.

Standard I-17. Each licensee shall implement a comprehensive written information security program for the protection of non-public customer information.

Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313.

Objective: This Standard addresses the Company's information security efforts to ensure that non-public consumer information is protected.

The Gramm-Leach-Bliley Act, §§ 502, 503, 504 and 505 and 16 CFR Part 313, set forth requirements for proper notice to consumers, and restrictions on a financial institution's ability to disclose consumers' non-public personal information to nonaffiliated third parties. Further, a financial institution must provide its customers with an annual written notice of its privacy policies and practices. In addition, a financial institution is prohibited from disclosing consumers' non-public personal information to nonaffiliated third parties, unless the institution satisfies various disclosure and opt-out requirements and the consumer has not elected to opt out of such disclosure.

Controls Assessment: See Standard I-10.

Controls Reliance: See Standard I-10.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for privacy compliance, and reviewed documentation supporting its privacy policies and procedures.

Transaction Testing Results:

Findings: None.

Observations: Based upon RNA's review of the Company's information security policies and procedures, it appears that the Company has implemented an information security program, which provides reasonable assurance that its information systems protect non-public customer information.

Recommendations: None.

II. COMPLAINT HANDLING

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures, (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard II-1. All complaints are recorded in the required format on the regulated entity complaint register.

M.G.L. c. 176D, § 3(10).

Objective: This Standard addresses whether the Company formally tracks complaints or grievances as required by statute.

Pursuant to M.G.L. c. 176D, § 3(10), an insurer is required to maintain a complete record of all complaints it received from the date of its last examination. The record must indicate the total number of complaints, the classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint and the time to process each complaint.

Controls Assessment: The following key observations were noted in conjunction with the review of Standards II-1 through II-4:

- Written Company policies and procedures govern the complaint handling process.
- The Company logs all written complaints in the complaint register in a consistent format.
- The complaint register includes the date received, the date closed, the person making the complaint, the insured, the policy number, state of residence, the nature of the complaint and the complaint disposition.
- The Company's policy is to respond to Division complaints within 14 calendar days of receipt when possible, and in a timely manner once it receives and evaluates all required information.
- The Company provides a telephone number and address in its written responses to consumer inquiries and on its web site.
- The Company generally monitors complaint activity and trends.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed management and staff responsible for complaint handling, and examined evidence of the Company's related processes and controls.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that the Company's format for recording complaints includes all necessary information. The Company reported no complaints during the examination period. Based upon the results of testing, it appears that the Company has a process for recording complaints in the required format in accordance with its policies, procedures, and statutory requirements.

Recommendations: None.

Standard II-2. The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

M.G.L. c. 176D, § 3(10).

Objective: This Standard addresses whether the Company has adequate complaint handling procedures and communicates those procedures to policyholders.

M.G.L. c. 176D, § 3(10) requires that (a) the Company has documented procedures for complaint handling (b) the procedures in place are sufficient to enable satisfactory handling of complaints received as well as to conduct root cause analyses in areas developing complaints; (c) there is a method for distribution of and obtaining and recording responses to complaints that is sufficient to allow response within the time frame required by state law, and (d) the Company provides a telephone number and address for consumer inquiries.

Controls Assessment: See Standard II-1.

Controls Reliance: See Standard II-1.

Transaction Testing Procedure: RNA interviewed management and staff responsible for complaint handling, and examined evidence of the Company's related processes and controls. The Company reported no complaints during the examination period. RNA also reviewed the Company's website, and various forms sent to policyholders, to determine whether the Company provides contact information for consumer inquiries as required.

Transaction Testing Results:

Findings: None.

Observations: It appears that the Company has adequate procedures in place to address complaints. The Company reported no complaints during the examination period. The Company is in the process of enhancing its complaint monitoring and trending capabilities.

Recommendations: The Company should complete the enhanced complaint monitoring and trending reporting process and timely implement its use.

Standard II-3. The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

Objective: This Standard addresses whether the Company response to the complaint fully addresses the issues raised, is properly documented, includes appropriate remedies and complies with statutes, regulations and contract language.

Controls Assessment: See Standard II-1.

Controls Reliance: See Standard II-1.

Transaction Testing Procedure: RNA interviewed management and staff responsible for complaint handling and reviewed the Company's related processes and controls.

Transaction Testing Results:

Findings: None.

Observations: The Company reported no complaints during the examination period. The Company appears to have a process to finalize and dispose of complaints in accordance with applicable statutes, rules, regulations and contract language.

Recommendations: None.

Standard II-4. The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

Objective: This Standard addresses the time required for the Company to process each complaint.

Massachusetts does not have a specific complaint processing time standard in the statutes or regulations. However, the Division has established a practice of requiring that insurers respond to complaints from the Division within 14 calendar days from the date they receive a notice of complaint.

Controls Assessment: See Standard II-1.

Controls Reliance: See Standard II-1.

Transaction Testing Procedure: RNA interviewed management and staff responsible for complaint handling and reviewed the Company's related processes and controls.

Transaction Testing Results:

Findings: None.

Observations: The Company reported no complaints during the examination period. The Company appears to have processes for responding to complaints in a timely manner

Recommendations: None.

III. MARKETING AND SALES

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures, (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard III-1. All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

M.G.L. c. 176D, § 3; Division of Insurance Bulletin 2001-02.

Objective: This Standard addresses whether the Company maintains a system of control over the content, form and method of dissemination for all advertisements of its policies.

Pursuant to M.G.L. c. 176D, § 3, it is deemed an unfair method of competition to misrepresent or falsely advertise insurance policies, or the benefits, terms, conditions and advantages of said policies. Pursuant to Division of Insurance Bulletin 2001-02, an insurer who maintains an Internet website must disclose on that website the name of the company appearing on the certificate of authority and the address of its principal office.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The corporate communications department, the legal department and the business line manager collaboratively develop advertising and sales materials targeted to consumers and producers.
- OB and the Company permit agents to develop advertising material. The standard agency contract requires agents to obtain home office approval prior to use of such material.
- OB's policy is to disclose its name and address on its website.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for advertising and sales materials, and reviewed six pieces of advertising and sales materials used during the examination period for compliance with statutory and regulatory requirements. RNA reviewed the standard agency contract for the requirement to obtain home office approval prior to use of agent-developed advertising material. Finally, RNA reviewed the OB website for appropriate disclosure of its name and address, and general compliance with statutory and regulatory requirements.

Transaction Testing Results:

Findings: None.

Observations: The results of RNA's testing showed that the Company's advertising and sales materials comply with Massachusetts M.G.L. c. 176D, § 3. The standard agency

contract contains the requirement to obtain home office approval prior to use of agent-developed advertising material. The Company's website disclosure complies with the requirements of Division of Insurance Bulletin 2001-02. However, the Company has not retained internal approval of three advertising materials used during the examination period.

Recommendations: The Company should adopt a written policy and procedure, which requires that approvals from corporate communications, the legal department and the business line manager are obtained before marketing materials are published. Further, the written policy and procedures should require that this documentation be retained by the Company as long as the materials are in use.

Subsequent Actions: The Company has implemented the recommendations noted above.

Standard III-2. Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.

Objective: This Standard addresses whether all of the Company's producer training materials are in compliance with state statutes, rules and regulations.

Controls Assessment: The following controls were noted as part of this Standard and Standard III-3:

- The Company has distributed producer training materials focusing on Company policies, practices and procedures, including those relating to underwriting and rating, policyholder service, and claims.
- The Company's producers have access to electronic policy and procedure manuals through the Company's agent web portal.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for developing and distributing producer training materials, and reviewed such materials in use during the examination period for accuracy and reasonableness.

Transaction Testing Results:

Findings: None.

Observations: The Company's producer training materials appear accurate and reasonable.

Recommendations: None.

Standard III-3. Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.

Objective: This Standard addresses whether the written and electronic communication between the Company and its producers is in accordance with applicable statutes, rules and regulations.

Controls Assessment: See Standard III-2.

Controls Reliance: See Standard III-2.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for developing and circulating written producer communications, and reviewed several such communications to producers during the examination period for accuracy and reasonableness.

Transaction Testing Results:

Findings: None.

Observations: The Company's communications to producers appear accurate and reasonable.

Recommendations: None.

Standard III-4. Regulated entity mass marketing of property and casualty insurance is in compliance with applicable statutes, rules and regulations.

No work performed. This Standard is not covered in the scope of examination because the Company does not mass market property and casualty insurance in Massachusetts.

IV. PRODUCER LICENSING

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures, (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard IV-1. Regulated entity records of licensed and appointed (if applicable) producers agree with department of insurance records.

18 U.S.C. § 1033; M.G.L. c. 175, §§ 162I and 162S; Division of Insurance Bulletins 1998-11 and 2001-14.

Objective: The Standard addresses licensing and appointment of the Company's producers.

M.G.L c. 175, § 162I requires that all persons who solicit, sell or negotiate insurance in the Commonwealth be licensed for that line of authority. Further, any such producer shall not act as an agent of the Company unless the producer has been appointed by the Company pursuant to M.G.L c. 175, § 162S.

Pursuant to 18 U.S.C. § 1033 of the Violent Crime Control and Law Enforcement Act of 1994 ("Act"), it is a criminal offense for anyone "engaged in the business of insurance" to willfully permit a "prohibited person" to conduct insurance activity without written consent of the primary insurance regulator. A "prohibited person" is an individual who has been convicted of any felony involving dishonesty or a breach of trust or certain other offenses, who willfully engages in the business of insurance as defined in the Act. In accordance with Division of Insurance Bulletins 1998-11 and 2001-14, any entity conducting insurance activity in Massachusetts has the responsibility of notifying the Division, in writing, of all employees and producers acting as agents who are affected by this law. Those individuals may either apply for an exemption from the law, or must cease and desist from their engagement in the business of insurance.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company's appointment procedures are designed to comply with statutory requirements, which state, in part, that an insurer seeking to appoint a licensed producer as agent must do so within 15 days from the date the producer's contract is executed, or when the first policy application is received.
- The Company's policy is to seek the Division's approval regarding the appointment of any "prohibited person" as noted above when it wishes to appoint such a person.
- The Company maintains an automated producer database that tracks all terminations, appointments and other licensing changes related to its appointed agents.
- The Company verifies that producers are properly licensed for the lines of business to be sold in Massachusetts prior to contracting with them as agents.
- All appointed agents are required to enter into a written contract with the Company prior to selling business. Standard contract terms and conditions address authorities and responsibilities, producer licensing, maintenance of records, ownership of business, privacy requirements, binding authority, commission rates, premium accounting, advertising, and termination/suspension provisions.
- The Company requires its appointed agents to maintain $1 million of E&O coverage.

- The Company's producer compensation policies are disclosed on the OB website.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed individuals with responsibility for producer contracting and processing of agent appointments. RNA reviewed evidence of agent appointments in conjunction with testing of six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period. RNA verified that the sales agent for each policy was included on the Division's list of the Company's appointed agents at the time of sale.

Transaction Testing Results:

Findings: Based on the results of RNA's testing of six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, one policy was sold by a producer who was not licensed in Massachusetts on the sale date in violation of M.G.L c. 175, § 162I. The producer was licensed in Rhode Island on the sale date, and is the process of becoming licensed in Massachusetts. All of the remaining producers who sold policies during the examination period were properly licensed. Further, all but three of the licensed producers were included on the Division's list of the Company's appointed agents when the policies were issued. The Company subsequently appointed the three producers as agents.

Observations: None.

Recommendations: The Company should implement a control procedure during underwriting to ensure that all producers are licensed and appointed as agents prior to selling business. Further, the Company and the Division shall complete a reconciliation of the Company's agent appointments at a mutually agreed upon date, to ensure that such appointment records are in agreement. Finally, internal audit, together with the producer appointment area, should conduct testing of underwriting controls designed to ensure that producers are licensed prior to selling business, to ensure that such controls are functioning properly.

Subsequent Actions: The Company states that it is now appointing all licensed producers as agents within the required time frame.

Standard IV-2. The producers are properly licensed and appointed (if required by state law) in the jurisdiction where the application was taken.

18 U.S.C. § 1033; M.G.L. c. 175, §§ 162I and 162S; Division of Insurance Bulletins 1998-11 and 2001-14.

See Standard IV-1 for testing.

