STATE OF ARIZONA
FILED

JUL 10 2013

DEPT. OF INSURANCE

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

WILSHIRE INSURANCE COMPANY

NAIC #13234

AS OF

DECEMBER 31, 2011

TABLE OF CONTENTS

AFFIDAVIT 4

FOREWORD 5

SCOPE AND METHODOLOGY 5

HISTORY OF THE COMPANY 6

PROCEDURES REVIEWED WITHOUT EXCEPTION 7

EXAMINATION REPORT SUMMARY 7

RESULTS OF PREVIOUS MARKET EXAMINATIONS 9

DECLINATIONS, CANCELLATIONS AND NON-RENEWALS 10

CLAIM PROCESSING 13

SUMMARY OF FAILED STANDARDS 18

SUMMARY OF PROPERTY AND CASUALTY STANDARDS 19

Department of Insurance
State of Arizona
Market Oversight Division
Examinations Section
Telephone: (602) 364-4994
Fax: (602) 364-2505

JANICE K. BREWER
Governor

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
www.azinsurance.gov

GERMAINE L. MARKS
Director of Insurance

Honorable Germaine L. Marks
Director of Insurance
State of Arizona
2910 North 44th Street
Suite 210, Second Floor
Phoenix, Arizona 85108-7269

Dear Director Marks:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, an examination has been made of the market conduct affairs of the:

WILSHIRE INSURANCE COMPANY
NAIC # 13234

The above examination was conducted by William Hobert, Examiner-in-Charge, and Market Conduct Examiners Laura Sloan-Cohen and Robert DeBerge.

The examination covered the period of January 1, 2011 through December 31, 2011.

As a result of that examination, the following Report of Examination is respectfully submitted.

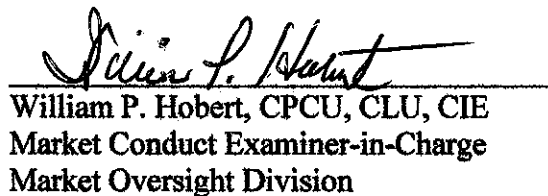
Sincerely yours,

Helene I. Tomme, CPCU, CIE
Market Conduct Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

William P. Hobert being first duly sworn, states that I am a duly appointed Market Conduct Examinations Examiner-in-Charge for the Arizona Department of Insurance. That under my direction and with my participation and the participation of Market Conduct Examiners Laura Sloan-Cohen and Robert DeBerge on the Examination of Wilshire Insurance Company, hereinafter referred to as "the Company," was performed at the examiners' residences. A teleconference meeting with appropriate Company officials was held to discuss this Report, but a copy was not provided to management as the Examination was incomplete and had not yet been finalized. The information contained in this Report, consists of the following pages, is true and correct to the best of my knowledge and belief and that any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

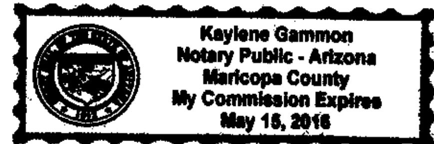


William P. Hobert, CPCU, CLU, CIE
Market Conduct Examiner-in-Charge
Market Oversight Division

Subscribed and sworn to before me this 21st day of February, 2013.

Notary Public

My Commission Expires May 15, 2016



FOREWORD

This target market conduct examination report of Wilshire Insurance Company (herein referred to as the "Company"), was prepared by employees of the Arizona Department of Insurance (Department) as well as independent examiners contracting with the Department. A target market conduct examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the state of Arizona. The examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158 and 20-159. The findings in this report, including all work product developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of the following Commercial Automobile (CA), Homeowner (HO) and Manufactured Homeowner (MHO) business operations:

1. Complaint Handling
2. Marketing and Sales
3. Producer Compliance
4. Underwriting and Rating
5. Declinations, Cancellations and Non-Renewals
6. Claims Processing

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The target market conduct examination of the Company covered the period of

January 1, 2011 through December 31, 2011 for business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws, and whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report and the results are reported beginning on page 7.

In accordance with Department procedures, the examiners completed a Preliminary Finding ("Finding") form on those policies, claims and complaints not in apparent compliance with Arizona law. The finding forms were submitted for review and comment to the Company representative designated by Company management to be knowledgeable about the files. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action.

