

# Market Conduct Examination

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## IFA INSURANCE COMPANY

Clark, New Jersey

STATE OF NEW JERSEY  
DEPARTMENT OF BANKING AND INSURANCE  
Consumer Protection Services

Market Conduct Examinations and Anti-Fraud Compliance

Report Filed: June 9, 2008

MARKET CONDUCT EXAMINATION

of the

IFA INSURANCE COMPANY

located in

Clark, New Jersey

as of

May 10, 2007

BY EXAMINERS

of the

STATE OF NEW JERSEY  
DEPARTMENT OF BANKING AND INSURANCE

CONSUMER PROTECTION SERVICES  
MARKET CONDUCT EXAMINATION AND ANTI-FRAUD COMPLIANCE

**REPORT DISTRIBUTED: June 9, 2008**

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# I. INTRODUCTION

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This is a report of the Market Conduct activities of the IFA Insurance Company (hereinafter referred to as “IFA” or “the Company”). In this report, examiners of the New Jersey Department of Banking and Insurance (NJDOBI) present their findings, conclusions and recommendations as a result of their market conduct examination.

## A. SCOPE AND PURPOSE OF THE EXAMINATION

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The purpose of this examination was to evaluate IFA’s compliance with selected portions of the FAIR ACT and the regulations and statutes pertaining to automobile terminations, underwriting, rating and claims. This examination covered the Company’s New Jersey private passenger automobile insurance business activities during the period July 1, 2005 through June 30, 2006. Between October 16, 2006 and December 22, 2006 the examiners completed their field work at the Company’s Clark, New Jersey office. On various dates thereafter, the examiners completed additional review work and report writing in Trenton, NJ. The Market Conduct Examiners included Monica Koch, Examiner-in-Charge, Robert Greenfield, Ralph Boeckman and John Sivon. The examiners randomly selected files and records from computer listings and documents provided by the Company. The random selection process is in accordance with the National Association of Insurance Commissioners’ Market Conduct Examination Handbook.

## B. ERROR RATIOS

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Error ratios are the percentage of files reviewed which an insurer handles in error. A file will also be counted as an error when it is mishandled or the insured is treated unfairly, even if no statute or regulation is applicable. If a file contains multiple errors, the examiners will count the file only once in calculating error ratios. However, any file which contains more than one error will be cited more than once in the report. In the event that the insurer corrects an error as a result of a consumer complaint or due to the examiners’ findings, the error will be included in the error ratio. If the insurer corrects an error independent of a complaint or NJDOBI intervention, the error is not included in the error ratios. For the most part, this is a report by exception. Most of the

statutes and/or regulations cited in this report define unfair practices or practices in general as specific acts that an insurer commits with such frequency that it constitutes an improper general business practice. The examiners have cited and identified in this report all errors that constitute an improper general business practice.

The examiners sometimes find improper general business practices of an insurer that may be technical in nature or which did not have an impact on a consumer. Even though such a practice would not be in compliance with applicable law, the examiners do not count each of these files as an error in determining error ratios. Whenever such business practices do have an impact on the consumer, each of the files in error will be counted in the error ratio. The examiners have identified all errors and files that are not included in the error ratio.

The examiners submitted written inquiries to Company representatives on the errors cited in this report. This provided IFA the opportunity to respond to the examiners' findings and to provide exception to the statutory and/or regulatory errors or mishandling of files reported herein. In response to these inquiries, IFA agreed with some of the errors cited in this report. On those errors with which the Company disagreed, the examiners evaluated the individual merits of each response and gave due consideration to all comments provided. In some instances, the examiners did not cite the files due to the Company's explanatory responses. In others, the errors remained as cited in the examiners' inquiries.

## C. COMPANY PROFILE

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IFA Insurance Company, located in Clark, New Jersey was incorporated under the laws of New Jersey on December 11, 1972 and began business on December 4, 1973. IFA is an independent monoline automobile insurance company that exclusively writes private passenger automobile insurance in New Jersey.

The day-to-day operations of the Company are managed by David Walsh and Patrick Walsh. Ownership of the outstanding stock resides with the sponsor, Independent Financial Agents, Inc. Financial control of Independent Financial agents resides with its approximately 160 shareholders.

## II. COMPLAINTS

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### A. INTRODUCTION

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During the period of July 1, 2005 through June 30, 2006, IFA's complaint register indicates that consumers filed a total of 22 complaints with the New Jersey Department of Banking and Insurance and with the Company. The examiners reviewed only the Company's complaint register for compliance with **N.J.S.A. 17:29B-4(10)**. The examiners used Chapter VI - Conducting Property and Casualty Insurance Examinations of the Market Conduct Examination Handbook, as a guide to conduct this review.

### B. COMPLAINT LOG

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In accordance with **N.J.S.A. 17:29B-4(10)**, insurers are required to maintain a record of all complaints received by the company. These records shall indicate the total number of complaints, the classification by line of insurance, the nature and the disposition of each complaint and the time it took to process each complaint. This statute conforms to the complaint handling section, Standard One of the NAIC Market Conduct Examiners Handbook, which states that "All complaints (should be) recorded in the required format on the company complaint register." The examiners noted that the Company's complaint register is compliant with **N.J.S.A. 17:29B-4(10)**.

# III. RATING AND UNDERWRITING

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## A. INTRODUCTION

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The examiners reviewed randomly selected policy files from IFA's database run of 20,004 renewals and 2,964 new business policies that were in force during the period July 1, 2005, through June 30, 2006. The examiners checked for compliance with specific statutes and regulations, including N.J.S.A. 17:29A-6 and 15 (filed and approved rating methodologies), N.J.S.A. 17:29A-38 (reduction of rates for operators 65 years or older), N.J.S.A. 17:29A-46 (uniform application of underwriting guidelines), N.J.A.C. 11:3-15 (coverage selection forms), N.J.A.C. 11:3-35; (automobile insurance underwriting rules), N.J.S.A. 39:6A-4.1 and N.J.A.C. 11:3-21 (PIP rate discounts). These requirements are related to NAIC Standards of Chapter VIII: "Conducting Property and Casualty Insurance Examinations" of the Market Conduct Handbook.

## B. ERROR RATIOS

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The examiners calculated error ratios for each random sample by applying the procedure outlined in the introduction of this report. Error ratios are itemized separately for the review samples as indicated in the chart that follows.

<u>Review sample</u>	<u>Files Reviewed</u>	<u>Files in Error</u>	<u>Error ratio</u>
<b>New Business</b>	39	6	15%
<b>Renewals</b>	<u>40</u>	<u>2</u>	5%
<b>Total Random Review</b>	<b>79</b>	<b>8</b>	<b>10%</b>
<b>Select Review</b>	<b>20</b>	<b>2</b>	<b>10%</b>

## C. EXAMINERS' FINDINGS

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- Failure to Conduct Physical Damage Inspections on Added Vehicle Endorsements and New Business Policies - 5 Files in Error - Improper General Business Practice (Random Sample)**

Pursuant to **N.J.A.C. 11:3-36.3(a)**, “No insurer shall provide automobile physical damage insurance coverage prior to conducting an insurance inspection ... [w]hen a new policy or endorsement adding physical damage coverage insuring a private passenger automobile is affected.”

While reviewing randomly selected underwriting policies, the examiners found that IFA provided physical damage coverage on five files without conducting the vehicle inspection required by **N.J.A.C. 11:3-36.3(a)**. In response to an inquiry the Company confirmed this error, stating that “Effective October 21, 2005 we notified our brokers that all inspections would be waived and would be the responsibility of IFA to order them where we felt they were necessary.” The examiners note, however, that inspections may be waived only under specific circumstances outlined in **N.J.A.C. 11:3-36.4(a)** through **(d)**. Specifically, **N.J.A.C. 11:3-36.4(d)** permits a waiver “...based solely on underwriting criteria (that is) uniformly applied...” Notably, IFA did not include any such underwriting criteria in its filed and approved underwriting guidelines. Accordingly, the examiners cited this error as an Improper General Business Practice.

#### **SEE APPENDIX A1 FOR A LIST OF FILES IN ERROR**

### **2. Failure to Follow Filed and Approved Rating Plan Resulting in Overcharge of Medical Expense Portion of the PIP Premium – 2 Files in Error (Select Review) - Improper General Business Practice**

**N.J.S.A. 17:29A-6** and **15** requires insurers to charge only those rates that are filed with and approved by the Commissioner. The examiners conducted a select review of 20 underwriting files in order to test rating accuracy on both new and renewal business. The examiners compared these 20 policies with sample rate calculations submitted by IFA. On two policies, the examiners noted on the declaration page that the Company overcharged the PIP premium by \$1.00 on policy numbers **F71815** and **F114607**. In response to an inquiry the Company agreed with this error and stated that, “With an invalid code ... the rating program doubled the \$1 premium normally charged for the Medical Expense for each car that had the incorrect code.”

In response to a follow-up inquiry the Company stated that 29 active policies had been coded incorrectly in the Medical Expense Benefit field. The Company also advised that, “... it is unable to determine when the invalid code was entered ...” and agreed to endorse a one dollar credit for each of these policies and for each car on the policy for every policy period since inception.

The examiners cited this error as an improper general business practice on those files in which this error occurred, and noted that this error would occur whenever the insured selected the increased Medical Expense Benefit limit of \$10,000.