Standard IV-3. Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

M.G.L. c. 175, §§ 162R and 162T.

Objective: This Standard addresses the Company's termination of producers in accordance with applicable statutes requiring notification to the state and the producer.

Pursuant to M.G.L. c. 175, § 162T, the Company must notify the Division within 30 days of the effective date of a producer's termination, and if the termination was "for cause" as defined in M.G.L. c. 175, § 162R, the Company must notify the Division of such cause. Further, M.G.L. c. 175, § 162R provides the reasons for which the Company may terminate a producer's appointment as agent, and the reasons for which the Division may terminate a producer's license.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company's policy and practice is to notify the Division of agent terminations as required by statute.
- The Company's policy and practice is to notify the Division of the reason for agent terminations when the termination is "for cause."
- The Company has a process for notifying agents that their appointments have been terminated, which complies with statutory and contractual requirements.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed individuals with responsibility for producer contracting and termination processing. RNA selected three terminated agents from the Company's termination listing and the Division's termination records, and compared the termination information on both listings.

Transaction Testing Results:

Findings: None.

Observations: The results of RNA's testing showed that the Company appears to be notifying the Division when it terminates agent appointments.

Recommendation: None.

Standard IV-4. The regulated entity's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

Objective: This Standard addresses the Company's policy for ensuring that producer appointments and terminations do not unfairly discriminate against policyholders.

Controls Assessment: See Standards IV-1 and IV-3.

Controls Reliance: See Standards IV-1 and IV-3.

Transaction Testing Procedure: RNA interviewed individuals with responsibility for producer contracting, appointments and terminations. In conjunction with testing six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, RNA reviewed documentation for any evidence of unfair discrimination against policyholders resulting from the Company's policies regarding producer appointments and terminations.

Transaction Testing Results:

Findings: None.

Observations: Through RNA's testing of six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed, no evidence of unfair discrimination against policyholders was noted as a result of the Company's policies regarding producer appointments and terminations.

Recommendations: None.

Standard IV-5. Records of terminated producers adequately document the reasons for terminations.

M.G.L. c. 175, §§ 162R and 162T.

Objective: The Standard addresses the Company's documentation of producer terminations.

Pursuant to M.G.L. c. 175, § 162T, the Company must notify the Division within 30 days of the effective date of a producer's termination, and if the termination was "for cause" as defined in M.G.L. c. 175, § 162R, the Company must notify the Division of such cause. Further, M.G.L. c. 175, § 162R provides the reasons for which the Company may terminate a producer's appointment as agent and the reasons for which the Division may terminate a producer's license.

Controls Assessment: See Standard IV-3.

Controls Reliance: See Standard IV-3.

Transaction Testing Procedure: RNA interviewed individuals with responsibility for producer contracting and termination processing, and selected three terminated agents from the Company's termination listing to review the reasons for each termination..

Transaction Testing Results:

Findings: None.

Observations: Based on RNA's testing, the Company's internal records adequately document reasons for agent terminations. None of the terminations that RNA tested was "for cause" as defined by statute.

Recommendations: None.

Standard IV-6. Producer account balances are in accordance with the producer's contract with the insurer.

No work performed. This Standard is not covered in the scope of examination because the Company direct bills most premium, thus excessive debit account balances are not a significant issue. If material debit account balances existed, they would be evaluated in the scope of the statutory financial examination of the Company.

V. POLICYHOLDER SERVICE

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures, (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard V-1. Premium notices and billing notices are sent out with an adequate amount of advance notice.

M.G.L. c. 175, §§ 193B and 193B ½.

Objective: This Standard addresses efforts to provide policyholders with sufficient advance notice of premiums due and notice of cancellation due to non-payment.

Pursuant to M.G.L. c. 175, §§ 193B and 193B ½, motor vehicle premiums may be paid in installments, with interest charged on the unpaid balance due as of the billing date.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company directly bills policyholders, who receive a billing notice from the Company approximately 20 days prior to the premium due date. The Company receives premium payments by electronic funds transfer or check.
- Company policy generally requires a 30% premium down payment at the time a homeowners application is taken, and a 25% premium down payment at the time a commercial application is taken.
- All billing notices contain disclosures regarding grace periods and policy cancellation for non-payment of premium.
- The Company bills the agent monthly for premium activity of some commercial customers, or the agent provides the Company a record of monthly activity using a policy listing. Payment from the agent is due in 45-50 days after billing, or after the date the agent provides the monthly activity listing.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for policyholder service. RNA also reviewed billing notice dates for policies issued or renewed during the examination period, and reviewed installment and interest charges on a limited basis.

Transaction Testing Results:

Findings: None.

Observations: The premium and billing transactions tested were processed according to the Company's policies and procedures. Based upon the results of testing, the Company's processes for mailing billing notices with adequate advance notice, and

properly applying monthly service charges on installment payments, appear to be functioning in accordance with its policies, procedures, and statutory requirements.

Recommendation: None.

Standard V-2. Policy issuance and insured requested cancellations are timely.

M.G.L. c. 175, § 187B.

Objective: This Standard addresses the Company's procedures to ensure customer cancellation requests are processed timely. Objectives pertaining to policy issuance are included in Underwriting and Rating Standard VI-6. Return of premium testing is included in Policyholder Service Standard V-7.

Pursuant to M.G.L. c. 175, § 187B, insurers are required to return unearned premium in a reasonable time upon receipt of the policyholder's request to cancel.

Controls Assessment: The following key observations were noted in conjunction with the review of cancellation and withdrawals under this Standard:

- Company policy is to cancel policies upon notification from the producer of the policyholder's request, and to process premium refunds in a timely manner.
- The Company refunds unearned premium to policyholders on a pro-rata or short rate basis, pursuant to statutory and regulatory guidelines.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for policyholder service, and tested five homeowners, nine commercial multi-peril and two workers' compensation cancellations processed during the examination period, for evidence that each cancellation request was processed timely.

Transaction Testing Results:

Findings: None.

Observations: The insured-requested cancellations tested were processed timely according to the Company's policies and procedures. Based upon the results of testing, the Company's processing of insured-requested cancellations appears to be functioning in accordance with its policies, procedures, and statutory requirements. Computer system limitations required the cancellation of one commercial multi-peril policy and one workers' compensation policy, in order to change a producer code or a commission.

Recommendations: The Company should consider computer system enhancements to allow changes in producer codes and commissions without canceling and rewriting existing policies.

Standard V-3. All correspondence directed to the regulated entity is answered in a timely and responsive manner by the appropriate department.

Objective: This Standard addresses the Company's procedures to provide timely and responsive information to customers by the appropriate department. Complaints are covered in the Complaint Handling section. Claims are covered in the Claims section.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- Customer service representatives answer policyholders' general questions about their policies or billing matters.
- The Company considers its producers as having the primary relationship with the policyholder. Since customer service representatives are not licensed producers, policyholders must request endorsements and policy changes through the producer. Policyholders who request such changes through customer service can be transferred to the producer for servicing.
- The Company monitors its monthly accumulation of Key Performance Indicators ("KPIs") for policyholder service performance.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA discussed correspondence procedures with Company personnel, and reviewed correspondence in conjunction with underwriting, rating, policyholder service and claims standards. RNA also obtained and reviewed documentation showing customer service KPIs.

Transaction Testing Results:

Findings: None.

Observations: Based upon a review of general correspondence between policyholders and the Company regarding underwriting, rating, policyholder service and claims, and review of the above information, it appears that the Company handles customer inquiries and correspondence directed to it in a timely and responsive manner.

Recommendations: None.

Standard V-4. Whenever the regulated entity transfers the obligations of its contracts to another regulated entity pursuant to an assumption reinsurance agreement, the regulated entity has gained the prior approval of the insurance department and the regulated entity has sent the required notices to affected policyholders.

No work performed. The Company does not enter into assumption reinsurance agreements.

Standard V-5. Policy transactions are processed accurately and completely.

Objective: This Standard addresses procedures for the accurate and complete processing of policy transactions. Objectives pertaining to policy issuance, renewal and endorsements are included in Underwriting and Rating Standard VI-6. Return of premium testing is included in Policyholder Service Standard V-7. Billing transactions are reviewed in Policyholder Service Standard V-1, and insured-requested cancellations are tested in Policyholder Service Standard V-2. Company cancellations and non-renewals are tested in Underwriting and Rating Standard VI-7 and VI-8.

Standard V-6. Reasonable attempts to locate missing policyholders or beneficiaries are made.

M.G.L. c. 200A, §§ 1, 2, 7-7B, 8A and 9.

Objective: This Standard addresses efforts to locate missing policyholders or beneficiaries and to comply with escheatment and reporting requirements.

M.G.L. c. 200A, §§ 1, 2, 7-7B, 8A and 9 state that amounts due policyholders or beneficiaries are presumed abandoned if unclaimed for more than three years after the funds become payable. Annual reporting to the State Treasurer's Office regarding efforts to locate owners is required, and the statutes require payments to the State Treasurer's Office for escheated property.

Controls Assessment: The following controls were noted in review of this Standard:

- Company policy requires that un-cashed checks, including claims and premium refunds, be reported and escheated when the owner can not be found.
- The Company has implemented procedures for locating lost owners via Company records and public databases. The Company conducts further research for uncashed checks, and sends a letter to the last known address in an attempt to locate the owner.
- The Company annually reports escheatable funds to the State Treasurer by November 1st as required by law. Prior to escheatment of funds, a final attempt is made to locate the owner.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA discussed the Company's procedures for locating missing policyholders and escheatment of funds with Company personnel, and reviewed supporting documentation.

Transaction Testing Results:

Findings: None.

Observations: The Company appears to have processes for locating missing policyholders and claimants, and appears to make reasonable efforts to locate such

individuals. The Company appears to report unclaimed items and escheat them as required by law.

Recommendations: None.

Standard V-7. Unearned premiums are correctly calculated and returned to appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

General: M.G.L. c. 175, §§ 187B and 187C.
Automobile: M.G.L. c. 175, §§ 113A and 176A; 211 CMR 85.00.

Objective: This Standard addresses return of the correctly calculated unearned premium in a timely manner when policies are cancelled.

Pursuant to M.G.L. c. 175, § 187B, a company is required to refund the proper amount of unearned premium upon any policy termination. Under M.G.L. c. 175, § 187C, a company canceling a policy of insurance must tender the full return premium due, without deductions, at the time the cancellation notice is served on the insured.

M.G.L. c. 175, § 113A provides, in part, that when a motor vehicle policy is cancelled by either the insured or the company, insureds that paid the premium in full are entitled to a return of premium calculated on a pro rata basis. Pursuant to M.G.L. c. 175, § 176A, premium refunds on cancelled policies must be paid to the policyholder within 30 days, and notice of the cancellation must be given. Pursuant to 211 CMR 85.00, short rate tables may be required to calculate automobile premium refunds, depending on when the policy is cancelled.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- Company policy is to cancel policies upon notification from the producer of the policyholder's request, and to process premium refunds in a timely manner.
- The Company refunds unearned premium to policyholders on a pro-rata or short rate basis, pursuant to statutory and regulatory guidelines.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected five homeowners, nine commercial multi-peril and two workers' compensation cancellations processed during the examination period, to test for timely payment of properly calculated refunds.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, premium refunds appear to be calculated properly and returned timely.

Recommendations: None.

Standard V-8. Claims history and loss information is provided to insured in timely manner.

Objective: This Standard addresses the Company's procedures for timely providing claim history and loss information to insureds.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company's producers and its claims personnel have access to policyholders' claims history and paid loss information from a private Comprehensive Loss Underwriting Exchange database.
- The Company's policy is to ask the producer to provide a policyholder their claims history and paid loss information upon request.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA discussed with Company personnel its policies and procedures for responding to policyholder inquiries regarding claims history and paid loss information.

Transaction Testing Results:

Findings: None.

Observations: The testing of underwriting and rating, claims, complaints and policyholder service noted no evidence of the Company failing to respond to policyholder inquiries on claims history and paid loss information.

Recommendations: None.

VI. UNDERWRITING AND RATING

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures, (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard VI-1. The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity rating plan.