The examiners utilized both examinations by test and examination by sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examinations by test and by sample were completed without the need to utilize computer software.

File sampling was based on a review of underwriting and claim files that were systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company. Samples are tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data will result in an exception ratio, which determines whether or not a standard is met. If the exception ratio found in the sample is, generally less than 5%, the standard will be considered as "met." The standard in the areas of procedures and forms use will not be met if any exception is identified.

HISTORY OF THE COMPANY

The Company was incorporated in 1956 in California as a CA liability and physical damage insurer. Under a redomestication plan, the Company merged 12/31/85 with a North Carolina company with the same name. The Company is a 100% owned subsidiary of McM Corporation (McM) and is one (1) of four (4) property and casualty companies in a holding company group, Occidental/Acceptance Group. IAT Reinsurance Company, Ltd. (IAT), a Bermuda based reinsurer, controls all outstanding McM common stock.

The Company emphasizes writing full coverage for local, intermediate and long haul CA risks. CA business is written out of the Company's Omaha, NE and Lancaster, CA business units. The Company primarily produces business through independent agents on a direct bill basis, although a small portion is generated via general agents on an account current basis. The Company is licensed in twenty (20) states and writes on a non-admitted basis in thirteen (13) others. The Company's administrative headquarters is located in Raleigh, NC. Arizona admitted the Company as a property and casualty insurer on 4/8/71.

PROCEDURES REVIEWED WITHOUT EXCEPTION

The examiners' review of the following Company departments[1] or functions indicates that they appear to be in compliance with Arizona statutes and rules:

Complaint Handling   Marketing and Sales   Producer Compliance   Underwriting & Rating

EXAMINATION REPORT SUMMARY

The examination revealed six (6) issues that resulted in 90 exceptions due to the Company's failure to comply with statutes and rules that govern all insurers operating in Arizona. These issues were found in two (2) of the six (6) sections of Company operations examined. The following is a summary of the examiners' findings:

Declinations, Cancellations and Non-Renewals

In the area of Cancellations and Non-renewals, two (2) compliance issues are addressed in this report as follows:

- The Company failed to provide a Summary of Rights to thirty six (36) insureds that had their policies terminated for an adverse underwriting decision.
- The Company failed to provide fourteen (14) MHO policyholders at least a ten (10) day prior notice of a pending non-payment cancellation.

Claims Processing

In the area of Claims Processing, four (4) issues are addressed in this report as follows:

- The Company failed to provide a fraud warning statement on one (1) claim form.

[1] If a department name is listed there were no exceptions noted during the review.

- The Company failed to correctly calculate and fully pay the transaction privilege tax (TPT) on twenty (20) first party real property losses
- The Company failed to return the proportionate amount of one (1) MHO insured's deductible after recovery from the at-fault party.
- The Company failed to provide eighteen (18) claimants a denial in writing within fifteen (15) working days after receipt of proofs of loss.

FACTUAL FINDINGS

RESULTS OF PREVIOUS MARKET EXAMINATIONS

During the past three (3) years, California conducted and finalized a market conduct examination of the Company.

FACTUAL FINDINGS

DECLINATIONS, CANCELLATIONS AND NON-RENEWALS

Commercial Automobile (CA):

The examiners reviewed:

(1) all seventy (70) CA non-payment cancellations;
(2) all seven (7) CA non-renewals; and
(3) the only CA underwriting cancellation.

Homeowner (HO):

The examiners reviewed:

(1) the only HO non-payment cancellation; and
(2) all fourteen (14) HO underwriting cancellations.

The Company stated no HO non-renewals were processed during the exam period.

Manufactured Homeowner (MHO):

The examiners reviewed:

(1) fifty (50) MHO non-payment cancellations from a population of 182;
(2) all three (3) MHO non-renewals; and
(3) all nineteen (19) MHO cancellations for underwriting reasons.