**SEE APPENDIX A2 FOR A LIST OF FILES IN ERROR.**

**3. Premium Overcharge due to Failure to Follow Filed and Approved Rating Plan – 1 File in Error (Random Sample)**

Pursuant to **N.J.S.A. 17:29A-6** and **15** an insurer is required to charge rates in strict conformity with its rating system as filed with and approved by the Commissioner. In accordance with IFA's filed rating plan, a vehicle that would normally be eligible for Tier 2 is to be assigned to Tier 4 if the operator has a chargeable accident. Contrary to these statutes, the examiners found on new policy number F128423 that IFA erroneously placed the vehicle in Tier 4 based on a non-chargeable accident. This error resulted in an overcharge of \$724.00. The Company agreed with this error and advised that it would issue the insured a \$724.00 credit for the overcharge.

**SEE APPENDIX A3 FOR A LIST OF FILES IN ERROR**

**4. Incorrect Assignment of Class Code - 2 Files in Error (Random Sample)**

Pursuant to **N.J.S.A. 17:29A-6** and **15**, insurers are required to follow their filed and approved rating plans. During the underwriting review, the examiners found two renewal policies where the Company failed to apply the correct class code in calculating the policy premium. On each policy the insured was between the ages of 65-74 when the policy was written but turned 75 prior to the latest renewal of the policy. IFA originally rated both policies properly with a class code of 8021 which represents the operator's age range of 65-74. However, the Company failed to update the class code on both policies to 8031 when the operators turned 75 years of age. In response to an inquiry, the Company agreed with the examiners' findings and stated that, "As the policy renewed year after year and the insured's age hit 75 our renewal program should have updated the class code to 8031. In November of 2005 we noticed that some of the policies did not update as the operator turn [sic] 75 years old. At that point we corrected our new business program to read the operator's age to demonstrate the 8031 rating accordingly. The existing files had to be manually reviewed and the class codes were update [sic] upon renewal." The Company further stated, "These two files bypassed our manual review. These two files will be corrected and the review of our existing policies will be instituted again."

This error did not result in any over/under charges.

**SEE APPENDIX A4 FOR A LIST OF FILES IN ERROR**

# IV. TERMINATIONS

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## A. INTRODUCTION

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During the review period July 1, 2005 to June 30, 2006, IFA nonrenewed 115 automobile policies, mid-term cancelled 155 automobile policies and cancelled 249 new business policies within the first 60 days. Errors, described by type, appear in the chart that follows in the next subsection. The examiners checked for compliance with applicable statutes and regulations and NAIC standards related to this area. These included N.J.A.C. 11:3-8 (nonrenewal of automobile policies), N.J.S.A. 17:33B-15 and 16 (“Take All Comers” laws), N.J.A.C. 11:3-34 and N.J.A.C. 11:3-40 (eligible persons), N.J.A.C. 11:3-44 (rules for effecting auto insurance coverage), N.J.A.C. 11:3-33 (appeals from denial of insurance) and N.J.S.A. 17:29C-7 and 10 (automobile insurance cancellations).

## B. ERROR RATIOS

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<u>Review Sample</u>	<u>Files Reviewed</u>	<u>Files in Error</u>	<u>Error Ratio</u>
<b>Nonrenewals</b>			
1. Nonrenewals for Cause	11	11	100%
2. Two-Percent Nonrenewals	50	50	100%
<b>First 60 Day Cancellations</b>	50	24	48%
<b>Midterm Cancellations</b>	30	14	47%
<b>Insured’s Request</b>	<u>15</u>	<u>0</u>	0%
<b>Totals</b>	<b>156</b>	<b>99</b>	<b>63%</b>

## C. EXAMINERS' FINDINGS

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### **1. Failure to Include Specific Reasons for Nonrenewal on Termination Notices – 61 Files in Error – Improper General Business Practice**

According to N.J.A.C. 11:3-8.3(e) and N.J.A.C. 11:3-8.3(e)1, a nonrenewal notice shall not be valid unless it states the reason for nonrenewal and includes reference to the applicable underwriting provision(s), including dates and other facts necessary for identification of the incidents(s) that the insurer relies upon when deciding to nonrenew a policy.

A review of the Company's nonrenewal notices indicated that all of the notices failed to include reference(s) to the applicable underwriting provision(s), including dates and other facts necessary for identification of the incident(s). IFA's notices contained the following standard language: "You are notified in accordance with N.J.A.C. 11:3-8.5(a)2 that we have the right to non-renew this policy. Our records indicate a combination of two of the events: At-fault accident, four or more point violation, lapse in coverage." Clearly, this standardized language does not provide the level of specificity required by N.J.A.C. 11:3-8.3(e) and (e)1.

In response to an inquiry, IFA agreed with the examiners' findings. The examiners cited this error as an improper general business practice.

### **SEE APPENDIX B1 FOR FILES IN ERROR**

### **2. Failure to Advise Insured that Failure to Complete and Return Renewal Questionnaire may Result in Nonrenewal of the Policy at the Next Renewal Period – 9 Files in Error**

According to N.J.A.C. 11:3-8.6(b), no insurer shall nonrenew a policy for failure to complete and return a renewal questionnaire without having first given written notice to the policyholder one full policy cycle period prior to the issuance of the notice of nonrenewal stating that:

- a. At the next renewal, the insurer shall send the policyholder a renewal questionnaire, which must be completed and returned; and
- b. Failure to complete and return that renewal questionnaire may result in the nonrenewal of the policy.

The examiners found that IFA's renewal questionnaire fails to advise the insured that failure to complete and return the questionnaire may result in nonrenewal of the policy at the expiration of the next renewal period. In response to an inquiry the Company stated, "These insureds are required to

complete a questionnaire as part of their original application. Notice of failure to complete a questionnaire is included at the top of page one of the Underwriting Questionnaire.” While IFA’s questionnaire states, “Failure to complete and return that underwriting questionnaire may result in the nonrenewal of your automobile insurance policy,” it does not inform the insured that the nonrenewal would occur at the expiration of the next renewal period.

**SEE APPENDIX B2 FOR A LIST OF FILES IN ERROR**

**3. Failure to Accept the Minimum Information Necessary to Deem an Application Complete/Failure to Provide Coverage to Eligible Applicants - 4 Files in Error**

N.J.A.C. 11:3-44.3(a)1 through 10 lists the minimum information necessary to determine whether an applicant is an eligible person, as well as the minimum information necessary to rate and underwrite a policy. Further, N.J.A.C. 11:3-44.3(b) requires that an insurer provide coverage to an eligible person who submits a completed written application that includes the information referenced in N.J.A.C. 11:3-44.3(a). Lastly, N.J.A.C. 11:3-44.3(b)2 states that “any document required to be submitted in connection with an application or renewal shall be prominently requested in the application or renewal form.”

Contrary to the minimum information requirements referenced above, the examiners found that IFA cancelled four eligible applicants within the first 60 days due to the insureds’ failure or inability to respond to Company letters that requested one or more of the following documents: copies of vehicle titles, copies of declaration sheets from other policies in the household, accident reports and copies of previous declarations sheets. Notably, these documents are omitted from minimum information requirements outlined in N.J.A.C. 11:3-44.3(a)1 through 10. Furthermore, N.J.A.C. 11:3-44.3(a)6iii prohibits an insurer from requiring an applicant to provide a motor vehicle abstract. In response to an inquiry, the Company disagreed with this error and stated that these cancellations “...were valid, as requesting accident reports and/or company name & policy number so that we may properly rate the policy are clearly defined in our underwriting guidelines. It is our position that this is a valid reason for cancellation under N.J.A.C. 11:3-35.4(g)2.” The examiners disagree, and noted that IFA’s underwriting guidelines relative to evidence of prior or concurrent household insurance apply to the pricing of the risk and not eligibility. Therefore, IFA cancelled these policies erroneously. The examiners also noted that the insured on each cancelled policy was an eligible person in accordance with N.J.A.C. 11:3-34 and 35. Therefore, IFA terminated these policies in violation of N.J.S.A. 17:33B-15 and N.J.S.A. 17:29A-46, which prohibit an insurer from refusing to insure an eligible person.

**SEE APPENDIX B3 FOR A LIST OF FILES IN ERROR**

**4. Failure to Provide Option to Pay Full Premium to Applicant Whose Prior Insurance Cancelled Due to Non-payment of Premium - Improper General Business Practice**

Pursuant to **N.J.A.C. 11:3-34.4(a)6**, an eligible person includes an applicant whose automobile policy has been cancelled for nonpayment of premium with a lapse in coverage of at least 30 days within the immediately preceding two-year period, provided that applicant pays the policy premium in full before the policy effective date. Page one of IFA's new business underwriting guidelines, Section 1.C, contains this same provision.

While reviewing IFA's on-line new business quote and application system, the examiners found that an application is automatically rejected from the application process whenever the applicant discloses a prior policy lapse of greater than 30 days. Notably, the agent cannot bypass this rejection, even if the applicant was given the opportunity and agreed to pay the full annual premium at the time of application. Accordingly, the examiners cited this application process as contrary to **N.J.A.C. 11:3-34.4(a)6**, which permits the insured to pay the full policy premium as a means to satisfy eligibility criteria. This process also constitutes a violation of **N.J.S.A. 17:33B-15** and **N.J.S.A. 17:29A-46**, which prohibit an insurer from refusing to insure an eligible person.

In response to the examiners' inquiries, IFA disagreed with this error, stating that this regulation "... does not state that the company has to give the option to the insured to pay the premium in full." The examiners disagree. As outlined above, **N.J.A.C. 11:3-34.4(a)6** and IFA's own underwriting guidelines provide that payment in full constitutes eligibility where no other grounds for ineligibility exist. Failure to disclose this option is deceptive by omission.