General: M.G.L. c. 175, § 193R.
Property/Liability and Commercial Multi-peril: M.G.L. c. 174A, §§ 5, 6 and 9; M.G.L. c. 175 § 111H; 211 CMR 131.00.
Commercial Automobile and Commercial Multi-peril: M.G.L. c. 175A, §§ 5, 6 and 9.
Commercial Automobile: M.G.L. c. 175E, § 7; 211 CMR 78.00, 86.00, 91.00 and 124.00.
Workers' Compensation: M.G.L. c. 152, § 53A; 211 CMR 110.00, 211 CMR 113.00 and 211 CMR 115.00.

Objective: This Standard addresses whether the Company is charging premiums using properly filed rates.

M.G.L. c. 175, § 193R permits affinity group discounts based on experience for motor vehicle and homeowners policies. Pursuant to M.G.L. c. 174A, § 5, fire rates shall be based on past and prospective loss experience during a period of not less than the most recent five-year period for which such experience is available. In considering catastrophe hazards with respect to homeowners' insurance rates, the Commissioner shall consider catastrophe reinsurance and factors relating thereto. Fire rates shall also consider a reasonable margin for underwriting profit and contingencies. Finally, such rates shall not be excessive, inadequate or unfairly discriminatory. M.G.L. c. 174A, § 6 requires the filing of fire rates with the Commissioner, and M.G.L. c. 174A, § 9 requires insurers to use such filed rates, unless the insurer obtains approval from the Commissioner for a rate deviation.

M.G.L. c. 175, § 111H requires that any policy providing lead liability coverage be subject to rules and regulations set forth by the Commissioner, and 211 CMR 131.00 prescribes requirements for the filing of lead liability coverage rates with the Division.

Pursuant to M.G.L. c. 175A, § 5, rates for commercial automobile and multi-peril policies shall be based on past and prospective loss experience, a reasonable margin for underwriting profit and contingencies, investment income, unearned premium reserves and loss reserves. Rates shall not be excessive, inadequate or unfairly discriminatory, and must be filed with the Commissioner as provided by M.G.L. c. 175A, § 6 prior to use. Insurers must also use filed rates, unless they obtain approval for a rate deviation, as set forth in M.G.L. c. 175A, § 9.

For commercial automobile policies, M.G.L. c. 175E, § 7 and 211 CMR 78.00 require every insurer or rating organization authorized to file on behalf of such insurer to file with the Commissioner its classifications, rules and rates, rating plans and modifications of any of the foregoing not less than 45 days before the effective date thereof. 211 CMR 86.00 requires premium discounts for anti-theft devices, and 211 CMR 124.00 mandates premium discounts for certain safety features. Finally, 211 CMR 91.00 also prescribes requirements for the filing of rates with the Commissioner at least 45 days prior to their effective date.

M.G.L. c. 152, § 53A specifies a rate filing process and statistical reporting requirements for workers compensation policies using experience rating credits and payroll caps to ensure equitable distribution of premium based on wage differentials. Further, rates and producer commissions for business ceded to the Commonwealth reinsurance pool are determined by the Division. 211 CMR 110.00, 211 CMR 113.00 and 211 CMR 115.00 provide guidance on rate filing procedures, premium credit filings and the conduct of rate hearings.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard and Standard VI-10:

- The Company has written underwriting and rating policies and procedures, which are designed to reasonably assure consistency in classification and rating.
- The Company conducts compliance audits of its producers regarding required maintenance of certain underwriting information that is retained by the producer.
- Company policy prohibits unfair discrimination in the application of premium discounts and surcharges, and in the application of the general rating methodology, in accordance with company policies and procedures.
- Commercial automobile rates are determined by CAR for those risks ceded to CAR, and such rates are filed with the Division. After 2006, the Company was no longer ceding risks to CAR. All other commercial automobile rates are based on experience and filed with the Division for approval prior to use.
- Commercial multi-peril rates are based on a combination of experience and Insurance Services Office ("ISO") rates. The Company files such rates with the Division for use to comply with statutory and regulatory requirements. Property coverage rating criteria include territory, coverage amount and type, property age, protection class and structure type. Liability coverage rates are generally based on the type of business, number of employees, payroll and annual revenue.
- Workers' compensation rates are determined by the WCRIB, and such rates are filed with the Division.
- The WCRIB conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements, including those related to premium rates.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process, and reviewed other rating information. RNA selected three homeowners, four commercial multi-peril and two workers' compensation policies issued or renewed during the examination period to test rate classifications and premiums charged. RNA verified that each policy's premium, discounts and surcharges complied with Company policies and procedures.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, it appears that the Company calculates policy premiums, discounts and surcharges in compliance with its policies and procedures.

Recommendations: None.

Standard VI-2. All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.

Property/Liability and Commercial Multi-Peril: M.G.L. c. 175, §§ 99 and 99A; M.G.L. c. 174A, § 11.
Commercial Automobile and Commercial Multi-peril: M.G.L. c. 175A, § 11.
Workers' Compensation: M.G.L. c. 152, § 25A; 211 CMR 113.00 and 115.00.

Objective: This Standard addresses whether all mandated disclosures for rates and coverage are documented in accordance with statutes and regulations and timely provided to insureds.

Pursuant to M.G.L. c. 175, § 99 and 99A numerous disclosures and requirements must be included on a standard fire policy. Pursuant to M.G.L. c. 174A, § 11, rating organizations and insurers shall furnish rate information to any insured within a reasonable time after receiving a written request.

For commercial automobile and multi-peril policies, M.G.L. c. 175A, § 11, requires rating organizations and insurers to furnish rate information to any insured within a reasonable time after receiving a written request.

Pursuant to M.G.L. c. 152, § 25A, each insurer must offer policy deductibles for workers compensation policies, including reasonable small deductibles optional to the policyholder, which shall be fully disclosed to prospective policyholders in writing. 211 CMR 113.00 and 211 CMR 115.00 provide additional guidance on deductibles.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company has written policies and procedures for processing new and renewal business.
- The Company's supervisory procedures are designed to ensure that new business submissions from producers are accurate and complete, including the use of all Company required forms and instructions.
- The Company's insurance policies provide rate and coverage disclosures as required by Company policies and procedures.
- The Company conducts compliance audits of its producers regarding required maintenance of certain underwriting information that is retained by the producer.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA also selected six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, to test for timely disclosure of rates and coverages.

Transaction Testing Results:

Findings: None.

Observations: Based upon testing, the Company appears to provide required coverage disclosures to insureds upon initial application and renewal in accordance with policies and procedures.

Recommendations: None.

Standard VI-3. The regulated entity does not permit illegal rebating, commission cutting or inducements.

M.G.L. c. 175, §§ 182, 183 and 184; M.G.L. c. 176D, § 3(8).
Workers' Compensation: M.G.L. c. 152, § 53A.

Objective: This Standard addresses illegal rebating, commission cutting and inducements, and requires that producer commissions adhere to the commission schedule.

Pursuant to M.G.L. c. 175, §§ 182, 183 and 184, the Company, or any agent thereof, cannot pay or allow, or offer to pay or allow any valuable consideration or inducement not specified in the policy or contract. Similarly, under M.G.L. c. 176D, § 3(8), it is an unfair method of competition to knowingly permit or make any offer to pay, allow or give as inducement any rebate of premiums, any other benefits or any valuable consideration or inducement not specified in the contract. M.G.L. c. 152, § 53A requires the Division to determine producer commissions for workers' compensation business ceded to the Commonwealth reinsurance pool.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company has procedures for paying producers' commissions in accordance with home office approved written contracts.
- The Company's producer contracts, and its home office policies and procedures, are designed to comply with statutory underwriting and rating requirements that prohibit special inducements and rebates.
- The Company's producer compensation policies are disclosed on the OB website.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed individuals with responsibility for commission processing and producer contracting. In connection with the review of producer

contracts, RNA inspected new business materials, producer training materials and manuals for indications of rebating, commission cutting or inducements. RNA also evaluated the Company's response to the Division's survey on broker activities. Finally, RNA selected four homeowners, four commercial multi-peril and one workers' compensation policy issued or renewed during the examination period, to test commissions paid to producers and to look for indications of rebating, commission cutting or inducements.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing and review of the Company's response to the Division's survey on broker activities, it appears that the Company's processes for prohibiting illegal acts, including special inducements and rebates, are functioning in accordance with its policies, procedures and statutory requirements.

Recommendations: None.

Standard VI-4. The regulated entity underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.

General: M.G.L. c. 175, § 193T.
Property/Liability: M.G.L. c. 175, § 4C, and 95B.
Commercial Automobile: M.G.L. c. 175, § 22E.
Commercial Automobile and Commercial Multi-peril: M.G.L. c. 175A, § 5.
Commercial Multi-peril: M.G.L. c. 174A, § 5.

Objective: This Standard addresses whether unfair discrimination is occurring in insurance underwriting.

M.G.L. c. 175, § 193T prohibits discrimination in underwriting or in rates charged for all policies based on blindness or partial blindness, mental retardation or physical impairment, unless such discrimination is based on "sound actuarial principles or is related to actual experience."

Pursuant to M.G.L. c. 175, § 4C, no insurer shall take into consideration when deciding whether to provide, renew, or cancel homeowners' insurance the race, color, religious creed, national origin, sex, age, ancestry, sexual orientation, children, marital status, veteran status, the receipt of public assistance or disability of the applicant or insured. M.G.L. c. 175, § 95B notes that no insurer shall cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount or payment of premiums or rates charged, in the length of coverage, or in any other of the terms and conditions of a residential property insurance policy, based upon information that an applicant or policy owner, or any member of their family, has been a victim of domestic abuse.

Pursuant to M.G.L. c. 175, § 22E, no insurance company, and no officer or agent thereof on its behalf, shall refuse to issue, renew or execute as surety a commercial motor vehicle liability policy or bond, or any other insurance based on the ownership or operation of a motor vehicle, because of age, sex, race, occupation, marital status, or principal place of garaging of the vehicle.

Pursuant to M.G.L. c. 175A, § 5, rates for commercial automobile and multi-peril policies shall be based on past and prospective loss experience, a reasonable margin for underwriting profit and contingencies, investment income, unearned premium reserves and loss reserves. Rates shall not be excessive, inadequate or unfairly discriminatory.

Pursuant to M.G.L. c. 174A, § 5, fire rates for commercial multi-peril policies shall be based on past and prospective loss experience during a period of not less than the most recent five-year period for which such experience is available, and shall consider a reasonable margin for underwriting profit and contingencies. Finally, such rates shall not be excessive, inadequate or unfairly discriminatory.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- Company policy and practice prohibits unfair discrimination in underwriting in accordance with statutory requirements.
- Written Company underwriting guidelines are designed to reasonably assure appropriate acceptance and rejection of risks on a proper, consistent and fair basis.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, to test for evidence of unfair discrimination in underwriting.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, RNA noted no evidence that the Company's underwriting practices are unfairly discriminatory.

Recommendations: None.

Standard VI-5. All forms including contracts, riders, endorsement forms and certificates are filed with the Department of Insurance (if applicable).

General: M.G.L. c. 175, § 2B and 192.
Property/Liability: M.G.L. c. 175, §§ 99, 99B, and 111H; 211 CMR 131.00.
Commercial Automobile: M.G.L. c. 175, §§ 22A and 113A.
Workers' Compensation: M.G.L. c. 152, § 53A.

Objective: This Standard addresses whether policy forms and endorsements are filed with the Division for approval.

Pursuant to M.G.L. c. 175, § 2B, policy form language, size and content standards for all policies must meet statutory requirements for readability and understanding. Pursuant to M.G.L. c. 175, § 192, endorsements are part of policy forms and must be filed with the Division for approval prior to use.

Pursuant to M.G.L. c. 175, § 99 homeowners' policy forms must conform to the standards for policy language set forth in that section and, according to M.G.L. c. 175, § 99B, condominium and tenant policies must be filed with the Division for approval prior to use. M.G.L. c. 175, § 111H requires that any policy providing lead liability coverage be subject to rules and regulations set forth by the Commissioner, and 211 CMR 131.00 requires that forms be filed with and approved by the Division for homeowners' lead liability coverage.