The following Declination, Cancellation and Non-Renewal Standard failed:

#	STANDARD	Regulatory Authority
1	Declinations, Cancellations and Non-Renewals shall comply with state laws and Company guidelines including the Summary of Rights to be given to the applicant and shall not be unfairly discriminatory.	A.R.S. §§ 20-448, 20-2108, 20-2109 and 20-2110

Preliminary Findings #8 – No Summary of Rights - The Company failed to provide a Summary of Rights to fourteen (14) HO and nineteen (19) MHO insureds that had their policies cancelled and three (3) MHO insureds that had their policies non-renewed for an adverse underwriting decision. These represent a total of thirty-six (36) violations of A.R.S. § 20-2110.

HO AND MHO CANCELLATION AND NON-RENEWALS

Failed to provide a Summary of Rights to insureds receiving a cancellation or non-renewal notice

Violation of A.R.S. § 20-2110

Population	Sample	# of Exceptions	% to Sample
36	36	36	100%

A 100% error ratio does not meet the Standard; therefore, a recommendation is warranted.

Subsequent Event

The Company explained correction was implemented 1/23/13 and provided examiners an example of the Department recommended Summary of Rights form printed on the reverse side of all cancellation or non-renewal notices.

<u>The following Declination, Cancellation and Non-Renewal Standard failed:</u>

#	STANDARD	Regulatory Authority
2	Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, and shall not be unfairly discriminatory.	A.R.S. §§ 20-191, 20-443, 20-448, 20-1631, 20-1632, 20-1632.01

Preliminary Findings #6a – Late MHO Non-Payment Notices - The Company failed to provide fourteen (14) MHO policyholders their non-payment notices at least ten (10) days before the effective date of the cancellation, as required by policy provisions. These represent fourteen (14) violations of A.R.S. § 20-443(A) and Company policy provisions.

MHO NON-PAYMENT CANCELLATIONS

Failed to provide non-payment notice at least ten (10) days before effective date
Violation of A.R.S. § 20-443(A) and policy provisions

Population	Sample	# of Exceptions	% to Sample
182	50	14	28%

A 28% error ratio does not meet the Standard; therefore, a recommendation is warranted.

<u>Recommendation #1</u>

Within ninety (90) days of the filed date of this report, provide the Department with documentation that Company procedures and controls are in place to ensure MHO insureds receive notices of non-payment at least ten (10) days before the cancellation effective date, in accordance with the applicable state statute.

FACTUAL FINDINGS

CLAIM PROCESSING

Commercial Automobile (CA):

The examiners reviewed:

(1) all fifty-nine (59) CA claims closed without payment (CWP);
(2) fifty (50) CA paid claims from a population of 120; and
(3) all eight (8) CA subrogated claims.

Homeowner (HO):

The examiners reviewed:

(1) all twenty-five (25) HO claims CWP;
(2) thirty (30) HO paid claims from a population of 389; and
(3) both HO subrogated claims.

Manufactured Homeowner (MHO):

The examiners reviewed:

(1) all twenty-eight (28) MHO claims CWP;
(2) thirty (30) MHO paid claims from a population of 132; and
(3) the only MHO subrogated claim.

The following Claim Processing Standards were met:

#	STANDARD	Regulatory Authority
1	The initial contact by the Company with the claimant is within the required time frame.	A.R.S. § 20-461, A.A.C. R20-6-801
2	Timely investigations are conducted.	A.R.S. § 20-461, A.A.C. R20-6-801
4	Claim files are adequately documented in order to be able to reconstruct the claim.	A.R.S. §§ 20-461, 20-463, 20-466.03, A.A.C. R20-6-801
6	The Company uses reservation of rights and excess of loss letters, when appropriate.	A.R.S. § 20-461, A.A.C. R20-6-801
8	The Company responds to claim correspondence in a timely manner.	A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented.	A.A.C. R20-6-801
11	Adjusters used in the settlement of claims are properly licensed.	A.R.S. §§ 20-321 through 20-321.02

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
3	The Company's claim forms are appropriate for the type of product and comply with statutes, rules and regulations..	A.R.S. §§ 20-461, 20-466.03, 20-2106, A.A.C. R20-6-801

Preliminary Finding #9 – Fraud Warning Statement – The Company failed to include the required fraud warning statement on one (1) claim form. This represents one (1) violation of A.R.S. § 20-466.03

The following table summarizes the fraud warning statement findings:

	Form Title / Description	Form #
1	Property Damage Release	None

CLAIM FORMS
Failed to include the fraud warning statement
Violation of A.R.S. § 20-466.03

Population	Sample	# of Exceptions	% to Sample
N/A	N/A	1	N/A

Any error does not meet the Standard; therefore a recommendation is warranted.