Based on the foregoing, the examiners cited this error as an improper general business practice.

**5. Failure to Retain Certified Mail Receipt/Date Stamped Proof of Mailing of First 60 Day Cancellation Notices - 20 Files in Error - Improper General Business Practice**

According to **N.J.A.C. 11:3-44.3(d)** "If, during the first 60 days that a new policy is in effect, the insurer ascertains that the applicant failed to disclose the necessary information required on the application to determine whether the applicant or any regular operator is an eligible person, the insurer shall issue a written notice to the applicant which clearly and specifically identifies the deficiencies and allows the applicant 15 days to provide the requested information. The request for information shall either be sent by certified mail or

the insurer shall retain date stamped proof of mailing from the U.S. Post Office listing the name and address of the applicant...”

The examiners found 20 files in which IFA retained a copy of the appropriate letter in the file, but the Company was unable to provide either a certified mail receipt or a date stamped proof of mailing. In response to an inquiry, the Company agreed with the examiners’ findings and stated, “We will correct and modify our procedure from this point forward, and will issue any 15 day notice requesting documents to complete an application with certified mail or proof of mailing date stamped by the US Post Office.”

**SEE APPENDIX B4 FOR A LIST OF FILES IN ERROR**

**6. Failure to Include the Specific Reason for Termination for First 60 Day and Mid-term Cancellations – 19 Files in Error**

**N.J.S.A. 17:33B-16** and **N.J.A.C. 11:3-33.4(a) and (b)** require an explanation of the reason for a declination to be included on the termination notice. The reason must be specific, comprehensive and provide the specific basis for which the applicant fails to qualify as an eligible person. Furthermore, **N.J.S.A. 17:23A-10(a)** states that in the event of an adverse underwriting decision, the insurer is required to provide the policyholder with the specific reason or reasons for the adverse underwriting decision.

The examiners found that IFA did not comply with **N.J.S.A. 17:33B-16**, **N.J.A.C. 11:3-33.4(a) and (b)** and **N.J.S.A. 17:23A-10(a)** on five first 60 day cancellations and 14 mid-term cancellations. The notices issued to the insured included reasons such as, “Material Non-disclosure” and “No Cooperation.” These reasons are vague and non-specific; they do not inform the insureds of the reason or basis upon which IFA deemed the insured to be ineligible. The examiners do note, however, that the underlying reasons for termination were valid.

IFA disagreed with these errors and stated that, according to **N.J.S.A. 17:29C-12**, the insured has the option to request the specific reason in writing from the insurer. The examiners disagree, as this interpretation would supersede the informational disclosure requirements stated in **N.J.S.A. 17:33B-16**, **N.J.A.C. 11:3-33.4(a) and (b)** and **N.J.S.A. 17:23A-10(a)**. Moreover, and contrary to the Company’s response, **N.J.S.A. 17:29C-12** contains no provision that provides the insured with an affirmative option to receive or not receive the reason for termination; it merely provides a minimum period of 15 days from policy expiration for an insurer to respond to an insured request for the reason for termination where the actual reason is not provided with the initial notice of termination. The examiners cited this error as an improper general business practice.

**SEE APPENDIX B5 FOR A LIST OF FILES IN ERROR**

**7. Failure to Refer Files to OIFP for Further Investigation - 3 Files in Error**

**N.J.A.C. 11:16-6.7(a)1** states in part that an insurer should refer to the Office of Insurance Fraud Prosecutor (OIFP) any application or claim where the facts and circumstances create a reasonable suspicion that a person or entity has violated **N.J.S.A. 17:33A-4** (New Jersey Insurance Fraud Prevention Act). From the cancellation sample review, the examiners found three files where the facts created a reasonable suspicion that fraudulent activity did in fact occur, but where IFA did not refer these files to the OIFP as required.

IFA cancelled policy number F125119 due to the insured's failure to disclose her husband as a licensed relative who resided in her household. IFA did not refer this file to the OIFP. The Company agreed with this error and stated in part that, "The failure to correspond between our claims and SUI (sic) departments was the reason this particular file was not referred to OIFP."

The remaining two policies (I40106 and I41001) involve fraudulent use of credit cards that the applicants used to purchase automobile insurance policies. In both instances, the Company cancelled and referred these policies to IFA's SIU department. However, IFA failed to refer the results of its investigation to the OIFP. In response to an examiners' inquiry, the Company stated in part that it referred these cases only to local police departments because "...there was no intent to defraud IFA and the Department of Insurance." The examiners disagree with IFA's position on the basis that **N.J.S.A. 17:33A-4.a(4)(b)** defines a violation of the New Jersey Insurance Fraud Prevention Act to include any person who "Prepares or makes any written or oral statement, intended to be presented to any insurance company ... for the purpose of obtaining ... an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to an insurance application or contract..." Clearly, offering stolen assets in exchange for insurance coverage constitutes a false statement "concerning any fact or thing material to an insurance application ..." Therefore, these applicants violated **N.J.S.A. 17:33A-1 et seq.** Accordingly, IFA was obligated to notify the OIFP.

**SEE APPENDIX B6 FOR A LIST OF FILES IN ERROR**

**8. Improper Mid-term Cancellation - 1 File in Error**

**N.J.S.A. 17:29C-7** states that a notice of cancellation shall be effective only if it is based on one or more of the following reasons: nonpayment of premium; driver's license or vehicle registration, suspension or revocation;

material misrepresentation; and failure to meet the insurer's approved underwriting guidelines.

IFA cancelled policy number F128077 at midterm due to the insured's failure to cooperate in the underwriting process and the Company's inability to ascertain eligibility. However, N.J.S.A. 17:29C-7(A)(d) and N.J.A.C. 11:35.4(g)2 specify that such cancellations are permissible only when notice is issued within the first 60-days of coverage. Since this policy became effective March 15, 2006 with a notice date of May 18, 2006 (64 days beyond inception), this cancellation was improper.

**SEE APPENDIX B7 FOR FILE IN ERROR**

**9. Failure to Provide a Timely Notice of Nonrenewal – 1 File in Error**

N.J.A.C. 11:3-8.3(e) states that a notice of nonrenewal shall not be valid unless it is mailed or delivered by the insurer to the insured named policyholder no less than 60 days and no more than 90 days prior to the expiration of the current policy. Contrary to the above stated regulation, IFA mailed the notice on policy number F90078 on October 14, 2005, and the policy cancelled on December 7, 2005. Therefore, IFA provided only 54 of the minimum 60 days notice. In response to the examiners' inquiry, the Company agreed with this finding.

**SEE APPENDIX B8 FOR FILE IN ERROR**

**10. Improper Nonrenewal Based upon 2% Rule – 1 File in Error**

N.J.A.C. 11:3-8.6(c)2 sets forth the criteria that the insured or any other operator insured under a policy must meet in order for the policy to be eligible for a 2% nonrenewal. The examiners reviewed policy F123963 and found that there were two drivers listed on the policy and each driver was involved in an at-fault accident. However, when IFA reviewed the policy, it mistakenly cited one of the drivers as having both of the at-fault accidents and erroneously deemed the policy to qualify for nonrenewal based upon the 2% rule. In response to an inquiry, the Company agreed with the examiners' findings

**SEE APPENDIX B9 FOR FILE IN ERROR**

# V. CLAIMS

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## A. INTRODUCTION

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This review covers paid and denied Personal Injury Protection (PIP), collision, other-than-collision (hereinafter referred to as comprehensive), towing and property damage claims submitted under private passenger automobile insurance. Any such New Jersey claim closed during July 1, 2005 and June 30, 2006 was subject to review. IFA closed 1,564 PIP claims, 337 comprehensive claims, 2,182 collision claims, 2,076 property damage claims and 681 towing claims. From this total, the examiners randomly selected and reviewed 299 paid and denied claims.

In reviewing each claim, the examiners checked for compliance with all applicable statutes and regulations that govern timeliness requirements in settling first and third party claims. The examiners conducted specific reviews placing particular emphasis on N.J.S.A. 17:29B-4(9) and N.J.A.C. 11:2-17 (Unfair Claims and Settlement Practices), N.J.A.C. 11:3-10 (Auto Physical Damage Claims) and N.J.S.A. 39:6A-5 (Personal Injury Protection Claims). These requirements relate to the NAIC Market Conduct Standards of Chapter VI - Property and Casualty Insurance Examinations.

## B. ERROR RATIOS

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The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. Error ratios are itemized separately based on the review samples as indicated in the following charts. The PIP review consisted of one randomly selected bill from each file. The chart below itemizes all randomly selected paid and denied claims reviewed, along with total files in error and error ratio.

### 1. Paid Claims

<u>Type of Claim</u>	<u>Files Reviewed</u>	<u>Files in Error</u>	<u>Error Ratio</u>
PIP	50	22	44%
Physical Damage	84	34	40%
Property Damage	<u>47</u>	<u>8</u>	2%
Subtotal	181	64	35%

## 2. Denied Claims

<u>Type of Claim</u>	<u>Files Reviewed</u>	<u>Files in Error</u>	<u>Error Ratio</u>
PIP	25	6	24%
Physical Damage	40	6	15%
Property Damage	17	2	12%
Subtotal	82	14	17%
Towing	<u>36</u>	<u>0</u>	0%
Random Totals	299	78	26%

### C. PERSONAL INJURY PROTECTION CLAIMS

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#### 1. Failure to Pay PIP Claims Timely – 22 Files in Error – Improper General Business Practice

N.J.S.A. 39:6A-5(g) states that a claim "shall be overdue if not paid within 60 days after the insurer is furnished written notice of the fact of a covered loss..." N.J.A.C. 11:2-17.7(b) states that, "The maximum period for all personal injury protection (PIP) claims shall be 60 calendar days after the insurer is furnished written notice of the fact of a covered loss...; provided however that an insurer may secure a 45-day extension in accordance with N.J.S.A. 39:6A-5." Where such an extension is requested, the maximum settlement period may not exceed 105 days.