Pursuant to M.G.L. c. 175, §§ 22A and 113A, commercial automobile policy forms must be filed with the Division for approval prior to use. M.G.L. c. 152, § 53A requires workers' compensation policy forms to be filed with the Division.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard and Standard VI-20:

- Company policy requires the use of standard policy forms and endorsements, which are filed with and approved by the Division.
- Producers are required to use approved forms and endorsements as guidelines when providing quotes to customers.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, to test for the use of acceptable policy forms and endorsements in compliance with Company policies and procedures.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, it appears that the Company is using acceptable policy forms and endorsements in compliance with policies and procedures.

Recommendations: None.

Standard VI-6. Policies, riders and endorsements are issued or renewed accurately, timely and completely.

Objective: This Standard addresses whether the Company issues policies and endorsements timely and accurately.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company has written underwriting and rating policies and procedures, which are designed to reasonably assure consistency in classification and rating.
- Company policy prohibits unfair discrimination in the application of premium discounts and surcharges, and in the application of the general rating methodology, in accordance with company policies and procedures.
- Any changes in policy coverage must be requested through the producer, who must timely process such requests.
- Applications submitted by producers are reviewed by the underwriting department to ensure that they are complete and internally consistent.
- The Company conducts compliance audits of its producers regarding required maintenance of certain underwriting information that is retained by the producer.
- OB's underwriting department conducts quarterly peer reviews of each underwriter's business. In addition, the home office underwriting management conducts quality control audits every 18 months.
- The Company is subject to periodic audits by CAR for compliance with statutes and CAR Rules.
- The WCRIB conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements including those related to premiums.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies, and five policy endorsements issued or renewed during the examination period, to test whether new and renewal policies and endorsements were issued timely, accurately and completely.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, it appears that the Company generally issues new and renewal policies and endorsements timely, accurately and completely.

Recommendations: None.

Standard VI-7. Rejections and declinations are not unfairly discriminatory.

General: M.G.L. c. 175, § 193T.
Property/Liability: M.G.L. c. 175, §§ 4C and 95B
Commercial Automobile: M.G.L. c. 175, §§ 22E and 113D.

Objective: This Standard addresses the fairness of application rejections and declinations.

M.G.L. c. 175, § 193T prohibits discrimination based on blindness or partial blindness, mental retardation or physical impairment, unless such discrimination is based on "sound actuarial principles or is related to actual experience."

Pursuant to M.G.L. c. 175, § 4C, no insurer shall take into consideration when deciding whether to provide, renew, or cancel homeowners' insurance the race, color, religious creed, national origin, sex, age, ancestry, sexual orientation, children, marital status, veteran status, the receipt of public assistance or disability of the applicant or insured. M.G.L. c. 175, § 95B notes that no insurer shall cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount or payment of premiums or rates charged, in the length of coverage, or in any other of the terms and conditions of a residential property insurance policy based upon information that an applicant or policy owner, or any member of their family, has been a victim of domestic abuse.

Pursuant to M.G.L. c. 175, § 22E, no insurance company or agent thereof on its behalf, shall refuse to issue, renew or execute as surety a motor vehicle liability policy or bond, or any other insurance based on the ownership or operation of a motor vehicle because of age, sex, race, occupation, marital status, or principal place of garaging of the vehicle. In addition, M.G.L. c. 175, § 113D states that any person aggrieved by the refusal of any company or an agent thereof to issue such a policy may file a written complaint with the commissioner within 10 days after such refusal.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- Company policy and practice prohibits unfair discrimination in underwriting in accordance with statutory requirements.
- Written Company underwriting guidelines are designed to reasonably assure appropriate acceptance and rejection of risks on a proper, consistent and fair basis.
- Company policy allows for the cancellation of homeowners' policies when the nature of the risk at inception changes to an unacceptable risk during the coverage period.
- The Company's underwriting department conducts quarterly self-audits to evaluate compliance with statutory requirements for homeowners cancellations and non-renewals.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected 16 company-initiated cancellations, non-renewals and

declinations processed during the examination period, to ensure that cancellations were not unfairly discriminatory.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, company-initiated cancellations and non-renewals do not appear to be unfairly discriminatory.

Recommendations: None.

Standard VI-8. Cancellation/non-renewal, discontinuance and declination notices comply with policy provisions and state laws and regulated entity guidelines.

General: M.G.L. c. 175, § 187C.
Property/Liability: M.G.L. c. 175, §§ 99 and 193P.
Commercial Automobile: M.G.L. c. 175, §§ 113A and 113F.
Workers' Compensation: M.G.L. c. 152, §§ 55A and 65B.

Objective: This Standard addresses notice to policyholders for cancellation, non-renewal and declinations, including advance notice before expiration for cancellation and non-renewals.

Pursuant to M.G.L. c. 175, § 187C any Company shall effect cancellation of any policy by serving written notice thereof as provided by the policy, and by paying the full return premium due.

Pursuant to M.G.L. c. 175, § 99, any Company may cancel property/liability coverage by giving the insured five days written notice of cancellation, and 20 days written notice of cancellation to the mortgagee to whom the policy is payable, except when the stated reason for cancellation is nonpayment of premium, when 10 days written notice of cancellation is required. M.G.L. c. 175, § 193P requires an insurer to give written notice of intent to non-renew a policy to the insured at least 45 days prior to the expiration of the policy, accompanied by a written statement specifying reasons for such decision.

Pursuant to M.G.L. c. 175, § 113A, no cancellation of the policy shall be valid unless written notice of the specific reason or reasons for such cancellation is given at least 20 days prior to the effective date thereof, which date shall be set forth in the notice. M.G.L. c. 175, § 113F states that any Company which does not intend to issue, extend or renew a motor vehicle liability policy shall give written notice to the insured (or agent in certain circumstances) of its intent 45 days prior to the termination effective date. Such notice must also be sent to the Registry of Motor Vehicles. Every insurance agent or broker receiving such a notice from a company shall, within 15 days of its receipt, send a copy of such notice to the insured, unless another insurer has issued a motor vehicle policy covering that insured's vehicles.

M.G.L. c. 152 § 65B requires that any insurer canceling a workers' compensation policy shall give notice in writing to the rating organization and the insured of its desire to cancel. Such cancellation shall be effective unless the employer, within ten days after the receipt of such notice, files an objection with the Division. M.G.L. c. 152 § 55A allows mid-term notice of cancellation of a workers' compensation policy only if based on nonpayment of premium; fraud

or material misrepresentation affecting the policy or insured; or a substantial increase in the risk hazard.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard and Standard VI-9:

- Company policy requires that a written cancellation notice be given to homeowners policyholders in accordance with statutory requirements. The Company's practice is to give at least 20 days written notice to the policyholder prior to the effective date for such cancellations. The Company's general practice is to give notice to the producer, who is responsible for timely communicating the pending action to the policyholder.
- Company policy requires that a written non-renewal notice be given to homeowners policyholders at least 45 days prior to the effective date, in accordance with statutory requirements. The Company's general practice is to give notice to the producer, who is responsible for timely communicating the pending action to the policyholder.
- The Company generally does not cancel commercial policies after the first 60 days of coverage, nor do they rescind coverage. However, when the Company elects to cancel such coverage, its practice is to give notice to the producer at least 20 days prior to the effective date of the cancellation, Producers are then responsible for timely communicating the pending action to the policyholder.
- Company policy requires that written non-renewal notices for commercial policies be given to policyholders at least 45 days prior to the effective date. The Company's general practice is to give such notice to the producer, who is responsible for timely communicating the pending action to the policyholder.
- In cases where the producer has terminated his or her contract with the Company, the producer often will replace an insured's coverage with a new carrier upon policy expiration. In these cases, the producer generally does not provide a notice of non-renewal to the insured, since the producer has found a new carrier to provide coverage to the insured with no coverage lapse when the existing policy expires.
- The Company's generally does not rescind any type of coverage.
- The Company's underwriting department conducts quarterly self-audits to evaluate compliance with statutory notice requirements for homeowners cancellations and non-renewals.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected three homeowners company-initiated cancellations, two commercial auto company-initiated cancellations and two commercial multi-peril non-renewals processed during the examination period, to test compliance with cancellation and non-renewal notice procedures.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, the Company appears to comply with notice procedures for company-initiated cancellations and non-renewals. The homeowners' computer system cancellation report does not identify all company-initiated cancellations for underwriting reasons. The Company is changing its policy writing system, which will identify all company-initiated cancellations due to underwriting reasons.

Recommendations: The Company shall complete the conversion to the new policy writing system as soon as possible. The new system will allow the Company to enhance its tracking and monitoring of cancellations. In the interim, the Company shall devote resources and use all reasonable efforts to ensure that all company-initiated cancellations for underwriting reasons are tracked and monitored to comply with statutory requirements.

Standard VI-9. Rescissions are not made for non-material misrepresentation.

General: M.G.L. c. 175, § 187D.

Objective: This Standard addresses whether decisions to rescind and to cancel coverage are made appropriately.

M.G.L. c. 175, § 187D allows the cancellation of any policy for nonpayment of premium.

Controls Assessment: See Standard VI-8

Controls Reliance: See Standard VI-8.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected 16 company-initiated cancellations, non-renewals and declinations processed during the examination period, to test for evidence of improper rescission.

Transaction Testing Results:

Findings: None.

Observations: None of the policies tested were rescinded, and RNA noted no improper rescission in conjunction with other underwriting tests.

Recommendations: None.

<u>Standard VI-10</u>. Credits, debits and deviations are consistently applied on a non-discriminatory basis.

General: M.G.L. c. 175, § 193R.
Property/Liability and Commercial Multi-Peril: M.G.L. c. 174A, §§ 5, 6 and 9; M.G.L. c. 175 § 111H; 211 CMR 131.00.
Commercial Automobile and Commercial Multi-peril: M.G.L. c. 175A, §§ 5, 6 and 9.
Commercial Automobile: M.G.L. c. 175E, § 7; 211 CMR 78.00, 86.00, 91.00 and 124.00.
Workers' Compensation: M.G.L. c. 152, § 53A; 211 CMR 110.00, 113.00 and 115.00.

<u>Objective</u>: This Standard addresses whether unfair discrimination is occurring in the application of premium discounts and surcharges.

M.G.L. c. 175, § 193R permits affinity group discounts based upon experience for motor vehicle and homeowners policies. Pursuant to M.G.L. c. 174A, § 5, fire rates shall be based on past and prospective loss experience during a period of not less than the most recent five-year period for which such experience is available. In considering catastrophe hazards with respect to homeowners' insurance rates, the Commissioner shall consider catastrophe reinsurance and factors relating thereto. Fire rates shall also consider a reasonable margin for underwriting profit and contingencies. Finally, such rates shall not be excessive, inadequate or unfairly discriminatory. M.G.L. c. 174A, § 6 requires the filing of fire rates with the Commissioner, and M.G.L. c. 174A, § 9 requires insurers to use such filed rates, unless it obtains the Commissioner's approval for a rate deviation.

M.G.L. c. 175, § 111H requires that any policy providing lead liability coverage be subject to rules and regulations set forth by the Commissioner, and 211 CMR 131.00 prescribes requirements for the filing of lead liability coverage rates with the Division.

Pursuant to M.G.L. c. 175A, § 5, rates for commercial automobile and multi-peril policies shall be based on past and prospective loss experience, a reasonable margin for underwriting profit and contingencies, investment income, unearned premium reserves and loss reserves. Rates shall not be excessive, inadequate or unfairly discriminatory, and must be filed with the Commissioner as provided by M.G.L. c. 175A, § 6 prior to use. Insurers must also use filed rates, unless they obtain approval for a rate deviation, as set forth in M.G.L. c. 175A, § 9.

For commercial automobile policies, M.G.L. c. 175E, § 7 and 211 CMR 78.00 require every insurer or rating organization authorized to file on behalf of such insurer to file with the Commissioner its classifications, rules and rates, rating plans and modifications of any of the foregoing not less than 45 days before the effective date thereof. 211 CMR 86.00 requires premium discounts for anti-theft devices, and 211 CMR 124.00 mandates premium discounts for certain safety features. Finally, 211 CMR 91.00 also prescribes requirements for the filing of rates with the Commissioner at least 45 days prior to their effective date.