Subsequent Event
During the course of the exam, the Company provided the examiners a copy of their Property Damage Release form with a fraud warning notice in 12-point type.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	A.R.S. §§ 20-268 20-461, 20-462, 20-468, 20-469, A.A.C. R20-6-801

Preliminary Findings #2a – Incorrect Transaction Privilege Tax (TPT) - The Company failed to accurately calculate and fully pay the correct transaction privilege tax (TPT) on thirteen (13) HO and seven (7) MHO first party real property losses. These represent in total twenty (20) violations of A.R.S. §§ 20-461(A)(6), 20-462 and 44-1201.

HO AND MHO PAID LOSSES
Failed to correctly calculate and pay TPT with real property losses
Violation of A.R.S. §§ 20-461(A)(6), 20-462 and 44-1201

Population	Sample	# of Exceptions	% to Sample
521	60	20	33.3%

A 33.3% error ratio does not meet the Standard; therefore a recommendation is warranted.

Recommendation #2
Within ninety (90) days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company correctly calculates and fully pays any transaction privilege tax owed any first party claimant in the settlement of real property losses, in accordance with applicable state statutes and regulations.
Within ninety (90) days of the filed date of this report, the Company must also conduct a self-audit of the remaining first party paid real property claims during the exam period and provide the Department documentation, including copies of all refund letters, checks and/or drafts and a summary worksheet, for all monies, including interest, reimbursed.

Subsequent Event
During the course of the exam, the Company made restitution to all parties affected which totaled restitution of $3,179.92, which included $566.82 interest.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner.	A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801

Preliminary Finding #1 – Timely Deductible Reimbursement after Recovery – The Company failed to promptly return the proportionate amount of one (1) MHO insured's deductible after partial recovery from the at-fault party. This represents one (1) violation of A.R.S. § 20-461(A)(6).

MHO SUBROGATION RECOVERY
Failed to reimburse the deductible on a timely basis after subrogation recovery
Violation of A.R.S. § 20-461(A)(6)

Population	Sample	# of Exceptions	% to Sample
1	1	1	100%

A 100% error ratio does meet the Standard; therefore a recommendation is not warranted

Recommendation #3
Within ninety (90) days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company promptly reimburses insureds' their deductibles after successful subrogation recovery, in accordance with applicable state statutes and regulations.

Subsequent Event
During the course of the exam, the Company paid the insured total restitution of $203.62, which included $30.30 interest.

The following Claim Processing Standard failed:

#	STANDARD	Regulatory Authority
9	Denied and closed without payment claims are handled in accordance with policy provisions and state law.	A.R.S. §§ 20-461, 20-462, 20-463, 20-466, 20-2110, A.A.C. R20-6-801

Preliminary Finding #5 and #10 – Late Written Claim Denial – The Company failed to provide three (3) CA, three (3) HO and twelve (12) MHO claimants a written claim denial within fifteen (15) working days after receipt of proofs of loss. These represent in total eighteen (18) violations of A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a).

CA, HO AND MHO CLAIMS CLOSED WITHOUT PAYMENT

Failed to provide first party claimants claim denial in writing
Violation of A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a)

Population	Sample	# of Exceptions	% to Sample
112	112	18	16.1%

A 16.1% error ratio does not meet the Standard; therefore a recommendation is warranted

Recommendation #4

Within ninety (90) days of the filed date of this report, provide documentation to the Department that procedures and controls are in place to ensure the Company provides all CA, HO and MHO claimants, within fifteen (15) working days after receipt of proof of loss, a written explanation for the Company's claim denial, in accordance with applicable state statute.

