

**[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938,
THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE
CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]**

**WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT
EXAMINATION OF THE CLAIMS PRACTICES OF
HOMESITE INSURANCE COMPANY OF CALIFORNIA
NAIC # 11005 CDI # 4620-1**

AS OF NOVEMBER 30, 2013

ADOPTED MAY 31, 2016

STATE OF CALIFORNIA



**CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU**

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

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FOREWORD

This report is written in a “report by exception” format. The report does not present a comprehensive overview of the subject insurer’s practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer’s proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report.

While this report contains violations of law that were cited by the examiner, additional violations of CIC § 790.03 or other laws not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company’s responses, if any, have not undergone a formal administrative or judicial process.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

SCOPE OF THE EXAMINATION

Under the authority granted in Part 2, Chapter 1, Article 4, Sections 730, 733, and 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claim handling practices and procedures in California of:

**Homesite Insurance Company of California
NAIC # 11005**

Group NAIC # 0501

Hereinafter, the Company listed above also will be referred to as Homesite, HICC, or the Company.

This examination covered the claim handling practices of the aforementioned Company on Homeowner claims closed during the period from December 1, 2012 through November 30, 2013. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claim files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; and if any, a review of consumer complaints and inquiries about these Companies closed by the CDI during the period December 1, 2012 through November 30, 2013, a review of previous CDI market conduct claims examination reports on this Company; and a review of prior CDI enforcement actions.

The review of the sample of individual claim files was conducted at the offices of the California Department of Insurance in Sacramento, California.

EXECUTIVE SUMMARY

The Homeowner claims reviewed were closed from December 1, 2012 through November 30, 2013, referred to as the “review period”. The examiners randomly selected 70 HICC claim files for examination. The examiners cited 79 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample file review.

Findings of this examination included: the failure to communicate the correct time period to collect the full replacement cost; the failure to fully explain the basis for any adjustment to the claimant in writing; the failure to document justification for the adjustment of the amount claimed due to depreciation in the claim file; the misrepresentation of pertinent facts or insurance policy provisions; and the failure to reference the California Department of Insurance in claim denials.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

HICC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Homeowner / Property	3,294	70	79
TOTALS	3,294	70	79

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	HICC Number of Alleged Violations
CIC §2051.5(b)(1) *[CIC §790.03(h)(1)]	The Company improperly imposed upon an insured a time limit to collect the full replacement cost of the loss. No time limit of less than 12 months from the date that the first payment toward the actual cash value is made shall be placed upon an insured in order to collect the full replacement cost of the loss, subject to the policy limit.	22
CCR §2695.9(f) *[CIC §790.03(h)(3)]	The Company failed to fully explain the basis for any adjustment to the claimant in writing	11
CCR §2695.9(f) *[CIC §790.03(h)(3)]	The Company failed to document in the claim file all justification for the adjustment of the amount claimed because of betterment, depreciation, or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property.	11
CIC §790.03(h)(1)	The Company misrepresented pertinent facts and insurance policy provisions relating to any coverage at issue.	6
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to reference the California Department of Insurance in its claims denial.	6
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	4
CCR §2695.4(a) *[CIC §790.03(h)(1)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	4
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	4
CCR §2695.9(f) *[CIC §790.03(h)(5)]	The Company improperly applied betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property.	4

Citation	Description of Allegation	HICC Number of Alleged Violations
CCR §2695.3(a) *[CIC §790.03(h)(3)]	The Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.	2
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.	2
CCR §2695.9(d) *[CIC §790.03(h)(3)]	The Company settled the claim on the basis of a written scope and/or estimate without supplying the insured with a copy of each document upon which the settlement was based.	2
CCR §2695.5(e)(1) *[CIC §790.03(h)(2)]	The Company failed to acknowledge notice of claim within 15 calendar days.	1
Total Number of Alleged Violations		79

***DESCRIPTONS OF APPLICABLE
UNFAIR CLAIMS SETTLEMENT PRACTICES**

- CIC §790.03(h)(1) The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
- CIC §790.03(h)(2) The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- CIC §790.03(h)(3) The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
- CIC §790.03(h)(5) The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.
- CIC §790.03(h)(13) The Company failed to provide promptly a reasonable explanation of the bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS

HOMEOWNER 2012 Written Premium: \$27,912,233 2013 Written Premium: \$39,323,941	NUMBER OF ALLEGED VIOLATIONS
AMOUNT OF RECOVERIES \$24,372.91	
CIC §2051.5(b)(1) [CIC §790.03(h)(1)]	22
CCR §2695.9(f) [CIC §790.03(h)(3)]	11
CCR §2695.9(f) [CIC §790.03(h)(3)]	11
CIC §790.03(h)(1)	6
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	6
CIC §790.03(h)(5)	4
CCR §2695.4(a) [CIC §790.03(h)(1)]	4
CCR §2695.7(d) [CIC §790.03(h)(3)]	4
CCR §2695.9(f) [CIC §790.03(h)(5)]	4
CCR §2695.3(a) [CIC §790.03(h)(3)]	2
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	2
CCR §2695.9(d) [CIC §790.03(h)(3)]	2
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	1
SUBTOTAL	79
TOTAL	79

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company should address corrective action for other jurisdictions when applicable.