For workers' compensation policies, M.G.L. c. 152, § 53A specifies a rate filing process and statistical reporting requirements using experience rating credits and payroll caps to ensure equitable distribution of premium based on wage differentials. Further, rates and producer commissions for business ceded to the Commonwealth reinsurance pool are determined by the Division. 211 CMR 110.00, 211 CMR 113.00 and 211 CMR 115.00 provide guidance on rate filing procedures, premium credit filings and the conduct of rate hearings.

Controls Assessment: See Standard VI-1.

Controls Reliance: See Standard VI-1.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process, and reviewed other rating information. RNA selected three homeowners, four commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, to test rate classifications and premiums charged. RNA verified that each policy's credits and deviations were consistently applied on a non-discriminatory basis.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, it appears that the Company consistently applies credits and deviations on a non-discriminatory basis.

Recommendations: None.

Standard VI-11. Schedule rating or individual risk premium modification plans, where permitted, are based on objective criteria with usage supported by appropriate documentation.

Commercial Automobile and Commercial Multi-peril: M.G.L. c. 175A, § 5.
Workers' Compensation: M.G.L. c. 152, § 53A; 211 CMR 110.00 and 211 CMR 113.00.

Objective: This Standard addresses whether schedule rating or individual risk premium modification plans are based on objective criteria and appropriately documented.

Pursuant to M.G.L. c. 175A, § 5, casualty, surety and certain commercial rates for commercial automobile and multi-peril policies must be based, in part, on past and prospective loss experience and catastrophe hazards, and must include a reasonable margin for underwriting profits and contingencies. Risks may be grouped by classifications to establish rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans, which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that demonstrate a probable effect upon losses or expenses.

M.G.L. c. 152, § 53A specifies a rate filing process and statistical reporting requirements for workers compensation policies that uses experience rating credits and payroll caps to ensure equitable distribution of premium based on wage differentials. Further, rates and producer commissions for business ceded to the Commonwealth reinsurance pool are determined by the Division. 211 CMR 110.00 provides guidance on rate filing procedures and the conduct of hearings. 211 CMR 113.00 requires premium credits to be filed with the Division by the WCRIB.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company has written policies and procedures for determining schedule rating and individual risk premium modification plans.
- Underwriting personnel are required to approve schedule rating and individual risk premium modification plans, and ensure that such decisions are documented in the underwriting files.
- The WCRIB conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements, including those related to premiums.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting and rating process. RNA selected one workers' compensation policy renewed during the examination period, to test whether schedule rating and individual risk premium modification plans are objective and properly documented

Transaction Testing Results:

Findings: None.

Observations: Based upon testing, the Company appears to objectively use and properly document schedule rating and individual risk premium modification plans.

Recommendations: None.

Standard VI-12. Verification of use of the filed expense multipliers; the regulated entity should be using a combination of loss costs and expense multipliers filed with the Department of Insurance.

Workers' Compensation: M.G.L. c. 152, § 53A and 211 CMR 110.00.

Objective: This Standard addresses the use of loss costs and expense multipliers filed with the Division.

M.G.L. c. 152, § 53A specifies a rate filing process and statistical reporting requirements for workers compensation policies that uses experience rating credits and payroll caps to ensure equitable distribution of premium based on wage differentials. Further, the Division determines rates and producer commissions for business ceded to the Commonwealth reinsurance pool. 211 CMR 110.00 provides guidance on rate filing procedures and the conduct of hearings.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company has written policies and procedures for the use of loss costs and expense multipliers.
- The WCRIB approves the use of loss costs and expense multipliers, and such deviations are filed with the Division.
- The WCRIB conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements, including those related to premiums.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting and rating process, and reviewed the WCRIB's most recent audit report. RNA selected one workers' compensation policy renewed during the examination period, to test the use of loss costs and expense multipliers as filed with the Division.

Transaction Testing Results:

Findings: None.

Observations: Based upon testing and review of the WCRIB's audit report, the Company appears to properly use loss costs and expense multipliers as filed with the Division.

Recommendations: None.

Standard VI-13. Verification of premium audit accuracy and the proper application of rating factors.

Objective: This Standard addresses the performance of premium audits to verify proper rating factors.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company has written policies and procedures for conducting premium audits to verify rate factors.
- The Company has written underwriting and rating policies and procedures, which are designed to reasonably assure consistency in classification and rating.
- The Company conducts compliance audits of its producers regarding required maintenance of certain underwriting information that is retained by the producer.
- Company policy prohibits unfair discrimination in the application of premium discounts and surcharges, and in the application of the general rating methodology, in accordance with company policies and procedures.

- The WCRIB conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements, including those related to premiums.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting and rating process. RNA selected one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, to look for evidence that the Company conducted premium audits to verify rate factors, when applicable.

Transaction Testing Results:

Findings: None.

Observations: Based upon testing, the Company appears to properly conduct premium audits and verify rate factors.

Recommendations: None.

Standard VI-14. Verification of experience modification factors.

Workers' Compensation: M.G.L. c. 152, § 53A and 211 CMR 110.00.

Objective: This Standard addresses the use of experience modification factors.

M.G.L. c. 152, § 53A specifies a rate filing process and statistical reporting requirements for workers' compensation policies that uses experience rating credits and payroll caps to ensure equitable distribution of premium based on wage differentials. Further, the Division determines rates and producer commissions for business ceded to the Commonwealth reinsurance pool. 211 CMR 110.00 provides guidance on rate filing procedures and the conduct of hearings.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company has written policies and procedures for verifying experience modification factors.
- The WCRIB approves experience modification factors, and such deviations are filed with the Division.
- The WCRIB conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements, including those related to premiums.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting and rating process and reviewed the WCRIB's most recent audit report. RNA selected one workers' compensation policy renewed during the examination period to test for the use of experience modification factors as filed with the Division.

Transaction Testing Results:

Findings: None.

Observations: Based upon testing and review of the WCRIB's audit report, the Company appears to properly use experience modification factors as filed with the Division.

Recommendations: None.

Standard VI-15. Verification of loss reporting.

Objective: This Standard addresses the maintenance and verification of accurate loss histories.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company has written policies and procedures for the maintenance and verification of accurate loss histories.
- The WCRIB conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements, including those related to premiums.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting and rating process, and reviewed the WCRIB's most recent audit report. RNA selected one workers' compensation policy renewed during the examination period to test maintenance and verification of accurate loss histories.

Transaction Testing Results:

Findings: None.

Observations: Based upon testing and review of WCRIB's audit report, the Company appears to maintain and verify accurate loss histories.

Recommendations: None.

Standard VI-16. Verification of regulated entity data provided in response to the NCCI call on deductibles.

No work performed. This Standard is not covered in the scope of examination because the Company is not subject to NCCI data calls.

Standard VI-17. Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim.

Objective: This Standard addresses whether underwriting, rating and classification decisions are based on adequate information developed at or near inception of the coverage, rather than near expiration or following a claim.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- Written Company policies and procedures are designed to reasonably assure consistency in the application of underwriting guidelines, rating classifications, premium discounts and surcharges determined at or near the inception of coverage.
- Company policy and practice prohibits unfair discrimination in underwriting in accordance with statutory requirements.
- Written Company underwriting guidelines are designed to reasonably assure appropriate acceptance and rejection of risks on a proper, consistent and fair basis.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, to test whether underwriting, rating and classification are based on adequate information developed at or near inception of coverage.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, it appears that the Company is using underwriting, rating and classification guidelines based on adequate information developed at or near inception of coverage.

Recommendations: None.

Standard VI-18. Audits, when required, are conducted accurately and timely.

See Standard VI-13 for premium audits and Standard I-1 in Company Operations/Management for audits by external and internal auditors.

Standard VI-19. The regulated entity underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.

See Standard VI-4 for testing of this standard.

Standard VI-20. All forms and endorsements, forming a part of the contract are listed on the declaration page and should be filed with the Department of Insurance (if applicable).

General: M.G.L. c. 175, § 2B and 192.
Property/Liability: M.G.L. c. 175, §§ 99, 99B, and 111H; 211 CMR 131.00.
Commercial Automobile: M.G.L. c. 175, §§ 22A and 113A.
Workers' Compensation: M.G.L. c. 152, § 53A.

Objective: This Standard addresses whether policy forms and endorsements are filed with the Division for approval.

Pursuant to M.G.L. c. 175, § 2B, policy form language, size and content standards for all policies must meet statutory requirements for readability and understanding. Pursuant to M.G.L. c. 175, § 192, endorsements are part of policy forms and must be filed with the Division for approval prior to use.

Pursuant to M.G.L. c. 175, § 99 homeowners' policy forms must conform to the standards for policy language set forth in that section and, according to M.G.L. c. 175, § 99B, condominium and tenant policies must be filed with the Division for approval prior to use. M.G.L. c. 175, § 111H requires that any policy providing lead liability coverage be subject to rules and regulations set forth by the Commissioner, and 211 CMR 131.00 requires that forms be filed with and approved by the Division for homeowners' lead liability coverage.

Pursuant to M.G.L. c. 175, §§ 22A and 113A, commercial automobile policy forms must be filed with the Division for approval prior to use. M.G.L. c. 152, § 53A requires that workers' compensation policy forms be filed with the Division.

Controls Assessment: See Standard VI-5.

Controls Reliance: See Standard VI-5.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the

examination period, to test for the use of policy forms and approved endorsements in compliance with statutory requirements.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, it appears that the Company is using approved policy forms and endorsements in compliance with statutory requirements.

Recommendations: None.

Standard VI-21. The company does not engage in collusive or anti-competitive underwriting practices.

M.G.L. c. 176D, §§ 3(4) and 3A.

Objective: This Standard addresses whether the Company has engaged in any collusive or anti-competitive underwriting practices.

Pursuant to both M.G.L. c. 176D, § 3(4) and M.G.L. c. 176D, § 3A, it is an unfair method of competition, and an unfair or deceptive act or practice in the business of insurance, to enter into any agreement, or to commit any act of boycott, coercion or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- Company policy requires that the underwriting department apply consistent underwriting practices, and that no underwriter or producer shall engage in collusive or anti-competitive practices.
- The Company conducts compliance audits of its producers regarding required maintenance of certain underwriting information that is retained by the producer.
- Company policy prohibits unfair discrimination in the application of premium discounts and surcharges, and in the application of the general rating methodology, in accordance with company policies and procedures.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, to determine whether any underwriting practices appeared collusive or anti-competitive.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, RNA noted no instances where the Company's underwriting policies and practices appeared collusive or anti-competitive.

Recommendations: None.

Standard VI-22. The regulated entity underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations in application of mass marketing plans.

No work performed. This Standard is not covered in the scope of examination because the Company does not offer mass marketing plans.

Standard VI-23. All group personal lines property and casualty policies and programs meet minimum requirements.

No work performed. This Standard is not covered in the scope of examination because the Company does not offer group products.

Standard VI-24. Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

General: M.G.L. c. 175, § 187C.
Property/Liability: M.G.L. c. 175, §§ 99 and 193P.
Commercial Automobile: M.G.L. c. 175, §§ 113A and 113F.
Workers' Compensation: M.G.L. c. 152, §§ 55A and 65B.

See Standard VI-8 for testing of this standard.

Standard VI-25. Regulated entity verifies that VIN number submitted with application is valid and that the correct symbol is utilized.

Objective: This Standard addresses whether the Company verifies that the VIN submitted with the application is valid and accurate.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The producer is responsible for obtaining the VIN and symbol when the application is completed.

- Company policy and procedures require that pre-insurance inspections of vehicles be conducted to verify the VIN and symbol numbers.
- The Company's underwriting system compares the VIN and symbol to its industry database to ensure that both are accurate.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected one commercial automobile policy issued during the examination period, to determine whether the Company verifies the VIN and symbol.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, it appears that the Company issues automobile policies with VINs that are valid and symbols that are accurate.

Recommendations: None.

Standard VI-26. All policies are correctly coded.