SUMMARY OF FAILED STANDARDS

EXCEPTION	Rec. No.	Page No.
DECLINATIONS, CANCELLATIONS & NON-RENEWALS		
Standard #2 Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, and shall not be unfairly discriminatory.	1	12
CLAIM PROCESSING		
Standard #5 Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	2	16
Standard #7 Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner.	3	16
Standard #9 Denied and closed without payment claims are handled in accordance with policy provisions and state law.	4	17

SUMMARY OF PROPERTY AND CASUALTY STANDARDS

A. Complaint Handling

#	STANDARD	PASS	FAIL
1	The Company takes adequate steps to finalize and dispose of the complaints in accordance with applicable statutes, rules, regulations and contract language. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	The time frame within which the Company responds to complaints is in accordance with applicable statutes, rules and regulations. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

B. Marketing and Sales

#	STANDARD	PASS	FAIL
1	All advertising and sales materials are in compliance with applicable statutes, rules and regulations. (A.R.S. §§ 20-442 and 20-443)	X	

C. Producer Compliance

#	STANDARD	PASS	FAIL
1	The producers are properly licensed in the jurisdiction where the application was taken. (A.R.S. §§ 20-282, 20-286, 20-287, 20-311 through 311.03)	X	
2	An insurer shall not pay any commission, fee, or other valuable consideration to unlicensed producers. (A.R.S. § 20-298)	X	

D. Underwriting and Rating

#	STANDARD	PASS	FAIL
1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the Company Rating Plan. (A.R.S. §§ 20-341 through 20-385)	X	
2	Disclosures to insureds concerning rates and coverage are accurate and timely. (A.R.S. §§ 20-259.01, 20-262, 20-263, 20-264, 20-266, 20-267, 20-2110)	X	
3	All forms and endorsements forming a part of the contract should be filed with the director (if applicable). (A.R.S. § 20-398)	X	

#	STANDARD	PASS	FAIL
4	Schedule rating, individual risk premium modification (IRPM) or experience rating plans, where permitted, are based on objective criteria with usage supported by appropriate documentation. (A.R.S. §§ 20-400.01)	X	
5	All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations, including, but not limited to, the Notice of Insurance Information Practices and the Authorization for Release of Information. (A.R.S. §§ 20-2104, 20-2106, 20-2110 and 20-2113)	X	
5	Policies and endorsements are issued or renewed accurately, timely and completely. (A.R.S. §§ 20-1120, 20-1121, 20-1632, 20-1654, 20-1677)	X	
6	Rescissions are not made for non-material misrepresentations. (A.R.S. §§ 20-463 and 20-1109)	X	

E. Declinations, Cancellations and Non-Renewals

#	STANDARD	PASS	FAIL
1	Declinations, Cancellations and Non-Renewals shall comply with state laws and Company guidelines including the Summary of Rights to be given to the applicant and shall not be unfairly discriminatory. (A.R.S. §§ 20-448, 20-2108, 20-2109 and 20-2110)		X
2	Cancellations and non-renewal notices comply with state laws, Company guidelines and policy provisions, including the amount of advance notice required and grace period provisions to the policyholder, nonrenewal based on condition of premises, and shall not be unfairly discriminatory. (A.R.S. §§ 20-191, 20-443, 20-448, 20-1631, 20-1632, 20-1632.01, 20-1651 through 20-1656 and 20-1671 through 20-1678)		X

F. Claim Processing

#	STANDARD	PASS	FAIL
1	The initial contact by the Company with the claimant is within the required time frame. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
2	Timely investigations are conducted. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

#	STANDARD	PASS	FAIL
3	The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations. (A.R.S. §§ 20-461, 20-466.03, 20-2106, A.A.C. R20-6-801)		X
4	Claim files are adequately documented in order to be able to reconstruct the claim. (A.R.S. §§ 20-461, 20-463, 20-466.03, A.A.C. R20-6-801)	X	
5	Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. (A.R.S. §§ 20-268, 20-461, 20-462, 20-468, 20-469, A.A.C. R20-6-801)		X
6	The Company uses reservation of rights and excess of loss letters, when appropriate. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
7	Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)		X
8	The Company responds to claim correspondence in a timely manner. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	
9	Denied and closed without payment claims are handled in accordance with policy provisions and state law. (A.R.S. §§ 20-461, 20-462, 20-463, 20-466, 20-2110, A.A.C. R20-6-801)		X
10	No insurer shall fail to fully disclose to first party insureds all pertinent benefits, coverages, or other provisions of an insurance policy or insurance contract under which a claim is presented. (A.A.C. R20-6-801)	X	
11	Adjusters used in the settlement of claims are properly licensed. (A.R.S. §§ 20-321 through 20-321.02)	X	