Money recovered within the scope of this report was \$5,274.53 as described in section numbers 4, 6, 7, and 9 below. Following the findings of the examination, a closed claims survey as described in section four below was conducted by the Company resulting in additional payments of \$19,098.38. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$24,372.91.

HOMEOWNER

1. **In 22 instances, the Company improperly imposed upon an insured a time limit to collect the full replacement cost of the loss. No time limit of less than 12 months from the date that the first payment toward the actual cash value is made shall be placed upon an insured in order to collect the full replacement cost of the loss, subject to the policy limit.** Specifically, in each instance, the Company's settlement letter states that the insured has 180 days or six months from the date of loss to claim recoverable depreciation under the replacement cost provision. The Department alleges these acts are in violation of CIC §2051.5(b)(1) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company respectfully disagrees that it is in violation of CIC §2051.5(b)(1) and CIC §790.03(h)(1). At the time these claims were handled, all payment letters indicated that the insured had 180 days or six months from the date of loss to claim recoverable depreciation under the replacement cost provision. The policy language provides,

You may then make claim within 180 days after loss for any additional liability according [to] the provisions of this Condition....

The Company requires the insured to “make claim” or notify the Company of the intent to repair or replace within 180 days. The Company provides a reasonable period for the repairs to actually take place and for the insured to submit documentation of repair or replacement in order collect the appropriate depreciation. Since the Company allows a reasonable amount of time for the insured to actually collect the depreciated value, based on the specific facts and circumstances of the loss, the Company does not believe that it improperly imposed a time limit for the recovery of depreciation pursuant to CIC §2051.5(b)(1).

However, the Company agrees that the language on the settlement letters could better reflect the California requirement. To ensure future compliance, the Company added this requirement to the California specific training documents and informed the unit dedicated to recoverable depreciation of the requirements under this code. Additionally, effective November 6, 2014, the Company changed its state-specific California settlement letters

2. In 11 instances, the Company failed to fully explain the basis for any adjustment to the claimant in writing. Specifically, although a copy of the estimate was provided to the insured, the estimate does not fully explain the basis for depreciation and does not reflect a measurable difference in market value attributable to the condition and age of the property. The estimate details the replacement cost, depreciation amount applied, and actual cash value of each item. The estimate does not include the age, condition, or life expectancy of the items depreciated. The Department alleges these acts are in violation of CCR §2695.9(f) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company respectfully disagrees that it is in violation of CIC §790.03(h) and that CCR §2695.9(f) requires that the Company provide additional and specific information over and above the information already provided to the insured explaining that depreciation is based on the age and condition of the item. The Company further disagrees that the industry practice is to provide that information on the estimate and that the Company's written estimate is in anyway outside of the industry norm.

Nonetheless, to reflect the Company's commitment to meeting regulatory concerns, it updated its Xactimate® profile on September 1, 2014, to print the age and condition of the property on the estimate provided to the insured. The desktop version of Xactimate® utilizes the word "usage" for "condition". The Company instructed its vendor to revise the definitions from the use-related descriptions of "light", "normal", and "heavy" to the condition-related descriptions of "above average", "average", "below average", "new", and "replaced." The Company cannot provide a specific date as to when the desktop version was installed and operational; however, as of October 12, 2015, the updated desktop version of Xactimate® was being utilized by claims staff.

The Company also stated its current practices require that all estimates be provided to and reviewed with the insured. To ensure future compliance, the Company conducted training with its field adjusters and IA vendors in the fourth quarter of 2015. Additionally, beginning in 2016, the adjuster that inspects the property (either the field adjuster or the independent adjuster) will document the condition of all items within the estimate.