Objective: This Standard addresses the accuracy of statistical coding.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- The Company has written underwriting policies and procedures which are designed to reasonably assure consistency in classification and rating.
- Company policy is to timely report complete and accurate premium data in the required formats to appropriate rating bureaus such as the Automobile Insurers Bureau of Massachusetts ("AIB"), CAR, ISO or the WCRIB.
- The Company monthly reports commercial automobile premium data to CAR in the required format.
- The Company reconciles underlying quarterly and annual premium data with data submitted to CAR.
- The Company reports quarterly premium data to ISO for all lines except commercial automobile. ISO then provides the workers' compensation data to the WCRIB.
- The Company reports workers' compensation premium data to the WCRIB 20 months after policy effective dates.
- The Company has a process for correcting data coding errors and making subsequent changes, as needed.
- The WCRIB conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements, including those related to premiums.

- The Company is subject to periodic audits by CAR for compliance with statutes and CAR Rules, including statistical coding requirements related to premiums.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process, and selected six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, to test data coding. RNA reviewed the latest CAR audit reports on the Company's compliance with CAR statistical coding requirements. Finally, RNA reviewed the most recently completed triennial audit of the Company's compliance with the WCRIB statistical coding requirements.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, it appears that the Company uses proper data coding procedures. The WCRIB audit dated August 10, 2006 indicated that the Company generally uses proper workers' compensation statistical data related to premiums. However, numerous errors were noted in the 2005 CAR audit report of the Company's 2003 activity, and the 2007 CAR audit report of its 2005 activity. Some common errors were reported in both years. The Company states that it has made changes to its automobile premium statistical reporting methodology due to the issues identified during 2003, which were reflected in the 2005 CAR audit report; however, some of the results of such changes were not yet evident in 2005, as documented in the 2007 CAR audit report. Some of the errors noted included vehicle premium statistical errors related to age, class and VIN, and errors related to policies. The Company states that it has completed research to identify the root causes of the errors, modified computer system logic as necessary, developed a self-review process to address these errors and conducted training of commercial underwriters.

Recommendations: The Company's internal audit function, together with the business information services department, shall conduct a review and evaluation of the new computer logic and procedures, to ensure that controls over coding and statistical reporting are effectively designed and properly implemented. The Company shall periodically update the Division, as requested, on these results of the audits.

Standard VI-27. Application or enrollment forms are properly, accurately and fully completed, including any required signatures, and file documentation supports underwriting decisions made.

Objective: This Standard addresses whether policy file documentation adequately supports decisions made in underwriting and rating.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- Company policy requires that the underwriting files support its underwriting and rating decisions.
- Producers are responsible for completing applications for new business and obtaining information needed to properly underwrite and rate the policy.
- Underwriting personnel review the applications submitted by producers for completeness and internal consistency.
- The Company conducts compliance audits of its producers regarding required maintenance of certain underwriting information that is retained by the producer.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting process. RNA selected six homeowners, one commercial automobile, 17 commercial multi-peril and two workers' compensation policies issued or renewed during the examination period, to test whether the policy files adequately support the Company's decisions.

Transaction Testing Results:

Findings: None.

Observations: Based on the results of testing, it appears that policy files adequately supported the Company's decisions. However, RNA's review of the underwriting department's peer reviews indicated that, in several instances, individual commercial lines underwriters exceeded their authority limits during the underwriting process. As a result, the Company has provided training to all underwriters emphasizing adherence to authority limits.

Recommendations: The Company should enhance controls and procedures contemporaneous with the underwriting of risks, to ensure adherence to authority limits during the underwriting process. Such controls could include, for example, supervisory review of underwriters' work prior to the approval of new risks; information technology controls which prevent underwriters from approving risks that exceed their underwriting authorities; a risk underwriting assignment methodology that allows management to assess and monitor adherence to authority limits during the underwriting process, or other relevant effective controls.

VII. CLAIMS

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard VII-1. The initial contact by the regulated entity with the claimant is within the required time frame.

M.G.L. c. 176D, § 3(9)(b) and M.G.L. c. 152, § 7.

Objective: The Standard addresses the timeliness of the Company's initial contact with the claimant.

Pursuant to M.G.L. c. 176D, § 3(9)(b), unfair claim settlement practices include failure to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

M.G.L. c. 152, § 7 requires the insurer to either commence payment of weekly benefits within 14 days of an insurer's receipt of an employer's first report of injury or an initial written claim for weekly benefits, or to notify the Department of Industrial Accidents ("DIA"), the employer, and, the employee of its refusal to commence payment. The notice shall specify the grounds and factual basis for the refusal to commence payment and be delivered by certified mail.

Controls Assessment: The following key observations were noted in conjunction with the review of Standards VII-1 through VII-13:

- Written Company policies and procedures govern the claims handling process.
- A majority of claims are reported through one of the Company's agents. Written claim forms are received via fax, electronically or through the 800 customer service telephone number. Company policy requires that a claim file be established and a claims representative be assigned within 24 hours of receipt of a claim.
- Company policy and claim handling procedures do not distinguish between claims on policies ceded to CAR or those retained by the Company.
- Company policy is to respond to automobile physical damage claims within two business days after receiving a loss report, as required by CAR standards. Appraisers are dispatched to adjudicate all automobile physical damage claims during that time.
- Company policy is to complete automobile physical damage appraisals within five days of the date of the appraisal assignment, as required by CAR standards.
- The Company's general policy is to acknowledge claims within 24 hours.
- The Company's policy is to accept or reject all workers' compensation claims within 14 days of the claim filing, in compliance with DIA regulatory requirements.
- OB's claim department performs monthly branch self-audits to review processed claims for adherence to OB and Company policies and procedures. Further, OB's home office claims management conducts quality control audits to evaluate settlement practices, by reviewing bodily injury settlements, liability claims and material damage claims.
- Claims management periodically reviews open claims to evaluate settlement issues and ensure appropriate reserves have been established.

- Company policy is to pay claims upon receiving a proof of a claim..
- Claims management uses exception reports to measure operational effectiveness and claim processing time.
- The Company periodically surveys claimants to ask about their experience when filing a claim. The results are compiled and analyzed, and necessary follow-up on specific comments is performed by claims department management.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to evaluate the Company's compliance with its claim handling policies and procedures. RNA verified the date each selected claim was reported to the Company, and noted whether its initial contact with the claimant was timely acknowledged.

Transaction Testing Results:

Findings: None.

Observations: The claim transactions tested were processed according to the Company's policies and procedures, and the Company's initial contact with claimants was timely. Based upon the results of testing, it appears that the Company's processes for making initial contact with claimants are functioning in accordance with its policies, procedures, and statutory requirements.

Recommendations: None.

Standard VII-2. Timely investigations are conducted.

M.G.L. c. 176D, § 3(9)(c).

Objective: The Standard addresses the timeliness of the Company's claims investigations.

Pursuant to M.G.L. c. 176D, § 3(9)(c), unfair claims settlement practices include failure to adopt and implement reasonable standards for the prompt investigation of a claim.

Controls Assessment: See Standard VII-1.

Controls Reliance: See Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to evaluate the Company's

compliance with its claim handling policies and procedures, and to verify that it conducts timely investigations.

Transaction Testing Results:

Findings: None.

Observations: Based upon the results of testing, it appears that the Company's processes for investigating claims are functioning in accordance with its policies, procedures and statutory requirements.

Recommendations: None.

Standard VII-3. Claims are resolved in a timely manner.

General: M.G.L. c. 176D, § 3(9)(f); M.G.L. c. 175, §§ 28 and 112.
Automobile: M.G.L. c. 175, §§ 113O and 191A; 211 CMR 123.00.
Workers' Compensation: M.G. L. c. 152, § 7.

Objective: The Standard addresses the timeliness of the Company's claim settlements.

Pursuant to M.G.L. c. 176D, § 3(9)(f), unfair claim settlement practices include failing to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In addition, if an insurer makes a practice of unduly engaging in litigation, or of unreasonably and unfairly delaying the adjustment or payment of legally valid claims, M.G.L. c. 175, § 28 authorizes the Commissioner to make a special report of findings to the General Court.

M.G.L. c. 175, § 112 states that liability of any company under a motor vehicle liability policy, or under any other policy insuring against liability for loss or damage on account of bodily injury, death, or damage to property, shall become absolute whenever the loss or damage for which the insured is responsible occurs, and the satisfaction by the insured of a final judgment for such loss or damage shall not be a condition precedent to the right or duty of the company to make payment on account of said loss or damage.

Automobile Claims:

M.G.L. c. 175, § 113O states payments to the insured under theft or comprehensive coverage shall not be made until a claim form has been received from the insured, stating that the repair work described in an appraisal made pursuant to regulations promulgated by the automobile damage appraiser licensing board has been completed. Insurers are required to make such payments within seven days of receipt of the above claim form. However, direct payments to insureds without a claim form may be made in accordance with a plan filed and approved by the Commissioner. Any such plan filed with the Commissioner must meet stated standards for selecting approved repair shops, vehicle inspection, insurer guarantees of the quality and workmanship used in making repairs, and prohibitions on discrimination for selection of vehicles for inspection. 211 CMR 123.00 sets forth procedures for the Commissioner's approval of, and minimum requirements for, direct payment and referral repair shop plans.

M.G.L. c. 175, § 191A requires insureds to give timely notice of a property damage loss to the company or its agent. Further, insureds must also report theft to the police, and the Company must pay such claims within 60 days after a proof of loss is filed. The statute also sets forth a process for selecting a disinterested appraiser in the event the insured and the company fail to agree on the amount of loss.

Workers' Compensation Claims:

M.G.L. c. 152, § 7 requires the insurer to either commence payment of weekly benefits within 14 days of its receipt of an employer's first report of injury or an initial written claim for weekly benefits, or to notify the DIA, the employer, and the employee of its refusal to commence payment. The notice shall specify the grounds and factual basis for the refusal to commence payment, and must be delivered by certified mail.

Controls Assessment: See Standard VII-1.

Controls Reliance: See Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to verify that claim resolutions were timely.

Transaction Testing Results:

Findings: None.

Observations: Based upon the results of testing, it appears that the Company timely resolves claims in compliance with Company policies, procedures and statutory requirements.

Recommendation: None.

Standard VII-4. The regulated entity responds to claim correspondence in a timely manner.

M.G.L. c. 176D, §§ 3(9)(b) and 3(9)(e).
Workers Compensation: M.G. L. c. 152, § 7.

Objective: The Standard addresses the timeliness of the Company's response to all claim correspondence.

Pursuant to M.G.L. c. 176D, §§ 3(9)(b) and 3(9)(e), respectively, unfair claim settlement practices include failure to promptly address communications for insurance claims, and failure to affirm or deny coverage within a reasonable time after the claimant has given proof of loss.

M.G.L. c. 152, § 7 requires the insurer to either commence payment of weekly benefits within 14 days of its receipt of an employer's first report of injury or an initial written claim for weekly

benefits, or to notify the DIA, the employer, and the employee of its refusal to commence payment. The notice shall specify the grounds and factual basis for the refusal to commence payment, and must be delivered by certified mail.

Controls Assessment: See VII-1.

Controls Reliance: See VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to verify that claims correspondence was answered timely.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that correspondence for the tested claims was generally answered timely. Based upon the results of testing, it appears that the Company timely responds to claim correspondence, in compliance with its policies, procedures and statutory requirements.

Recommendations: None.

Standard VII-5. Claim files are adequately documented.

Objective: The Standard addresses the adequacy of information maintained in the Company's claim records.

Controls Assessment: See VII-1.

Controls Reliance: See VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to verify that claim files were adequately documented.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that the files for tested claims were adequately documented. Based upon the results of testing, it appears that the Company's processes for documenting claim files are generally functioning in accordance with its policies and procedures. While not required by law or regulation, the Company has established a

procedure to compile a list of bad faith claims for internal reporting to the Board of Directors. RNA noted one claim that was inadvertently excluded from the list of bad faith claims.

Recommendations: The Company should adopt a new control procedure to ensure that the list of bad faith claims is complete and accurate. The procedure should include periodic reconciliation of that list to similar data maintained in the claims department.

Subsequent Actions: The Company states that it has implemented the new control procedure and that the data is now reconciled monthly.

Standard VII-6. Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

M.G.L. c. 176D, §§ 3(9)(d) and 3(9)(f); M.G.L. c. 175, §§ 22I, 24D, 24E, 24F, 111F, 112, 112C and 193K.
Property/Liability: M.G.L. c. 175, §§ 96, 97, 97A, 100, 102; M.G.L. c. 139, § 3B.
Commercial Automobile: M.G.L. c. 175, §§ 113J and 113O; 211 CMR 75.00 and 133.00.
Workers' Compensation: M.G. L. c. 152, §§ 7, 8, 29, 31, 33, 34, 34A, 35, 36, 36A, and 50.