The examiners reviewed 50 paid PIP claims and found that IFA failed to settle 22 claims within the maximum 60-calendar day time frame without securing the 45 day extension for additional time to investigate. Delays ranged from a low of 2 days beyond 60 to a high of 30 days beyond 60. In response to the examiners' inquiries, the Company agreed with these findings.

#### SEE APPENDIX C1 FOR A LIST OF FILES IN ERROR

#### 2. Failure to Pay Interest on Delayed PIP Payments – 22 Files in Error - Improper General Business Practice

N.J.S.A. 39:6A-5(h) requires the payment of interest on all overdue benefits. Contrary to this requirement, IFA failed to pay interest on all 22 of the PIP bills cited. As a result of the examiners' inquiries, the Company agreed with these findings.

Since the Company failed to pay interest on all 22 delayed settlements, the examiners cited this error as an improper general business practice.

**SEE APPENDIX C2 FOR A LIST OF FILES IN ERROR**

**3. Improper Denial of PIP Claims – 1 File in Error**

Pursuant to **N.J.A.C. 11:2-17.8(i)**, no insurer shall deny payment of a claim when it is reasonably clear that either full or partial benefits are payable. On claim **48503**, IFA denied benefits because the PIP claimant was as undisclosed licensed driver. However, the person claiming benefits was determined to be a nine year old child and therefore could not have been a licensed operator residing in the insured's household. The Company agreed with the examiners' findings.

**SEE APPENDIX C3 FOR FILE IN ERROR**

**4. Failure to Issue 45-Day PIP Delay Notice on Denied PIP Claims - 3 Files in Error**

**N.J.S.A. 39:6A-5(g)** and **N.J.A.C. 11:2-17.7(b)** require that within 60 calendar days of receipt of notice of claim, an insurer notify the claimant in writing of the denial of the claim or the need for additional time, not to exceed 45 days, to investigate the claim. Of the 25 denied PIP claims reviewed, the examiners found three files in which the Company did not issue a 45-day delay letter and denied the claim beyond the maximum 60-day settlement period.

**SEE APPENDIX C4 FOR A LIST OF FILES IN ERROR**

**5. Failure to Conduct a Proper Investigation – 1 File in Error**

Pursuant to **N.J.S.A. 17:29B-4(9)(d)**, insurers may not refuse to pay claims without conducting a reasonable investigation based upon all available information. The examiners found that IFA failed to conduct a reasonable investigation on one denied PIP claim.

On claim 49093, the insured disclosed on the application for insurance that her 21 year old son resided in her household. She also stated that he was not a licensed driver on the new business underwriting questionnaire. The insured's son filed a claim for PIP benefits for injuries he sustained in a loss on December 9, 2005. At the time of this loss he was a passenger in another person's vehicle. However, the Company denied coverage and cited him as an undisclosed operator on the insured's policy. The Company based its decision on a motor vehicle record search that listed the son as having a moving violation 3 years and 8 months prior to the date of loss.

IFA disagreed with the examiner's findings and stated in part that, "His MVR shows violations of 4/8/02 & 7/2/05. This led us to believe that he had a previous

license.” The Company further stated that, “if he had been unlicensed on 4/8/02 the MVR would have listed him as an unlicensed driver.” The examiners disagree, as IFA drew this conclusion based upon assumption rather than documentation. Notably, the examiners’ review of the underwriting file revealed that IFA did not attempt to obtain written records on file with the New Jersey Commission of Motor Vehicles and local prosecutors in order to test its assumption. Nor did IFA attempt to obtain written records relative to any court proceedings. Accordingly, IFA had no direct, verifiable knowledge as to whether the claimant was or was not licensed at the time of these losses. Therefore, IFA was unable to demonstrate that it conducted a reasonable investigation within the context of **N.J.S.A. 17:29B-4(9)(d)**. In response to further examiner inquiry regarding the propriety of its underwriting review, IFA merely stated, “A thorough review of the file was done prior to issuance of the denial.” Once again, however, IFA did not provide documentation to support this contention.

**PLEASE SEE APPENDIX C5 FOR FILE IN ERROR**

**6. Failure to Maintain Complete Claim File - 1 File in Error**

**N.J.A.C. 11:3-10.10** and **N.J.A.C. 11:2-17.12(b)** require a company to maintain a complete claim file in order to permit the Commissioner’s representatives to reconstruct the insurer’s activities relative to claims settlement. IFA denied PIP benefits on claim 47622 because the insured failed to disclose that the claimant was a licensed, household operator. The claim was reported via the broker on an Acord form which clearly identified the fact that the claimant moved into the insured’s household after the policy’s renewal. However, the Acord form failed to list the actual date that the event occurred. A review of the documentation in the claim file does not support an attempt by the Company to determine the date when the claimant became a member of the insured’s household. IFA instead denied the claim based upon the claimant being an undisclosed operator. In response to an inquiry the Company stated, “A thorough review of the file was done prior to the issuance of the denial.” Even though the Company stated that a thorough review was done, IFA failed to provide documentation to support the denial. Therefore, the Company failed to comply with the above-stated regulations.

**SEE APPENDIX C6 FOR A LIST OF FILES IN ERROR**

**D. PHYSICAL AND PROPERTY DAMAGE CLAIMS**

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**7. Improper Deduction of Towing-Related Fees from Total Loss and Partial Loss Claim Settlements - 20 Files in Error – Improper General Business Practice**

**N.J.A.C. 11:3-10.4(a)** states in part that, “...if the insurer elects to make a cash settlement, it must bear in mind that the insured’s position is that of a retail consumer, and that the settlement must be reasonable and fair for a person in that position...”

Moreover, if the insurer elects to make a cash settlement, its offer is subject to applicable additions and deductions plus applicable sales tax. Permissible additions and deductions include betterment and depreciation (N.J.A.C. 11:3-10.3(i)), prior damage and condition (N.J.A.C. 11:3-10.3(j)) and mileage depreciation where applicable (N.J.A.C. 11:3-10.4(f)). N.J.A.C. 11:3-10.4(h) makes these requirements applicable to total and partial losses. Contrary to these requirements, the examiners found 19 total losses and one partial loss in which IFA deducted “administrative” and/or “yard fees” from the claim settlement. These fees were charged to IFA by the towing vendor that removed the vehicle from the location of loss. Notably, such fees do not qualify as valid settlement deductions within the range of permissible deductions allowed in N.J.A.C. 11:3-10 and N.J.A.C. 11:3-10.4.

IFA disagreed with these errors, stating that, “We do not allow for administrative fees, police fees (or) yard charges...These fees can’t be considered a direct loss to the covered auto, they are incidental expenses that are not covered. Towing coverage encompasses towing and labor charges, these fees are neither towing nor labor and therefore are not covered.” The examiners disagree, as the towing portion of these settlements was based not on separate towing coverage or endorsements as the company contends. Rather, they were covered under that portion of IFA’s policy contract (Part E-Duties After an Accident of Loss, Section D) that provides indemnity for the insured’s mandatory but reasonable loss mitigation efforts after a covered loss. IFA erroneously held the insured accountable for unreasonable loss mitigation efforts on all claims cited for this error. Claim number 50024 serves as an example in which IFA deducted \$625 from the actual cash value:

Tow Company Overcharge of Labor:	\$250.00
Law Enforcement Traffic Control:	\$250.00
Miscellaneous Shop Supplies:	\$ 70.00
Office Expense:	<u>\$ 50.00</u>
Total Invalid Deductions	\$625.00

These deductions are not permissible as outlined above in N.J.A.C. 11:3-10.3, N.J.A.C. 11:3-10.4 and IFA’s own policy contract. Accordingly, these deductions constitute unfair settlements which are prohibited by N.J.S.A. 17:29B-4(9)(f). The examiners found a total of \$1,636.40 in such settlement deductions that occurred on 20 claims cited for this error.

**SEE APPENDIX C7 FOR A LIST OF FILES IN ERROR**

**8. Unfair Exclusion of Salvage Retention Value from Sales Tax Calculation of Total Losses– 6 Files in Error – Improper General Business Practice**

N.J.A.C. 11:3-10.4(a) states in part that, “...if the insurer elects to make a cash settlement, it must bear in mind that the insured’s position is that of a retail consumer, and that the settlement must be reasonable and fair for a person in that position...” Moreover, if the insurer elects to make a cash settlement, its offer is subject to

additions and deductions plus applicable sales tax. Permissible additions and deductions include betterment and depreciation (N.J.A.C. 11:3-10.3(i)), prior damage and condition (N.J.A.C. 11:3-10.3(j)) and mileage depreciation where applicable (N.J.A.C. 11:3-10.4(f)), or otherwise specified in N.J.A.C. 11:3-10.4(a), (b) and (j). The latter addresses the insurer’s option to deduct salvage from the settlement when a vehicle owner retains the damaged vehicle.

IFA utilizes the NADA/Redbook actual cash value methodology to establish the cash settlement offer referenced above. N.J.A.C. 11:3-10.2 defines actual cash value as a value for which the damaged vehicle can be replaced with one that is substantially similar. N.J.A.C. 11:3-10.2 further defines a substantially similar vehicle as one that is the same make, model, year and condition of the damaged vehicle at the time of loss.