3. In 11 instances, the Company failed to document in the claim file all justification for the adjustment of the amount claimed because of betterment, depreciation or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property. Specifically, the basis of all depreciation, which includes both condition and age, is not fully explained in the file notes or in the estimate. Although the estimate identifies the structural components subject to depreciation and the amount of depreciation, factors such as age, condition, and useful life of the property, which form the basis for the amount of depreciation, are not documented in the file. The Department alleges these acts are in violation of CCR §2695.9(f) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company stated its current practices require that all estimates be reviewed with the insured. The review includes a discussion of the calculation of the depreciation deducted and addresses any items the insured believes are unclear or inaccurate. Additionally, the Company currently conducts quality assurance reviews to verify and ensure that the claim file is adequately documented to reflect the basis of the estimate and the explanation provided to the insured. To ensure future compliance, the Company conducted training with its field adjusters and IA vendors in the fourth quarter of 2015. Additionally, beginning in 2016, the adjuster that inspects the property (either the field adjuster or the independent adjuster) will document the condition of all items within the estimate and attach the estimate to the file.

4. In six instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. In these instances, the Company misinformed the insured that depreciation was not recoverable when applied to cameras and golf clubs. However, these items are subject to recoverable

depreciation under the Replacement Cost Endorsement of the policy. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company respectfully disagrees that it is in violation of CIC §790.03(h)(1). At the time the Company handled claims for cameras and golf clubs, the Company's interpretation of the Replacement Cost Endorsement was that cameras and similar equipment were to be settled at actual cash value only and were not subject to a claim for replacement cost.

Although the Company disagrees that its interpretation of this endorsement equates to misrepresenting pertinent facts or insurance policy provisions relating to any coverage at issue, the Company has taken a more expansive view and depreciation on cameras, golf clubs, and similar equipment is now recoverable. To ensure future compliance, the Company addressed the issue of applying non-recoverable depreciation to golf clubs, cameras, etc. with claims staff by disseminated training materials on February 6, 2014 outlining the Company's broader interpretation of the policy provisions regarding loss settlement of these items. As a result of the findings of this examination, the Company reopened the claims and issued payments totaling \$503.79.

In addition, the Company has taken remediation steps by contacting insureds affected by the prior interpretation and advising the insured of the availability of recoverable depreciation. In response to the concern that the Company wrongly advised insureds that depreciation was unrecoverable outside the sample files reviewed, the Company conducted an internal review of 140 claims that were closed from January 1, 2011 through April 1, 2014, and issued \$19,098.38 in recoverable depreciation payments.

5. In six instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges these acts are in violation of CCR § 2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees at the time these claims were handled, the required CDI language was not included on certain claim denial letters. The Company added the required California language to its denial letter template and implemented this correction to the letter template system on September 6, 2013. Additionally, the Company stated all new and renewed policies contain a notification that the California Department of Insurance responds to questions and complaints about insurance matters.

6. In four instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In two instances, although the insured submitted an inventory of property along with a

signed Sworn Statement of Theft required by the Company, which included the California fraud warning, the Company denied coverage for the property on the basis the insured was unable to provide bills, receipts, and other documentation as proof of ownership. The policy instructs the insured to provide bills, receipts or other documentation to substantiate the figures in the inventory and does not state the claim will be denied in the absence of such documents. In one instance, the Company failed to pay a water mitigation bill that it had received. In one instance, the Company applied 25% depreciation to a laptop computer that was stolen four days after it was purchased. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: In two instances, the Company respectfully disagrees that it is in violation of CIC §790.03(h)(5) and continues to disagree that the policy does not allow the Company to require proof of ownership documents. Nonetheless, the Company will not deny a claim based solely on the inability to provide a receipt for an item. To ensure future compliance, the Company conducted adjuster training the week of December 15, 2014 regarding the type of evidence that will be accepted for proof of ownership so there is a consistent process across all claims. In addition, the Company added language to the personal property inventory form on October 9, 2015 that explains what types of documentation may be requested during the investigation of the claim and the insured's obligations under the terms of the policy to provide certain information and/or documentation. As a result of the findings in these two instances, the Company reopened the claims and issued payments totaling \$1,395.52.

In the third instance, the Company acknowledges that the water mitigation bill was not addressed by the adjuster. As of January 16, 2015, management receives a daily report indicating all documents not reviewed within three business days of receipt to assure that all documents are addressed. The Company believes this management tool, which is already in place, should be sufficient for purposes of corrective action. Additionally, it is Homesite's practice to issue payment for water mitigation upfront to ensure emergency services are provided as soon as possible to prevent further damage to the property, including mold. In this case, the water mitigation estimate was not paid. To correct the error, the Company issued a supplemental payment of \$2,163.33.

In the fourth instance, the Company acknowledges that the depreciation percentage was not appropriate based on the age and condition of the laptop. This may have been an unintentional data entry error. The Company's current practice includes the age and condition of the item on the estimate that is provided to the insured. In the event of a typographical or other inadvertent error in entering the age and condition data, the error is easily identified by the insured and/or the adjuster. The Company believes that this practice, which is already in place, should be sufficient for purposes of corrective action. As the laptop was new when stolen, the Company reopened the claim to address depreciation and issued payment of \$359.70 to the insured.