Objective: The Standard addresses whether appropriate claim amounts have been paid to the appropriate claimant/payee.

Pursuant to M.G.L. c. 176D, §§ 3(9)(d) and 3(9)(f), respectively, unfair claim settlement practices include refusal to pay claims without conducting a reasonable investigation based upon all available information; and unfair trade practices include failure to effectuate prompt, fair and equitable settlement of claims in which liability has become reasonably clear.

M.G.L. c. 175, § 22I allows companies to retain unpaid premium due from claim settlements. Claim payments must also comply with M.G.L. c. 175, § 24D to intercept non-recurring payments for past due child support. M.G.L. c. 175, § 24E, requires the insurer to exchange information with the Commonwealth not less than 10 business days prior to making payment to a claimant who has received public assistance benefits. M.G.L. c. 175, § 24F requires communication with the Commonwealth regarding unpaid taxes. Medical reports must be furnished to injured persons or their attorney pursuant to M.G.L. c. 175, § 111F. In addition, M.G.L. c. 175, § 112C requires companies to reveal to an injured party making a claim against an insured, the amount of the limits of said insured's liability coverage upon receiving a request in writing for such information.

M.G.L. c. 175, § 112 states that liability of any company under a motor vehicle liability policy, or under any other policy insuring against liability for loss or damage on account of bodily injury, death, or damage to property, shall become absolute whenever the loss or damage for which the insured is responsible occurs, and the satisfaction by the insured of a final judgment for such loss or damage shall not be a condition precedent to the right or duty of the company to make payment on account of said loss or damage.

M.G.L. c. 175, § 193K prohibits discrimination by companies in the reimbursement of proper expenses paid to certain professions and occupations, such as physicians or chiropractors.

Property/Liability Claims:

M.G.L. c. 175, § 96 limits the Company's liability to the actual cash value of the insured property when a building is totally destroyed by fire. In addition, if the insured has paid premiums on a coverage amount in excess of said actual cash value, the statute states the insured shall be reimbursed the proportionate excess of premiums paid with interest at six percent per year.

M.G.L. c. 175 § 97 requires the Company to pay fire losses to mortgagees of property upon satisfactory proof of rights and title in accordance with the insurance policy. Further, when a claim for loss or damage to property exceeds five thousand dollars, M.G.L. c. 175 § 97A requires the Company to ensure that the claimant submits to them a certificate of municipal liens from the collector of taxes of the city or town wherein such property is located. The Company shall pay to the city or town any amounts shown on the certificate of municipal liens as outstanding on the date of loss. The provisions of M.G.L. c. 175 § 97A do not apply to certain owner-occupied dwellings.

M.G.L. c. 139, § 3B prohibits the Company from paying claims covering loss or damage to a building or other structure (defined as "dangerous" pursuant to M.G.L. c. 143, § 6) in excess of one thousand dollars, without having given 10 days written notice to the building commissioner or inspector of buildings appointed pursuant to the state building code, to the fire department, and to the board of health, in the city or town where the property located.

M.G.L. c. 175, § 100 sets forth standards for selecting a referee if the parties to a claim fail to agree on the amount of loss. In addition, M.G.L. c. 175 § 102 states the failure of the insured under a fire policy to render a sworn statement shall not preclude recovery if the insured renders a sworn statement after receiving a written request for such sworn statement from the Company. M.G.L. c. 175, § 102 further defines requirements related to such a request for a sworn statement made by the Company.

Commercial Automobile Claims:

Medical reports must be furnished to injured persons or their attorney pursuant to M.G.L. c. 175, § 113J. M.G.L. c. 175, § 113O prohibits payments by an insurer for theft coverage, until the insured has received notice from the appropriate police authority that a statement has been properly filed. Additionally, companies are required to report the theft or misappropriation of a motor vehicle to a central organization engaged in motor vehicle loss prevention. 211 CMR 75.00 designates the National Insurance Crime Bureau as the central organization to be used for this purpose.

211 CMR 133.00 sets forth uniform standards for repair of damaged motor vehicles, but only applies when an insurer pays the costs of repairs. The regulation addresses how damage and repair costs are determined, requires that like kind repair parts be used, and sets forth methods for determining vehicle values. It further allows vehicles deemed a total loss to be repaired subject to certain requirements and limits. Lastly, the regulation requires an insurer to have licensed appraisers conduct "intensified" appraisals of at least 25% of all damaged vehicles for which the damage is less than $1,000, and 75% of all damaged vehicles for which the appraised cost of repair is more than $4,000 for collision, limited collision, and comprehensive claims. The "intensified" appraisal is to determine if the repairs were made in accordance with the initial appraisal and any supplemental appraisals.

Workers' Compensation Claims:

M.G.L. c. 152, § 7 requires the insurer to either commence payment of weekly benefits within 14 days of an insurer's receipt of an employer's first report of injury or an initial written claim for weekly benefits, or to notify the DIA, the employer, and the employee of its refusal to commence payment. The notice shall specify the grounds and factual basis for the refusal to commence payment, and must be delivered by certified mail.

M.G.L. c. 152, § 8 allows an insurer to terminate or modify payments without penalty at any time within 180 days of commencement of disability, if such change is based on the actual income of the employee or if it gives the employee and the Department at least seven days written notice of its intent to stop or modify payments and to contest any claim filed. The notice shall specify the grounds and factual basis for stopping or modifying payment of benefits and the insurer's intention to contest.

Pursuant to M.G.L. c. 152, § 29, no compensation shall be paid for any injury which does not incapacitate the employee from earning full wages for a period of five or more calendar days. If incapacity extends for a period of 21 days or more, compensation shall be paid from the date of onset of incapacity. If incapacity extends for a period of at least five but less than 21 days, compensation shall be paid from the sixth day of incapacity. Generally, no compensation shall be paid for any period for which any wages were earned.

Pursuant to M.G.L. c. 152, § 31, if death results from the injury, the insurer shall pay compensation to dependents of the employee who were wholly dependent upon his or her earnings for support. M.G.L. c. 152, § 33 requires the insurer to pay the reasonable expenses of burial not exceeding $4,000.

Pursuant to M.G.L. c. 152, § 34, while incapacity is total, during each week of incapacity the insurer shall pay the injured employee compensation equal to 60 percent of his or her average weekly wage before the injury, subject to defined limits. The total number of weeks of compensation due the employee shall not exceed 156 weeks. Pursuant to M.G.L. c. 152, § 34A, when the injury is both permanent and total, the insurer shall pay to the injured employee, following payment of compensation provided in M.G.L. c. 152, §§ 34 and 35, a weekly compensation equal to two-thirds of the average weekly wage before the injury, subject to defined limits.

Pursuant to M.G.L. c. 152, § 35, when injury is partial, during each week of incapacity the insurer shall pay the injured employee a weekly compensation equal to 60 percent of the difference between the average weekly wage before the injury, and the weekly wage he or she is capable of earning after the injury, but not more than 75 percent of what the employee would receive if eligible for total incapacity benefits. An insurer may reduce the amount paid to an employee to the amount at which the employee's combined weekly earnings and benefits are equal to two times the average weekly wage in the Commonwealth at the time of such reduction.

Pursuant to M.G.L. c. 152, § 36, additional sums are designated for specific injuries, provided that the employee has not died from any cause within 30 days of such injury. M.G.L. c. 152, § 36A states that where any loss is a result of an injury involving brain damage, a lump sum payment resulting from brain damage shall not exceed an amount equal to the average weekly wage in the Commonwealth at the date of injury, multiplied by 105. Payments shall not be made where death occurs within 45 days of the injury.

Pursuant to M.G.L. c. 152, § 50, if payments are not made within 60 days of being claimed by an employee, dependent or other party, interest at the rate of 10% per annum of all sums due from the date of the receipt of the notice of the claim by the DIA, to the date of payment, shall be required. Whenever such sums include weekly payments, interest shall be computed on each unpaid weekly payment.

Controls Assessment: See VII-1.

Controls Reliance: See VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to verify that claims were handled in accordance with applicable policy provisions, and statutory and regulatory requirements.

Transaction Testing Results:

> *Findings:* The Company did not give proper notice to the inspector of buildings for one homeowners claim over $5,000 and one commercial multi-peril claim over $1,000, in violation of M.G.L. c. 139, § 3B. The file for the same homeowners claim did not include a certificate of municipal liens from the city tax collector, in violation of M.G.L. c. 175 § 97A. The Company's processes for handling claims in accordance with policy provisions, statutory and regulatory requirements are otherwise functioning in accordance with its policies and procedures.
>
> *Observations:* RNA verified that when required, the Company responded to written requests for an insured's policy limits within 30 days, pursuant to M.G.L. c. 175, § 112C. When required, the Company properly verified that claim recipients were not subject to the intercept requirements in M.G.L. c. 175, §§ 24D, 24E and 24F, prior to making the claim payment.
>
> RNA verified that the Company has procedures for providing claimants with a list of registered repair shops, as well as repair shops that qualify as a referral shop, as required by 211 CMR 123.00. Further, RNA noted that the Company performs re-inspections of repaired vehicles following completion of repairs, as required by 211 CMR 123.00.

Recommendations: The Company shall establish additional controls to ensure that claims are paid in accordance with statutory requirements including M.G.L. c. 139, § 3B and M.G.L. c. 175 § 97A. Further, internal audit, together with the claims department, shall review the newly established controls and periodically test and monitor claims handling policies, procedures and statutory requirements.

Subsequent Actions: The Company states that it has provided training to adjustors regarding statutory notice requirements.

Standard VII-7. Regulated entity claim forms are appropriate for the type of product.

M.G.L. c. 152, § 7.

Objective: The Standard addresses the Company's use of claim forms that are proper for the type of product.

M.G.L. c. 152, § 7 requires the use of specific DIA-developed forms for workers' compensation claims.

Controls Assessment: See Standard VII-1.

Controls Reliance: See Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA reviewed 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to note whether claim forms were appropriate for the type of product.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that claim forms for the tested claims were appropriate and used in accordance with the Company's policies and procedures.

Recommendations: None.

Standard VII-8. Claims are reserved in accordance with the regulated entity's established procedures.

Objective: The Standard addresses the adequacy of information maintained in the Company's claim records related to its reserving practices.

Controls Assessment: See Standard VII-1.

Controls Reliance: See Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA reviewed 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to note whether claim reserves were evaluated, established and adjusted in a reasonably timely manner.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that reserves for the tested claims were evaluated, established and adjusted according to the Company's policies and procedures. Based upon the results of testing, it appears that the Company's processes for evaluating, establishing and adjusting claim reserves are functioning in accordance with its policies and procedures, and are reasonably timely.

Recommendations: None.

Standard VII-9. Denied and closed without payment claims are handled in accordance with policy provisions and state law.

M.G.L. c. 176D, §§ 3(9)(d), 3(9)(h) and 3(9)(n).
Workers' Compensation: M.G.L. c. 152, § 8, 29, 34, 34A, 35, 36A.

Objective: The Standard addresses the Company's decision-making and documentation of denied and closed-without-payment claims.

Pursuant to M.G.L. c. 176D, § 3(9)(d), unfair claims settlement practices include refusal to pay claims without conducting a reasonable investigation based upon all available information. Pursuant to M.G.L. c. 176D, § 3(9)(h), unfair claims settlement practices include attempting to settle a claim for an amount less than a reasonable person would have believed he or she was entitled to receive. M.G.L. c. 176D, § 3(9)(n) considers failure to provide a reasonable and prompt explanation of the basis for denial of a claim an unfair claims settlement practice.

Workers' Compensation Claims:

M.G.L. c. 152, § 8 allows an insurer to terminate or modify payments at any time within 180 days of commencement of disability without penalty, if such change is based on the actual income of the employee, or if it gives the employee and the Department at least seven days written notice of its intent to stop or modify payments and to contest any claim filed. The notice shall specify the grounds and factual basis for stopping or modifying payment of benefits, and the insurer's intention to contest.