While reviewing total loss evaluations, the examiners noted on six claims in which the vehicle owner retained salvage that IFA routinely reduced the pre-tax actual cash value by the amount of the salvage retention reduction. As such, and contrary to N.J.A.C. 11:3-10.4(a), IFA’s cash offer failed to include sales tax on this value, ultimately resulting in claim underpayments. This method of settlement is also inconsistent with the approved deduction and settlement calculation methodology outlined in N.J.A.C. 11:3-10.4(a) and N.J.A.C. 11:3-10.2. The following chart outlines IFA’s incorrect settlement methodology (Column A) that resulted in an underpayment on claim 48945, as well as the correct settlement methodology (Column B):

A. Incorrect IFA Evaluation		B. Correct Evaluation	
Average Book Value	\$6,800.00	Average Book Value	\$6,800.00
Salvage Retention	-\$1,100.00	Sales Tax (6% - NJ)	+\$408.00
Subtotal	\$5,700	Subtotal	\$7,208.00
Sales Tax (6% - NJ)	<u>+\$342.00</u>	Salvage Retention	<u>-\$1,100.00</u>
Settlement	\$6,042.00	Settlement	\$6,108.00
		Total Underpayment to Insured:	\$66.00

IFA disagreed with this error, stating that the vehicle owner is not entitled to tax on the salvage retention value, and implied that any possible, subsequent salvage sale by the owner would result in an overpayment of sales tax. The examiners note, however, that N.J.A.C. 11:3-10 et seq. and N.J.A.C. 11:2-17 et seq. do not provide for reductions in claim settlement values based on the insurer’s presumption of the claimant’s possible future actions. Moreover, and as outlined above, salvage retention settlement reductions are not included in the approved method of establishing actual cash values which represent the value a retail consumer would spend to replace the damaged vehicle with one that is substantially similar. Salvage retention value

deductions are extraneous to the actual cash value and must be applied as a whole dollar deduction to the final actual cash value which includes tax. This error resulted in a total underpayment of \$143.48 on the six claims cited in error.

**SEE APPENDIX C8 FOR A LIST OF ALL FILES IN ERROR**

**9. Improper Deduction of Auto Manufacturer Rebate from Total Loss Settlement – 1 File in Error**

N.J.A.C. 11:3-10.4(f) states that in instances when the insured vehicle is of the current model year and has not been superseded in the market place by an officially introduced succeeding model, the insurer is given two choices to determine a settlement. The first settlement choice is presented in N.J.A.C. 11:3-10.4(f)1 and states that the insurer shall pay the insured an amount equal to the reasonable purchase price on the date of the loss of a new identical vehicle, less any applicable deductible and an allowance for depreciation in accordance with the applicable depreciation schedule. The second settlement choice is presented in N.J.A.C. 11:3-10.4(f)2, which permits the insurer to provide the insured with a new identical replacement vehicle, less any applicable depreciation in accordance with the schedule.

The Company settled claim 49628 based on N.J.A.C. 11:3-10.4(f)1 and relied upon a copy of the original purchase contract between the insured and the dealership where the vehicle was purchased. File documentation demonstrated that IFA used the purchase price of the vehicle that was negotiated between the insured and the car dealer at the time of purchase. The Company deducted the appropriate depreciation for mileage that accrued on the vehicle and added New Jersey state sales tax. However, contrary to N.J.A.C. 11:3-10.4(f)1 and 2, IFA then deducted a \$1,500.00 manufacturer's consumer incentive/rebate for which the insured qualified at the time the damaged vehicle was purchased. The examiners note that the above-referenced regulations do not permit deductions based on marketing incentives such as rebates, as they constitute variable sales tactics designed to dispose of inventory. Moreover, such deductions based on variable, point-of-sale cost adjustments do not reflect a vehicle's prevailing retail value at the time of loss.

Although IFA disagreed with this error, it nevertheless advised that it would remit the \$1,500 deduction to the insured.

**SEE APPENDIX C9 FOR FILE IN ERROR**

**10. Settlement Delays and Failure to Issue Delay Notices – 16 Files in Error – Improper General Business Practice**

N.J.A.C. 11:3-10.5(a) and N.J.A.C. 11:2-17.7(c) state that unless clear justification exists, the maximum payment period for physical damage claims shall be 30 calendar days and 45 calendar days for property damage claims, respectively.

**N.J.A.C. 11:3-10.5(b)** and **N.J.A.C. 11:2-17.7(e)** state that, if the insurer is unable to settle the claim within the time periods specified, the insurer must send the claimant written notice by the end of the payment periods. This notice must specify the reason for the delay. **N.J.A.C. 11:3-10.5(b)** and **N.J.A.C. 11:2-17.7(e)** also require an insurer to send an updated, written notice of delay every 30 and 45 days respectively thereafter, until all elements of the claim are paid or denied. IFA failed to settle 16 claims (two third party, 11 collision and three comprehensive) within the correct time frame and did not issue the appropriate delay letter for each claim.

On four claims where the delayed settlement was on a total loss claim, the Company disagreed with the examiners' findings and stated, "A total loss settlement package was sent to the insured... This is considered an offer of payment." The examiners note, however, that an offer of payment within a maximum settlement period does not constitute payment within that period. Moreover, **N.J.A.C. 11:3-10.5(a)** defines a payment period as "...the period between the date of receipt of the notice of loss by the insured, and .... [t]he date the settlement check is mailed..." Accordingly, the examiners cited this error as an improper general business practice.

### **SEE APPENDIX C10 FOR A LIST OF FILES IN ERROR**

#### **11. Claims Denied Under Incorrect Coverage – 6 Files in Error**

**N.J.A.C. 11:2-17.8(a)**, states that no insurer shall deny or offer to compromise a claim because of a policy provision, including any concerning liability, a condition or exclusion without providing a specific reference to such language and a statement of the facts which make that language operative. Contrary to this regulation, IFA failed to state the correct coverage for which the claim was denied. In each claim, the denial letter incorrectly identified collision coverage as the reason for denial instead of comprehensive coverage. In response to multiple inquiries, the Company agreed with the examiners' findings.

### **SEE APPENDIX C11 FOR A LIST OF FILES IN ERROR**

#### **12. Unfair Denial of Comprehensive and Property Damage Claims – 4 Files in Error**

Pursuant to **N.J.A.C. 11:2-17.8(i)**, no insurer shall deny payment of a claim when it is reasonably clear that either full or partial benefits are payable. In addition, **N.J.S.A. 17:29B-4(9)(f)** requires an insurer to attempt good faith efforts to effectuate prompt, fair and equitable settlement when liability has become reasonably clear. The examiners found that IFA failed to comply with these requirements on two improperly denied third party property damage claims and two comprehensive claims.

On property damage claim 49707, IFA denied a liability settlement to a third party claimant. The examiners' review of this file revealed that an unknown vehicle stopped abruptly, causing the claimant, who was directly in front of the insured, to stop. The insured then struck the rear of the claimant's car. The examiners' review of the police report confirmed these facts. Moreover, the insured was issued a traffic violation for careless driving due to following too closely to the claimant's vehicle. In addition to the above, IFA's claim file included a written statement by the claimant that revealed the following, "The car in front of me stopped and I reduced the speed of my car...just then the car behind me bumped the back of my car."

In response to the examiners' inquiry, IFA disagreed and stated, "Although the insured was issued a ticket, her MVR shows that the charge was reduced to 'unsafe operation of a motor vehicle'." However, IFA erroneously concluded that its insured had no liability for this loss even though the facts contained in the claim file indicated otherwise. Police reports, statements and damage estimates in the file confirm that IFA's insured held the greater degree of liability for the accident.

On property damage claim 48658, IFA denied benefits based on its determination that the insured was not at fault. The information presented on the police report showed that the loss involved two vehicles, and that the IFA insured was unable to stop in time and struck the vehicle in front of her in the rear. However, the insured's written and signed statement taken one week after the accident stated that it was a three car accident. In response to an inquiry, the Company referenced the signed statement and declared, "This statement tells us that our insured was almost at a complete stop when she was hit by the ... rental truck. The impact from the truck caused her to hit the rear of the claimant vehicle causing the cosmetic damage. We are not liable for this damage." The examiners reviewed the signed statement and were unable to find any information that supported the Company's above-quoted response. In fact, a sentence in the signed statement appeared to directly contradict IFA's response, and stated in part that, "The Honda apparently hit the brakes so hard that the Honda bucked & I hit my brakes and almost stopped but just tapped the rear bumper, then the ... rental truck hit into the rear of my van & pushed me into the Honda..." Based on this information, the IFA insured impacted the vehicle in front prior to and independent of the rental truck's impact with the insured. Accordingly, the examiners cited IFA for an unfair denial pursuant to **N.J.A.C. 11:2-17.8(i)** and **N.J.S.A. 17:29B-4(9)(f)**.

On comprehensive claim 46851, the insured vehicle was stolen and later recovered by police. When IFA issued the settlement for damages, the Company erroneously denied benefits for the first and second tow. The first denied tow occurred from where the police recovered the vehicle and removed it to an impound yard. The second denied tow occurred from the impound yard to the insured's repair shop of choice. IFA denied coverage because the policy did not include a towing endorsement. However, the examiners note that loss mitigation

language in IFA's policy contract (Part E, Section D 1 and 2 – Duties After and Accident or Loss) does in fact provide coverage for towing this insured's vehicle from the point of recovery to the police impound lot. In response to an inquiry, IFA agreed in part, and stated that "...the initial tow should have been paid." The examiners note, however, that the second tow was also covered since an impound lot is not a secure location due to potential for additional damage. Accordingly, IFA still owes the insured benefits for the second tow (from impound lot to shop).