7. In four instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy that may apply to the claim presented by the claimant. In two instances, the Company failed to advise the insured that coverage could be extended to a bike lock and a rug. In the third instance, file notes do not show the Company discussed coverage with the insured prior to the settlement. In the fourth instance, the Company failed to explain the appraisal provision of the policy in response to the insured's dispute over the denial of payment for personal property items. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: In the first two instances, the Company agrees it failed to extend coverage. As a result of these findings, the Company reopened the claims and issued payments including interest in the amounts of \$61.67 and \$38.75, respectively.

In the third instance, the Company agrees that the claim file does not reflect that coverage was discussed with the insured prior to settlement. The Company now has templates for the adjusters that are included in the claim file, which document the coverages under the policy and the discussion of the coverages with the insured. The current "standard operating procedure" for adjusters requires that the adjuster discuss coverages, including specials limits and endorsements with the insured at initial contact. The Company also conducts quality assurance to verify that coverages are discussed with the insured and documented in the file.

In the fourth instance, the Company states its review of the file reflects the appraisal provision was not discussed as it was not triggered. The appraisal provision provides for dispute resolution when the insured and the insurer do not agree on the amount of the loss. Although the Company does not believe the appraisal provision was triggered, the Company acknowledges a full discussion with the insured advising of the type of documentation the Company would accept as proof of ownership was not in the file. Therefore, as a result of this examination, the Company agreed to pay the claim and issued payment in the amount of \$1,300.55. Payment was included in section number six above. Additionally, the Company conducted training during the week of December 15, 2014 on its proof of ownership standards, which is further described in section number six above.

8. In four instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. In two instances, the Company failed to investigate the cause of the loss to determine whether coverage would be afforded. In one instance, a gap in file activity is noted. In the fourth instance, the Company failed to investigate subrogation potential upon learning the name of a suspect. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company respectfully disagrees that it is in violation of CCR §2695.7(d) and CIC §790.03(h)(3) in two instances. Nonetheless, in the first instance involving the cause of loss, the Company implemented a revised process for the handling and investigation of claims reported as water back-ups effective February 26, 2014. Homesite adjusters now perform a thorough investigation into the cause of the back-up to determine whether the policy exclusion may apply. In the second instance involving the cause of loss, the Company implemented a procedure to obtain a heating, ventilation and air conditioning report to confirm the cause of the loss also effective February 26, 2014.

The Company agrees and states the gap in file activity, in one instance, is due to the independent adjuster's estimate being emailed directly to an adjuster who had left the Company. As of February 21, 2014, it is the Company's process to have all estimates sent to a centralized email inbox that automatically attaches the estimate to the claim file. Now, anyone reviewing the file would have access to the estimate. In addition, the Company upgraded its claim system on February 26, 2014 to allow emails to be sent and received within the claim system. The Company is confident that, with this upgrade, claim files will reflect fewer gaps in claims activity.

In the final instance, the Company agrees that there are no notes in the file addressing subrogation. However, it is the Company's procedure to investigate subrogation potential through the subrogation department. At the time of the loss, all subrogation was handled through a third-party vendor. The responsibility was on the adjuster to identify subrogation potential and send the information to the third-party vendor. As of March 10, 2014, Homesite created an in-house subrogation department which oversees all subrogation efforts and reviews all claims periodically to identify subrogation potential.

9. In four instances, the Company improperly applied betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property. In each instance, the Company applied depreciation to one or more structural components not normally subject to repair and replacement during the useful life of the structure. The structural components in the instances noted are not normally subject to repair or replacement during the items' lifespan absent some known reason to do so, such as damage sustained in an insurance loss. Additionally, the files' notes at issue did not contain any specific documentation regarding the condition of the items that would warrant betterment or depreciation. The Department alleges these acts are in violation of CCR §2695.9(f) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company respectfully disagrees in three instances that it is in violation of CCR §2695.9(f) and CIC §790.03(h)(5). The Company states the referenced code requires that a deduction for physical depreciation shall apply only to components that are normally subject to repair and replacement during the useful life of that structure. It is the Company's position that all components of a

structure are normally subject to repair and replacement during the useful life of that structure.

Nonetheless, the Company will provide appropriate training to all of its staff adjusters to ensure that structural items determined to not typically depreciate over the life of the dwelling are either not depreciated for purposes of establishing the Actual Cash Value (ACV), or, alternatively, that the file is appropriately documented with the condition of the item and the reason it warrants depreciation. This training will be completed by the end of the first quarter in 2016. As a result of these findings and for corrective measure, the Company reopened the identified claims and issued payments totaling \$733.15.