Pursuant to M.G.L. c. 152, § 29, no compensation shall be paid for any injury which does not incapacitate the employee from earning full wages for a period of five or more calendar days. If incapacity extends for a period of 21 days or more, compensation shall be paid from the date of onset of incapacity. If incapacity extends for a period of at least five but less than 21 days, compensation shall be paid from the sixth day of incapacity. Generally, no compensation shall be paid for any period for which any wages were earned.

Pursuant to M.G.L. c. 152, § 34, while incapacity is total, during each week of incapacity the insurer shall pay the injured employee compensation equal to 60 percent of his or her average weekly wage before the injury, but not more than the maximum weekly compensation rate, unless the average weekly wage of the employee is less than the minimum weekly compensation rate, in which case said weekly compensation shall be equal to his average weekly wage. The total number of weeks of compensation due the employee shall not exceed 156 weeks. Pursuant to M.G.L. c. 152, § 34A, when the injury is both permanent and total, the insurer shall pay to the injured employee, following payment of compensation provided in §§ 34 and 35, a weekly

compensation equal to two-thirds of the average weekly wage before the injury, but not more than the maximum weekly compensation rate nor less than the minimum weekly compensation rate.

Pursuant to M.G.L. c. 152, § 35, when injury is partial, during each week of incapacity the insurer shall pay the injured employee a weekly compensation equal to 60 percent of the difference between the average weekly wage before the injury and the weekly wage he or she is capable of earning after the injury, but not more than 75 percent of what the employee would receive if eligible for total incapacity benefits. An insurer may reduce the amount paid to an employee to the amount at which the employee's combined weekly earnings and benefits are equal to two times the average weekly wage in the Commonwealth at the time of such reduction.

M.G.L. c. 152, § 36A states that where any loss is a result of an injury involving brain damage, a lump sum payment resulting from brain damage shall not exceed an amount equal to the average weekly wage in the Commonwealth at the date of injury, multiplied by 105. Payments shall not be made where death occurs within 45 days of the injury.

Controls Assessment: See Standard VII-1.

Controls Reliance: See Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected four homeowners, four commercial automobile, four commercial multi-peril and one workers' compensation claim denied or closed without payment during the examination period for testing. RNA reviewed the claim correspondence and investigative reports, and noted whether the Company handled the claims timely and properly before closing them.

Transaction Testing Results:

Findings: None.

Observations: The Company could not locate the file for one homeowners claim filed in 1997 and closed in 2006. RNA otherwise noted that the files for the denied or closed without payment claims tested appeared complete, including correspondence and other documentation. Further, the Company's conclusions appeared reasonable. Based upon the results of testing, it appears that the Company's processes do not unreasonably deny or delay payment of claims.

Recommendations: The Company should implement new control procedures to ensure that all claim documentation can be located and easily tracked.

Subsequent Action: The Company states that it has revised its record retention process to ensure that claim documentation is available as necessary.

Standard VII-10. Cancelled benefit checks and drafts reflect appropriate claim handling practices.

Objective: The Standard addresses the Company's procedures for issuing claim checks as they relate to appropriate claim handling practices.

Controls Assessment: See Standard VII-1.

Controls Reliance: See Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA reviewed 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to note whether claim payment practices were appropriate, and whether there were inappropriate releases of Company liability.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that each claim selected for testing was recorded according to the Company's policies and procedures, and that claim payment documentation was adequate. RNA noted no instances where claim payment practices appeared inappropriate. Based upon the results of testing, it appears that the Company's processes for issuing claim payment checks are appropriate and functioning in accordance with its policies and procedures.

Recommendations: None.

Standard VII-11. Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

M.G.L. c. 176D, §§ 3(9)(g) and 3(9)(h), M.G.L. c. 175, § 28.

Objective: The Standard addresses whether the Company's claim handling practices force claimants to (a) initiate litigation for the claim payment, or (b) accept a settlement that is substantially less than what the policy contract provides.

Pursuant to M.G.L. c. 176D, §§ 3(9)(g) and 3(9)(h), unfair claims settlement practices include (a) compelling insureds to initiate litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds, and (b) attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application. Moreover, if an insurer makes a practice of unduly engaging in litigation, or of unreasonably and unfairly delaying the adjustment or payment of legally valid claims, M.G. L. c. 175, § 28 authorizes the Commissioner to make a special report of findings to the General Court.

Controls Assessment: See Standard VII-1.

Controls Reliance: See Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA reviewed 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to note whether claim reserves were evaluated, established and adjusted in a reasonably timely manner. When applicable, RNA verified the date the claims were reported, reviewed correspondence and investigative reports, and noted the whether the Company handled the claims timely and properly.

Transaction Testing Results:

Findings: None.

Observations: Except as noted below, documentation for the selected claims involving litigation appeared complete, including correspondence and other documentation, and the Company's conclusions appeared reasonable. Based upon the results of testing, it appears that the Company's processes do not unreasonably deny claims or compel claimants to initiate litigation.

However, RNA noted one commercial automobile claim where the initial offers to settle appeared low when compared to the claim reserve, to claim file documentation regarding the initial planned offer, and to the settlement authority granted at the time of the initial offer and the final settlement value of the claim. The Company stated that the initial offers were made as part of a "strategy" to obtain a fair final settlement. While the claimant's attorney and the Company reached a final settlement, and the final settlement appeared reasonable, claim documentation was inconsistent, and it was unclear that the initial offers were fair and reasonable.

Recommendations: The Company shall reinforce to claims adjustors its policy that all claim settlement offers be fair and reasonable. Further, file documentation of claim settlement offers, particularly in relation to the claim reserve, the settlement strategy and settlement authority, should fully support that each offer is fair and reasonable. Finally, internal audit shall test compliance with this policy and procedure as part of ongoing claims audit procedures.

Subsequent Actions: The Company states that it has provided training to adjustors on documentation of settlement evaluations and claim offers.

Standard VII-12. Regulated entity uses the reservation of rights and excess of loss letters, when appropriate.

Objective: The Standard addresses the Company's usage of reservation of rights letters and its procedures for notifying an insured when the amount of loss will exceed policy limits.

Controls Assessment: See VII-1.

Controls Reliance: See VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA reviewed 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers'

compensation claims processed during the examination period, to note whether reservations of rights or excess loss letters were warranted.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that the tested claims were reported according to the Company's policies and procedures, and noted no instances where a reservation of rights or excess loss letter was used inappropriately. Based upon the results of testing, it appears that the Company's processes for utilizing reservation of rights and excess loss letters are functioning in accordance with its policies and procedures.

Recommendations: None.

Standard VII-13. Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.

Objective: The Standard addresses the Company's timely refund of deductibles from subrogation proceeds.

Controls Assessment: See Standard VII-1.

Controls Reliance: See Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claims handling processes, and obtained documentation supporting such processes. RNA reviewed 10 homeowners, 10 commercial automobile, 10 commercial multi-peril and five workers' compensation claims processed during the examination period, to note whether subrogation recoveries were reasonably timely and accurate.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that the tested claims were accurately recorded according to the Company's policies and procedures, and noted no instances where subrogation recovery was not made in a timely and accurate manner. Based upon the results of testing, it appears that the Company's processes for making subrogation recoveries to insureds are functioning in accordance with its policies and procedures.

Recommendations: None.

Standard VII-14. Loss statistical coding is complete and accurate.

M.G.L. c. 175A, § 15(a); 211 CMR 15.00 and 211 CMR 115.00.

Objective: The Standard addresses the Company's complete and accurate reporting of loss statistical data to appropriate rating bureaus.

Pursuant to M.G.L. c. 175A, § 15(a), insurers must record and report their loss and countrywide expense experience in accordance with the statistical plan promulgated by the Commissioner and the rating system on file with the Commissioner, and the Commissioner may designate a rating agency or agencies to assist her in the compilation of such data. In accordance with 211 CMR 15.00, the Commissioner established and fixed various statistical plans to be used in relation to homeowners' insurance and related coverages, in accordance with M.G.L. c. 175A, § 15(a). 211 CMR 115.00 requires insurers to report workers' compensation losses and expenses for statistical purposes.

Controls Assessment: The following key observations were noted in conjunction with the review of this Standard:

- Company policy is to timely report complete and accurate loss data to appropriate rating bureaus.
- Company policy is to timely report complete and accurate loss data in the required formats to appropriate rating bureaus such as the AIB, CAR, ISO or the WCRIB. The data includes loss experience by line of business, type of loss, dollar amount, claim counts, accident dates, territory, etc.
- The Company monthly reports commercial automobile loss data to CAR in the required format.
- The Company reconciles underlying quarterly and annual loss data with data submitted to CAR.
- The Company reports quarterly loss data to ISO for all lines except commercial automobile. ISO then provides the workers' compensation data to the WCRIB.
- The Company reports workers' compensation loss data to the WCRIB 20 months after policy effective dates.
- The Company has a process for correcting data coding errors and making subsequent changes, as needed.
- The WCRIB conducts an audit every three years of the Company's compliance with workers' compensation statistical reporting requirements, including those related to claims.
- The Company is subject to periodic audits by CAR for compliance with statutes and CAR Rules, including statistical coding requirements related to claims.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its loss statistical reporting processes, and obtained documentation supporting such processes. RNA

reviewed the latest CAR audit reports on the Company's compliance with CAR statistical coding requirements. Finally, RNA reviewed the most recently completed triennial audit of the Company's compliance with the WCRIB statistical coding requirements.

Transaction Testing Results:

Findings: None.

Observations: The WCRIB audit dated August 10, 2006 indicated that the Company uses proper workers' compensation statistical data related to claims. RNA's review of property claims indicated three coding errors, where coverage was improperly coded 431 (homeowners property) instead of coded 312 (commercial property). The Company states that these coding errors do not impact statistical data reporting to ISO or financial reporting, and only impact internal Company reporting.

Further, numerous errors were noted in the 2005 CAR audit report of the Company's 2003 activity, and the 2007 CAR audit report of its 2005 activity. Some common errors were reported in both years. The Company states that it made changes to its automobile loss statistical reporting methodology due to the issues identified during 2003, which were reflected in the 2005 CAR audit report; however, some of the results of such changes were not yet evident in 2005, as documented in the 2007 CAR audit report. Some of the errors noted included vehicle loss statistical errors related to loss type and accident location, and some errors related to policies. The Company has identified the root causes of the statistical errors, and will be developing computer logic changes to correct these errors.

Recommendations: The Company shall timely complete the development of the computer logic changes to correct statistical errors noted in the CAR audit reports. Further, the Company's internal audit function, together with the business information services department, shall review and evaluate the controls over coding and statistical reporting to ensure that they are effectively designed and properly implemented. Lastly, the Company shall periodically update the Division, as requested, on progress of the implementation efforts and on the results of the audits.

SUMMARY

Based upon the procedures performed in this comprehensive examination, RNA has reviewed and tested Company operations/management, complaint handling, marketing and sales, producer licensing, policyholder service, underwriting and rating, and claims as set forth in the *2006 NAIC Market Regulation Handbook*, the market conduct examination standards of the Division, and the Commonwealth of Massachusetts insurance laws, regulations and bulletins. We have made recommendations to address various concerns in the areas of marketing and sales, producer licensing, policyholder service, underwriting and rating and claims.

ACKNOWLEDGEMENT

This is to certify that the undersigned is duly qualified and that, in conjunction with Rudmose & Noller Advisors, LLC, applied certain agreed-upon procedures to the corporate records of the Company in order for the Division of Insurance of the Commonwealth of Massachusetts to perform a comprehensive market conduct examination ("comprehensive examination") of the Company.

The undersigned's participation in this comprehensive examination as the Examiner-In-Charge encompassed responsibility for the coordination and direction of the examination performed, which was in accordance with, and substantially complied with, those standards established by the National Association of Insurance Commissioners ("NAIC") and the *2006 NAIC Market Regulation Handbook*. This participation consisted of involvement in the planning (development, supervision and review of agreed-upon procedures), administration and preparation of the comprehensive examination report. In addition to the undersigned, Dorothy K. Raymond of the Division's Market Conduct Section participated in this examination and in the preparation of the report.

The cooperation and assistance of the officers and employees of the Company extended to all examiners during the course of the examination is hereby acknowledged.

Matthew C. Regan, III
Director of Market Conduct &
Examiner-In-Charge
Commonwealth of Massachusetts
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