On claim 47974, the Company denied benefits because the claim estimate for damages was \$924.79, which was under the insured's \$1,000 deductible. However, the examiners noted that the total estimate and proofs of loss were not complete at the time of denial and that IFA was aware that supplemental proofs (rental and towing) would be forthcoming. After IFA denied the claim, the insured submitted a towing bill in the amount of \$110 and the rental bill in the amount of \$140. At that time, IFA paid each bill in full. Even though the Company's decision to pay the tow bill in full after the initial claim was denied did not cause harm to the insured, IFA should not have denied the claim until it was reasonably sure that it had all documentation necessary to support the facts that the amount claimed was under the deductible.

### **SEE APPENDIX C12 FOR A LIST OF FILES IN ERROR**

#### **13. Failure to Acknowledge Claim in a Timely Manner – 1 File in Error**

Pursuant to N.J.A.C. 11:2-17.6(a) every insurer, upon receiving notification of claim shall, within 10 working days, acknowledge receipt of such notice unless payment is made within such time period. IFA received report of claim number 48501 on September 29, 2005 but did not acknowledge it until October 28, 2005 or 11 working days after its initial report. Contrary to the aforementioned regulation, the Company failed to acknowledge the claim within 10 business days. In response to inquiries, IFA agreed with the examiners' findings.

### **SEE APPENDIX C13 FOR FILE IN ERROR**

#### **14. Failure to Respond to Pertinent Communication – 1 File in Error**

N.J.A.C. 11:2-17.6(e) states that an appropriate reply shall be made within 10 working days on all pertinent communications from a claimant which reasonably suggests that a response is expected. On claim number 47480, the insured obtained a shop estimate for a glass claim. The insured then forwarded the estimate to the Company for review and payment of the claim. The examiners were unable to find any evidence to suggest that the Company acknowledged receipt or reviewed the estimate in a timely fashion. In response to an inquiry the

Company agreed with the examiner's findings and stated that the estimate was mistakenly filed without being reviewed or paid.

**SEE APPENDIX C14 FOR FILE IN ERROR**

**E. MISCELLANEOUS ERRORS**

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**15. Failure to Include Required Information on 30 and 45 Day Delay Notice Forms**

**N.J.A.C. 11:2-17.7(e)** requires 30 and 45 day delay notices to include a telephone number which is toll free, or which can be called collect, or within the claimant's area code. The examiners found that on all files where one of these letters was issued, the Company did not list the required toll free number nor was there any indication on the letter that the phone number listed could be called toll free. In response to an inquiry the Company advised that it would add its toll free claim number to the letters. The examiners did not include this error in the error ratio.

## VI. RECOMMENDATIONS

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IFA should inform all responsible personnel and third party entities who handle the files and records cited as errors in this report of the examiners' recommendations and remedial measures that follow in the report sections indicated. The examiners also recommend that IFA establish procedures to monitor compliance with these measures.

Throughout this report, the examiners cite and/or discuss all errors found. If the report cites a single error, the examiners often include a "reminder" recommendation because if a single error is found, more errors may have occurred.

The examiners acknowledge that during the examination IFA had agreed and had already complied with, either in whole or in part, some of the recommendations. For the purpose of obtaining proof of compliance and for the Company to provide its personnel with a document they can use for future reference, the examiners have listed all recommendations below.

### A. GENERAL INSTRUCTIONS

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All items requested for the Commissioner and copies of all written instructions, procedures, recommended forms, etc., should be sent to the Commissioner, c/o Clifton J. Day, Manager of the Market Conduct Examinations and Anti-fraud Compliance Unit, Mary Roebing Building, 20 West State Street, PO Box 329, Trenton, N.J. 08625, within thirty (30) days of the date of the adopted report.

On all policies to be reopened with premium credits or refunds or additional claim payments, IFA should provide the insured with a cover letter that contains the following first paragraph (variable language is included in parentheses):

#### 1. Premium Credits

"During a review of our policy files by market conduct examiners of the New Jersey Department of Banking and Insurance, they found that we failed to discount your personal injury protection premium due to a passive restraint device in the vehicles(s) on your policy resulting in a PIP discount. Enclosed is our (payment/credit) in the amount of (insert amount) to correct our error. We have rerated your policy to provide you with this discount on all eligible vehicle(s)."

## 2. Underpaid claims

“During a review of your claim by Market Conduct examiners of the New Jersey Department of Banking and Insurance, they found that we (underpaid your Personal Injury Protection claim) (failed to pay interest on your Personal Injury Protection claim) (underpaid your physical damage/property damage claim). Enclosed is our payment in the amount of (insert amount) to correct our error.”

## B. RATING AND UNDERWRITING

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1. Except where permitted by waiver as outlined in this report, IFA must issue written instructions to appropriate personnel and its agents stating that, pursuant to **N.J.A.C. 11:3-36.3**, no insurer shall provide automobile physical damage insurance coverage prior to conducting an insurance inspection. This applies to the issuance of a new policy or to an endorsement that adds a new vehicle to a policy. The Company must also remind appropriate personnel that **N.J.A.C. 11:3-36.6** requires the inspection report and photographs to be retained in the insurer’s file on the insured for five years.
2. The Company must remind all appropriate personnel that, pursuant to **N.J.A.C. 17:29A-6** and **15**, insurers are required to follow their filed and approved rating guidelines when establishing Medical Benefits premiums. Although IFA provided documentation that it returned to the insured all Medical Benefits premium overcharges for all applicable policies and policy periods, the Company should provide the Commissioner with documentation that describes the actions and/or interventions designed to correct this error on a prospective basis.
3. IFA must issue written instructions to appropriate personnel and its agents reminding them that pursuant to **N.J.A.C. 17:29A-6** and **15** insurers are required to follow their filed and approved underwriting and rating plan when:
  - a. Assigning class codes when underwriting and rating a policy;
  - b. Assigning vehicles to the correct tier when underwriting and rating a policy.

IFA must provide documentation that it returned the \$724 overcharge to the insured relative to claim number F128423 cited in Section III.c.3 above

## C. TERMINATIONS

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4. In order to comply with **N.J.A.C. 11:3-8.3(e)** and **(e)1**, IFA must issue instructions to all appropriate personnel stating a nonrenewal shall not be valid

unless it states the reason for nonrenewal and includes reference to the applicable underwriting provision(s), including dates and other facts necessary for identification of the incidents(s) that the insurer relies upon when deciding to nonrenew a policy.

5. In order to comply with **N.J.A.C. 11:3-8.6(b)**, the Company's must amend its current survey or renewal questionnaire advising the insured that failure to complete and return the questionnaire may result in nonrenewal at the next renewal period.
6. The Company must remind all appropriate personnel that **N.J.A.C. 11:3-44.3(b)** requires an insurer to provide coverage to an eligible person who submits a completed application that includes the information referenced in **N.J.A.C. 11:3-44.3(a)**.
7. In order to comply with **N.J.A.C. 11:3-34.4(a)6**, IFA must cease its practice of automatically rejecting otherwise eligible applicants whose prior policies lapsed for 30 or more days and where such lapse occurred within the immediately preceding two year period of submitting an application. IFA must issue written instructions to all applicable company and agency staff, stating that such applicants must be given the opportunity to pay annual premiums in full. IFA must further amend its on-line application portal to assure that such applicants are not automatically rejected from the underwriting process.
8. Pursuant to **N.J.A.C. 11:3-44.3(d)**, the Company must inform all appropriate personnel that a date stamped proof of mailing or certified mail receipt from the U.S. Post Office must be retained when mailing cancellation notices.
9. The Company must issue written instructions to its appropriate staff, advising that the specific reason for adverse underwriting decisions on first 60 day and mid-term cancellations must be stated in the termination notices as required by **N.J.S.A. 17:33B-16** and **N.J.S.A. 17:23A-10(a)**.
10. Pursuant to **N.J.A.C. 11:16-6.7(a)1** and **N.J.S.A. 17:33A-4**, investigations must be referred to the OIFP within 30 days after the date the investigation is concluded if the investigation creates a reasonable suspicion that a person or entity has violated the New Jersey Insurance Fraud Prevention act.
11. Pursuant to **N.J.S.A. 17:29C-7** the Company must remind all personnel that policies cancelled mid-term (in excess of 60 days) are valid only for the following reasons: nonpayment of premium, suspension or revocation of driver's license or vehicle registration, material misrepresentation and/or failure to meet the insurer's approved underwriting guidelines.
12. The Company must remind all appropriate personnel that pursuant to **N.J.A.C. 11:3-8.3(e)**, a notice of nonrenewal shall not be valid unless it is mailed or delivered by the insurer to the insured named policyholder no

less than 60 days and no more than 90 days prior to the expiration of the current policy.

13. The Company must remind all appropriate personnel that pursuant to **N.J.A.C. 11:3-8.6(c)2**, the documentation to support a nonrenewal based upon the 2% rule must be correctly verified before the nonrenewal is issued.