In one instance, the Company acknowledges it depreciated the anti-microbial agent in error. To correct the error, the Company issued payment of \$18.62 plus interest to the insured.

The Company also states its practice is to issue the ACV amount based on the line item age and condition of the property that needs to be repaired or replaced. If the actual repair or replacement of the property is more than the ACV, the insured is entitled to any depreciated amount after repair or replacement is made. If the cost to repair or replace is still greater than the ACV plus depreciation, supplemental payments are made based upon revised estimates or contractor bids. As discussed in the Company's response to summary sections two and three, any deductions for depreciation will be documented in the claim file and discussed with the insured. The Company will also conduct quality assurance reviews to ensure that these procedures are being followed.

10. In two instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed. In one instance, file documentation does not exist regarding the amount of the property claimed. In the second instance, file documentation does not offer an explanation as to how the contents pricing was determined. The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company respectfully disagrees that it is in violation of CCR §2695.3(a) and CIC §790.03(h)(3). Nonetheless, since April 2013, the Company implemented a new control whereby all adjusters provide an email address for all claim communications to be sent. This mailbox is connected to the document management system and therefore all email communications are now automatically delivered to the imaging system attached to the claim file. In addition to the centralized email inbox, the Company upgraded its claim system on February 26, 2014 to allow emails to be sent and received within the claim system. The Company is confident that, with this upgrade, estimates will consistently be maintained in the claim file.

11. In two instances, the Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given. In these instances, denial letters are not found in the claim file. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company respectfully disagrees that it is in violation of CCR §2695.7(b)(1) and CIC §790.03(h)(13). Nonetheless, the Company acknowledges these findings. In one instance, the file does not contain a copy of the partial denial letter for the car stereo. It is Homesite's procedure to write partial denial letters when a portion of the claim is not being paid due to exclusion in the policy. In the other instance, the Company states that a denial letter was generated by the adjuster who failed to print it. Therefore, it remained pending in the claims system's form letter application. The Company discovered this issue and determined the cause was an adjuster processing error.

As a result of these findings, the Company immediately initiated corrective action by sending out all letters previously unprocessed in the claims systems' form application. In addition, the Company conducted training with claims staff to ensure all letters are processed correctly and completely. The claims staff reviewed the training materials which were also added to the claims department's internal site for storage and future use.

12. In two instances, the Company settled the claim on the basis of a written scope and/or estimate without supplying the insured with a copy of each document upon which the settlement was based. The Department alleges these acts are in violation of CCR §2695.9(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company respectfully disagrees that it is in violation of CCR §2695.9(d) and CIC §790.03(h)(3). The errors occurred prior to April 2013. Since April 2013, the Company implemented a new control whereby all adjusters provide an email for all claims communications that are to be sent. This mailbox is connected to the document management system and all email communications are now automatically delivered to the imaging system attached to each claim file. Also, adjusters now provide a centralized fax number to all claim participants which is linked to the document management system. In the event a document cannot be linked to a claim in the imaging department because it does not show the claim number or other readily identifiable indicators, the document is sent to an exception queue where Homesite's staff will review it to attach to the appropriate claim.

In addition to the centralized email inbox, the Company upgraded its claim system on February 26, 2014 to allow emails to be sent and received within the claim

system. The Company is confident that, with this upgrade, estimates will consistently be maintained in the claim file and provided to insureds.

13. In one instance, the Company failed to acknowledge notice of claim within 15 calendar days. The Department alleges this act is in violation of CCR §2695.5(e)(1) and is an unfair practice under CIC §790.03(h)(2).

Summary of the Company's Response: The Company respectfully disagrees that it is in violation of CCR §2695.5(e)(1) and CIC §790.03(h)(2). Nonetheless, the Company acknowledges additional attempts at contact should have been made via telephone, in accordance with the Company's claim handling procedures. If no contact could have been made by telephone, a letter requesting contact should have been sent to the insured advising that the claim would be closed if the insured continued to be unresponsive. In addition, the claim adjuster should have followed up regularly to attempt contact until the time period stated in the letter to receive a response had expired.

The system is currently programmed to issue an acknowledgement letter to the insured when a claim is set up in the system. In addition, the training materials document that initial contact by the adjuster should be made with the insured as soon as possible after assignment of the claim. A daily management report identifies files where there is no documented initial contact with the insured within 24 hours of the claim, such that the adjuster can make contact prior to the 15 day regulatory timeframe.