



Post Office Box 78190 San Francisco, CA 94107 415.247.7283 (FAX) 415.247.7290

Donald R. Bellinger
Vice President
e-mail: dbellinger@majesticinsurance.com

June 26, 2003

Hon. John Garamendi
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, CA 94105

Via certified mail 7002 0860 0004 5219 1289

**RE: FIELD CLAIMS EXAMINATION REPORT –
MAJESTIC INSURANCE COMPANY, NAIC #42269**

Dear Commissioner Garamendi:

Majestic Insurance Company (the "Company") hereby responds to the Field Clams Examination Report (the "Report") regarding the Company dated May 29, 2003. The Report reviews the Company's workers' compensation claims practices during 2001. In addition to its preliminary responses which are summarized in the Report, the Company respectfully responds as set forth below.

The Company's claims department is staffed by 29 seasoned professionals having a combined experience of more that 327 years. Caseloads average less than 140 per adjuster, which is low in the industry. The Company provides frequent training and close supervision of its adjusters and has implemented effective claims management systems. Reviews of the Company's claims handling by the Department of Industrial Relations, Workers' Compensation Division have been favorable.

The Report states that it contains alleged violations of Insurance Code Section 790.03 and the Fair Claims Settlement Practices Regulations. (10 Cal. Code Reg. §2695.1 et seq.) The cited regulations do not apply to workers' compensation claims, which are the only claims handled by the Company. (10 Cal. Code Reg. 2695.1(b)(1).) Moreover, no violations of those regulations are alleged.

The Report states that 75 alleged violations of Insurance Code Section 790.03(h) were found in a review of 125 claim files. However, the alleged violations were contained in only 45 claim files. The multiple violations alleged in those files were caused by increased workloads resulting from unexpected growth in the volume of claims during 2001. This particularly affected our Long Beach claims office and reflected industry trends in Southern California.

In our opinion, many of the multiple violations alleged in those files are duplicative. For example, in several instances the examiners allege that there were gaps in file handling exceeding 90 days and further allege that the Company failed to send required notices or take other necessary actions during the same period. These are essentially one and the same contention.

The Report further alleges that in 32 cases the Company did not promptly send required benefit notices. In many such cases, the delay in sending the notice was caused by the employer's failure to report the injury timely. The Company was not at fault. In its preliminary responses to the examiners, the Company inadvertently did not refer to this fact in connection with certain claims.

The Report also alleges that in 17 cases the Company failed to "adhere" to a standard of prompt investigation and processing of claims in violation of Insurance Code Section 790.03(h)(3). However, the cited section prohibits failure to "adopt and implement reasonable standards" for the handling of claims. The Company has adopted and implemented a standard procedure that requires periodic review of inactive files. This complies with the statutory requirement.

The Company acknowledges that in some cases its adjusters did not follow the procedure requiring periodic file review. If anything, this was a failure to follow the Company's own procedure which was relatively minor in the circumstances, and not a violation of Insurance Code Section 790.03(h).

In addition, the Company has pointed out to the examiners that certain of their findings relating to particular claim files are factually incorrect. Attached hereto is an appendix which sets forth the details of the Company's disagreements with the examiners regarding the matters alleged with respect to those files.

We respectfully submit that the remaining alleged violations were not committed knowingly or performed with such frequency as to indicate a general business practice within the meaning of Insurance Code Section 790.03(h). Where deficiencies in the Company's claims handling have been noted as a result of the examination, corrective action has been taken as described in the Report.

This response is submitted pursuant to Insurance Code Section 12938. The Company reserves its legal rights with respect to the matters discussed in the Report. Thank you for your consideration of this response.

Very truly yours,

MAJESTIC INSURANCE COMPANY

Donald R. Bellinger
Vice President, Claims

DRB:km

Appendix Attached

APPENDIX RE PARTICULAR CLAIM FILES

Majestic Insurance Company (the “Company”) has reported the following disagreements with the findings of the examiners with respect to particular claim files. Letter references are used below to identify those files rather than the Company’s claim file numbers, which are known to the examiners.

A. The examiners allege that the Company failed to pay a doctor’s lien timely or at all. The Company responded that payment was made within 16 days which is timely. Also, the doctor did not supply a tax ID number.

B. The examiners allege that the Company failed to send notices promptly. The Company disputes this contention because that the proper delay notice was issued and the claim was accepted one day before acceptance was due.

C. The examiners allege that the Company failed to calculate benefits and make payments timely. The Company responded that the payment was not late, and the claimant made no inquiry about benefit calculation.

D. The examiners allege that the Company’s benefit notice letter did not contain QME instructions. The Company responded that the required QME language was included in its notice.

E. The examiners allege that the Company improperly delayed sending a closing notice after medical discharge. The Company responded that the notice was only sent when complete discharge was certain. This was because the claimant had a history of seeking further treatment after discharge.

F. The examiners allege that the Company’s adjuster failed to document medical information in the file. The Company responded that a file note of 4/27/00 documented the activity on the file.

G. The examiners allege that the adjuster failed to review a medical discharge received 5/1/00. This was not stated in the examiners’ referral. The Company responded that the file notes show that the adjuster reviewed the discharge.

H. The examiners allege that the Company did not adequately document its file because there was no indication of the outcome of a WCAB application. The Company responded that it was advised that the application would be withdrawn so that no further follow-up was necessary.

I. The examiners allege that there was a gap in file handling from 4/23/01 to 10/1/01. The Company responded that item #4 of the referral from the examiners mentions the adjuster's file notes dated 6/22/01.