## D. CLAIMS

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14. IFA must issue written instructions reminding all appropriate personnel that **N.J.S.A. 39:6A-5** and **N.J.A.C. 11:2-17.7(a)** require all PIP claims to be settled (paid, denied, compromised) within 60 days unless an extension of 45 days is requested in writing and within this 60 day period, and for a total period not to exceed 105 days from the notice of loss. These instructions must also state that, in the event of delay, interest is required pursuant to **N.J.S.A. 39:6A-5h**.
15. The Company must reopen and review all PIP claims paid within the review period to the present to determine if interest is owed to the claimant. For all payments made beyond the required time period, interest should be calculated and paid for the period of delay as required by **N.J.S.A. 39:6A-5h**. A computer listing of all files reopened and the amount of interest paid should be generated and provided to the Commissioner to verify compliance with this recommendation. No interest payments of less than \$1.00 need to be issued; however, all amounts, even if less than \$1.00, are to be included on the computer listing as requested. IFA should also provide a summary ledger documenting all interest payments made on the claims cited in Appendix C.2 of this report. See General instructions for appropriate cover letter.
16. The Company must remind all appropriate personnel that **N.J.A.C. 11:2-17.8(i)** requires insurers to pay a claim when it is reasonably clear that full or partial benefits are due.
17. IFA must issue written instructions reminding all appropriate personnel that pursuant to **N.J.S.A. 17:29B-4(9)(d)**, the Company must investigate all reasonably available information prior to making a decision to either pay or deny a claim. IFA should reopen claim numbers 48503 and 49093 to determine if PIP benefits are available. The results of this review should be provided to the Commissioner.
18. The Company must issue a written reminder to all appropriate personnel stating that, pursuant to **N.J.A.C. 11:2-17.12(b)** and **N.J.A.C. 11:3-10.10**, all records of pertinent communications and documentation must be

maintained in the claim file in a manner that permits reconstruction of the claim settlement process.

19. Pursuant to **N.J.A.C. 11:3-10.4**, the Company must amend its procedures to include payment of reasonable administrative fees, police release fees, yard charges, etc., as related to tow bills associated with claims. A copy of these revisions should be forwarded to the Commissioner.
20. In addition to the claims cited in Appendix C7 of this report, the Company must reopen and review all first and third party total loss claims paid from January 1, 2005 to the present to determine if any administrative/yards fees were deducted from total loss settlements. IFA should then issue the claimant a refund for all such deductions. A computer listing of all files reopened and the amount paid should be generated and provided to the Commissioner to verify compliance with this recommendation. See General instructions for appropriate cover letter.
21. IFA must issue written instructions to all appropriate personnel stating that, unless clear justification exists, first party claims (**N.J.A.C. 11:3-10.5(a)**) and third party claims (**N.J.A.C. 11:2-17.7(c)**) must be settled within 30 or 45 days, respectively. In addition, **N.J.A.C. 11:3-10.5(b)** and **N.J.A.C. 11:2-17.7(f)**, require insurers to send written notices of delay every 30 or 45 days, respectively, if the insurer is unable to settle the claim within the time periods specified.
22. Pursuant to **N.J.A.C. 11:2-17.8(i)**, IFA must remind all appropriate personnel that the correct coverage must be listed on all denial letters in order to validate the claim denial.
23. **N.J.A.C. 11:2-17.8(i)** requires insurers to pay a claim when it is reasonably clear that full or partial benefits are due. For the files listed in Appendix C.12 of this report, the Company must reopen these claims and make the appropriate payments. IFA must remind all appropriate personnel of the following:
  - a. all repair and associated costs must be calculated prior to denial of a partial loss claim for the reason of being less than the policy deductible;
  - b. when investigating liability for a claim, all factors and information sources, including both first and third parties, must be considered in order to ascertain the probable cause of loss for purposes of evaluating and assessing comparative negligence.

In addition, IFA must provide written instructions to all claims staff stating that all reasonable loss mitigation tow claims must be honored in accordance with Part E, Section 1 of the IFA policy contract. IFA

must research all first party claims that were closed during the review period to determine if additional benefits are payable. A report of findings, including claim number, additional benefits paid, must be provided to the Commissioner for review.

24. IFA must amend its procedures and discontinue the practice of deducting rebates from current model year total loss claims pursuant to **N.J.A.C. 11:3-10.4(f)**. A copy of these revisions should be forwarded to the Commissioner.
25. Pursuant to **N.J.A.C. 11:2-17.6(a)**, the Company must issue a reminder to all appropriate personnel that all claims must be acknowledged within 10 working days from receipt of notice of claim.
26. IFA must remind all appropriate personnel that **N.J.A.C. 11:2-17.6(e)** requires insurers to respond to all pertinent communication within 10 working days where it is reasonably suggested that a response is expected.
27. Pursuant to **N.J.A.C. 11:2-17.6(e)**, the Company must make changes to its 30 and 45 day delay notices to include a toll free number for the insured and/or claimant to contact the Company, or otherwise indicate that the phone number listed can be called collect. IFA should forward a copy of the revised form to the Commissioner.

# APPENDIX A - RATING AND UNDERWRITING

1. **Failure to Conduct Physical Damage Inspections on Added Vehicle Endorsements and New Business Policies - 5 Files in Error - Improper General Business Practice (Random Sample)**

<b><u>Policy Number</u></b>	<b><u>Policy Status</u></b>
F 128679	New
F 128162	New
F 129087	New
F 127436	New
F 127523	New

2. **Failure to Follow Filed and Approved Rating Plan Resulting in Overcharge of Medical Expense Portion of the PIP Premium – 2 Files in Error (Select Review)**

<b><u>Policy Number</u></b>	<b><u>Policy Status</u></b>
F 71815	Renewal
F 114607	Renewal

3. **Premium Overcharge due to Failure to Follow Company Filed and Approved Rating Plan – 1 File in Error (Random Sample)**

<b><u>Policy Number</u></b>	<b><u>Policy Status</u></b>
F 128423	New

4. **Incorrect Assignment of Class Code – 2 Files in Error (Random Sample)**

<b><u>Policy Number</u></b>	<b><u>Policy Status</u></b>
F 49708	Renewal
F 68182	Renewal

# APPENDIX B – TERMINATIONS

**1. Failure to Include Specific Reasons for Nonrenewal on Termination Notices – 61 Files in Error – Improper General Business Practice**

<u>POLICY NUMBER</u>	<u>POLICY NUMBER</u>	<u>POLICY NUMBER</u>
F 100158	F 120282	F 52393
F 100999	F 121119	F 53171
F 102179	F 121210	F 54172
F 104375	F 121863	F 55932
F 105979	F 122131	F 59400
F 108157	F 123963	F 67148
F 108390	F 124636	F 67408
F 108496	F 124883	F 73302
F 109051	F 124975	F 73646
F 109372	F 124983	F 75549
F 109671	F 125134	F 77142
F 110111	F 125567	F 80365
F 110123	F 125733	F 90078
F 111566	F 125962	F 94574
F 113338	F 125981	F 96748
F 116698	F 126063	F 99415
F 117789	F 126394	F 99758
F 119719	F 36077	F105438
F 119949	F 40826	F118122
F 120076	F 41872	F119562
		I 12869

**2. Failure to Advise Insured that Failure to Complete and Return Renewal Questionnaire may Result in Policy Nonrenewal at the Next Renewal period – 9 Nonrenewed Files in Error – Improper General Business Practice**

<u>Policy Number</u>	<u>Policy Number</u>	<u>Policy Number</u>
F 125981	F 126394	F 125962
F 125733	F 125567	F 124636
F 124883	F 124983	F 125134

**3. Failure to Accept the Minimum Information Necessary to Deem an Application Complete and Failure to Provide Coverage to Eligible Applicants on First 60-Day Cancellations- 4 Files in Error (Improper General Business Practice)**

**Policy Number**

I 40557  
I 40639  
I 40623  
I 40764

**4. Failure to Retain Certified Mail Receipt/Date Stamped Proof of Mailing of 60 Day Cancellation Notices - 20 Files in Error - Improper General Business Practice**

<b><u>Policy Number</u></b>	<b><u>Policy Number</u></b>	<b><u>Policy Number</u></b>
I 40520	I 40627	A 40044
I 40786	I 40640	I 40750
I 40639	I 40623	I 40710
I 40298	I 40031	I 40773
A 40028	I 40596	I 40764
I 40177	I 40282	F 125165
I 40557	I 40301	

**5. Failure to Include the Specific Reason for Termination on First 60 Day and Mid-term Cancellations – 19 Files in Error**

<b><u>Policy Number</u></b>	<b><u>Policy Number</u></b>	<b><u>Policy Number</u></b>
I 40298 - 60 Day	I 40073 - MT	I 40101 - MT
F 126093 - 60 Day	I 40078 - MT	I 40071 - MT
I 40301 - 60 Day	F 126774 - MT	I 40216 - MT
I 40031 - 60 Day	F 126465 - MT	F 125011 - MT
I 40282 - 60 Day	F 125114 - MT	F 125145 - MT
	F 127866 - MT	F 128077 - MT
	F 125742 - MT	F 127957 - MT

**60 Day = 60 Day Cancellation**  
**MT = Mid-term Cancellation**

**6. Failure to Refer Files to OIFP for Further Investigation - 3 Files in Error.**

**Policy Number**

F 125119  
I 40106  
I 41001

**7. Improper Mid-term Cancellations - 1 File in Error**

<u>Policy Number</u>	<u>Effective Date</u>	<u>Cancellation Date</u>	<u>Days to Cancel</u>
F 127957	2/25/2006	5/11/2006	75

**8. Failure to Provide a Timely Notice of Nonrenewal – 1 File in Error**

**Policy Number**

F 90078

**9. Improper Nonrenewal Based Upon the 2% rule - 1 File in Error.**

**Policy Number**

F 123963

# APPENDIX C - CLAIMS

## 1. Failure to Pay PIP Claims Timely – 22 Files in Error

<u>Claim Number</u>	<u>Date Bill Received by Company</u>	<u>Date Bill Paid</u>	<u>Number of Days beyond 60</u>
47312	12/01/05	02/07/06	8
45464	09/19/05	11/23/05	5
49922	08/31/06	11/06/06	7
45939	07/22/05	09/27/05	7
44900	06/15/05	09/13/05	30
49013	03/22/06	05/23/06	2
48530	03/10/06	05/11/06	2
49359	05/24/06	08/03/06	11
49236	03/20/06	05/23/06	4
47789	09/12/05	11/15/05	4
48688	12/05/05	02/07/06	4
47214	08/15/05	10/17/05	3
47356	08/11/05	10/13/05	3
49163	03/03/06	05/11/06	9
46939	02/07/06	04/10/06	2
49423	05/01/06	07/10/06	10
48158	04/06/06	06/07/06	2
47672	09/19/05	11/29/05	11
47134	04/03/06	06/07/06	5
47139	12/02/05	02/07/06	7
49904	4/13/06	06/19/06	7
46848	7/27/05	9/28/05	3

## 2. Failure to Pay Interest on Delayed PIP Payments – 22 Files in Error - Improper General Business Practice

<u>Claim Number</u>	<u>Claim Number</u>	<u>Claim Number</u>	<u>Claim Number</u>
47312	48530	47356	47134
45464	49359	49163	47139
49922	49236	46939	49904
45939	47789	49423	46848
44900	48688	48158	49013
47214	47672		

## 3. Improper Denial of PIP Claim – 1 File in Error

<u>Claim Number</u>
48503

**4. Failure to Issue 45-Day PIP Delay Notice on Denied PIP Claims - 3 Files in Error**

**Claim Number**

50125  
48503  
50522

**5. Failure to Conduct a Proper Investigation – 1 File in Error**

**Claim Number      Coverage**

49093                      PIP

**6. Failure to Maintain Complete Claim File - 1 File in Error**

**Claim Number      Coverage**

47622                      PIP

**7. Improper Deduction of Towing Related Fees from Partial Loss and Total Loss Claim Settlements - 20 Files in Error – Improper General Business Practice**

<b><u>Claim Number</u></b>	<b><u>Coverage</u></b>	<b><u>Yard Fee</u></b>	<b><u>Admin Fee</u></b>	<b><u>Towing Cost</u></b>	<b><u>Tax</u></b>	<b><u>Wait Time</u></b>	<b><u>Total Underpaid</u></b>
49629*	Collision	N/A	\$25.00	N/A	N/A	N/A	\$25.00
49307	Collision	N/A	N/A	\$45.00	N/A	N/A	\$45.00
47270	Collision	\$35.00	\$25.00	N/A	N/A	N/A	\$60.00
46408	Collision	\$30.00	\$30.00	N/A	N/A	N/A	\$60.00
48269	Collision	\$35.00	N/A	N/A	N/A	N/A	\$35.00
47827	Collision	N/A	\$35.00	N/A	N/A	N/A	\$35.00
47740	Collision	N/A	\$40.00	N/A	N/A	N/A	\$40.00
47388	Collision	N/A	\$75.00	N/A	N/A	N/A	\$75.00
47056	Collision	N/A	\$45.00	N/A	N/A	\$60.00	\$105.00
50171	Collision	N/A	\$150.00	N/A	\$9.00	N/A	\$159.00
47795	Collision	\$35.00	N/A	N/A	N/A	N/A	\$35.00
48488	Collision	\$40.00	N/A	N/A	N/A	N/A	\$40.00
49464	Comp	\$40.00	N/A	N/A	\$2.40	N/A	\$42.50
47430	Collision	\$40.00	\$30.00	N/A	N/A	N/A	\$70.00
45484	Collision	N/A	\$25.00	N/A	N/A	N/A	\$25.00
47733	Collision	N/A	\$35.00	N/A	N/A	N/A	\$35.00
47329	Collision	\$35.00	N/A	N/A	N/A	N/A	\$35.00
47035	Collision	\$50.00	N/A	N/A	N/A	N/A	\$50.00
46243	Collision	N/A	\$40.00	N/A	N/A	N/A	\$40.00
50024	Collision	N/A	\$625.00^	N/A	N/A	N/A	\$625.00

Total Underpayments \$1,636.40

**\* - Partial Loss**

**^ - \$625.00 Deduction Itemized as: \$250.00-2 Hours Overstatement of Labor at scene of accident; \$250.00-Highway Traffic Control; \$75.00 Miscellaneous Shop Supplies; \$50.00 Office Expenses**

**8. Unfair Exclusion of Salvage Retention Value from Sales Tax Calculation on Total Loss Settlements – 6 Files in Error – Improper General Business Practice**

<u>Claim Number</u>	<u>Policy Coverage</u>	<u>Gross ACV<sup>1</sup></u>	<u>Salvage Deducted<sup>2</sup></u>	<u>Tax Paid<sup>3</sup></u>	<u>Tax Owed<sup>4</sup></u>	<u>Tax Underpaid<sup>5</sup></u>
46789	PD	\$2,887.50	\$300.00	\$223.17	\$249.05	\$25.88
49031	PD	\$1,350.00	\$35.00	\$78.90	\$81.00	\$2.10
49893	PD	\$3,162.50	\$400.00	\$165.75	\$189.75	\$24.00
48945	PD	\$6,800.00	\$1,100.00	\$342.00	\$408.00	\$66.00
47643	PD	\$2,162.50	\$100.00	\$123.75	\$129.75	\$6.00
47007	PD	\$2,212.50	\$325.00	\$113.25	\$132.75	\$19.50
Total						\$143.48

<sup>1</sup>Gross ACV for purposes of this chart, and to illustrate this error, includes only the NADA/RedBook averages and does not include prior damage, condition, mileage or other adjustments.

<sup>2</sup>This value represents IFA’s salvage retention deduction from Gross ACV.

<sup>3</sup> This value represents the incorrect amount of tax that IFA paid on the gross ACV minus the salvage retention value.

<sup>4</sup> This value represents the correct amount of tax that was payable on the Gross ACV without IFA’s erroneous order of calculation.

<sup>5</sup>This value represents the difference between items 4 and 3, and reflects that amount of tax that IFA underpaid due to its erroneous order of calculation.

**9. Improper Deduction of Auto Manufacturer Rebate from Total Loss Settlement – 1 File in Error – Improper General Business Practice**

<u>Claim Number</u>	<u>Coverage</u>
49268	Collision

**10. Settlement Delays and Failure to Issue Delay Notices – 16 Files in Error – Improper General Business Practice**

<u>Claim Number</u>	<u>Coverage</u>	<u>Date Claim Received</u>	<u>Date of Settlement</u>	<u>Days Beyond 30</u>	<u>Days Beyond 45</u>
48716	Collision*	11/17/05	12/23/05	6	N/A
49155	Collision*	12/29/05	2/24/06	27	N/A
49115	Collision	12/27/05	2/1/06	6	N/A

50359	Collision	5/9/06	6/9/06	1	N/A
48183	Collision	9/26/05	11/7/05	12	N/A
48488	Collision*	10/27/05	12/2/05	6	N/A
46799	Collision	5-12-05	9/9/05	90	N/A
46988	Collision*	6/2/05	7/11/05	9	N/A
49943	Collision	3/23/06	5/4/06	12	N/A
49112	Collision	12/27/05	2/1/06	6	N/A
48501	Comprehensive	9/29/05	11/7/05	9	N/A
48182	Comprehensive	9/28/05	11/7/05	10	N/A
49892	Comprehensive	3/20/06	5/5/06	16	N/A
47480	Comprehensive	7/18/05	8/31/05	44	N/A
48601	Property Damage	11/7/05	5/2/06	N/A	131
49707	Property Damage	3/1/06	4/18/06	N/A	3

\*Designates Total Losses

**11. Claims Denied Under Incorrect Coverage – 6 Files in Error**

<u>Claim Number</u>	<u>Coverage</u>	<u>Claim Number</u>	<u>Coverage</u>
50743	Comprehensive	47480	Comprehensive
47974	Comprehensive	47996	Comprehensive
48321	Comprehensive	47527	Comprehensive

**12. Unfair Denial of Comprehensive and Property Damage Claims – 4 Files in Error**

<u>Claim Number</u>	<u>Coverage</u>
49707	Property Damage
48658	Property Damage
47974	Comprehensive
46851	Comprehensive

**13. Failure to Acknowledge Claim in a Timely Manner – 1 File in Error**

<u>Claim Number</u>	<u>Coverage</u>	<u>Date Claim Received</u>	<u>Date Claim Acknowledged</u>	<u>Days Beyond 10 Business Days</u>
48501	Comp	9/29/05	10/28/05	11

**14. Failure to Respond to Pertinent Communications – 1 File in Error**

<u>Claim Number</u>	<u>Coverage</u>
47480	Comprehensive

## V. VERIFICATION PAGE

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I, Monica Koch, am the Examiner-in-Charge of the Market Conduct Examination of IFA Insurance Company conducted by examiners of the New Jersey Department of Banking and Insurance. This verification is based on my personal knowledge as acquired in my official capacity.

The findings, conclusions and recommendations contained in the foregoing report represent, to the best of my knowledge, a full and true statement of the Market Conduct examination of IFA Insurance Company as of May 10, 2007.

I certify that the foregoing statements are true. I am aware that if any of the foregoing statements made by me is willfully false, I am subject to punishment.

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Date:

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Monica Koch  
Examiner-In-Charge  
New Jersey Department  
of Banking and Insurance