REPORT OF TARGET MARKET EXAMINATION

OF

FARMERS INSURANCE COMPANY OF ARIZONA

NAIC # 21598

AS OF

DECEMBER 31, 2006

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CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Urias:

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

FARMERS INSURANCE COMPANY OF ARIZONA

NAIC # 21598

The above examination was conducted by William P. Hobert, Examiner-in-Charge, and Market Examiners Laura Sloan-Cohen and James Warrington.

The examination covered the period of January 1, 2006 through December 31, 2006.

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

Sincerely yours,

Paul J. Hogan, FLMI, ALHC, CI, CIE
Market Oversight Administrator
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, William P. Hobert, being first duly sworn state that I am a duly appointed Market Examinations Examiner-in-Charge for the Arizona Department of Insurance. That under my direction and with my participation and the participation of Market Examiners Laura Sloan-Cohen and James Warrington, the Examination of Farmers Insurance Company of Arizona, hereinafter referred to as the "Company" was performed at the Company's offices at 18444 North 25th Ave., Phoenix, AZ 85023. A teleconference meeting with appropriate Company officials was held to discuss this Report, but a copy was not provided to management, as the Examination Report was not finalized. The information contained in this Report, consisting 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

William P. Hobert, CPCU, CLU, CIE
Market Examinations Examiner-in-Charge

Subscribed and sworn to before me this 19th day of July, 2007.

Mary M. Kitterman
Notary Public

Official Seal
Mary M. Kitterman
Notary Public - State of Arizona
Maricopa County
My Comm. Expires June 13, 2008

My Commission Expires June 13, 2008

FOREWORD

This targeted market examination of Farmers Insurance Company of Arizona ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent examiners contracting with the Department. A targeted market 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 products developed in the production of this Report, are the sole property of the Department.

This examination consisted of a review of the Company's Private Passenger Automobile claim settlement practices. Examiners reviewed Private Passenger Automobile claim files to determine whether the Company was using claim methods and practices for acknowledging, investigating, settling and subrogating claims that were nondiscriminatory, equitable, thorough and compliant with policy provisions, state statutes and rules. Claim records were examined to determine if the objectivity and consistency of Company practices in negotiating settlement amounts were reasonable and compliant.

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

This 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. This target market examination of the Company covered the period from January 1, 2006 through December 31, 2006 for the business reviewed. The purpose of the examination was to determine compliance with A.R.S. §§ 20-268, 20-461, 20-462, 20-463, 20-466, 20-466.03, 20-2106, 20-2110 and A.A.C R20-6-801.

In accordance with Department procedures, the examiners completed a Preliminary Finding ("Finding") 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 examination 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's Representative, Connard Dillon, Regulatory Compliance Consultant. 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, forms and policy forms use will not be met if any exception is identified.

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during this examination is stated in this Report and the results are reported below.

The examiners reviewed 58 Department and 15 consumer complaints sent directly to the Company. Company responses were complete, adequately documented and timely. The examiners found no trends or areas of concern.

The Company failed Claim Standard No. 3 because the Company failed to:

(a) provide a fraud warning on 10 claim forms and/or claim letters used during the examination period;

(b) specify on one authorization form, used to collect other then claim information, that the duration the authorization remains valid may not exceed one year;

(c) specify on one authorization form, used to collect claim information, that the authorization remains valid for the duration of the claim;

(d) specify on one authorization form the purpose for which the information is collected, and

(e) advise on three authorization forms that the individual or persons authorized to act on behalf of the individual were entitled to receive a copy of the authorization form.

The Company failed Claim Standard No. 7 because the Company failed to return, after recovery from an adverse carrier, the proportionate share of three first party claimants' deductibles.

The Company passed all other Claim Processing Standards.

FACTUAL FINDINGS

CLAIM STANDARD 3

The following Claim Standard Failed:

#	STANDARD	Regulatory Authority
3	The Company claim forms are appropriate for the type of product and comply with statutes, rules and regulations.	A.R.S. § 20-466.03

Procedures Performed

The examiners reviewed the information provided by the Company in response to the Coordinator's Handbook, Attachments A and B, and follow-up requests that related to claim processing procedures. These documents and materials were reviewed without comment.

Phase I Examination – The Company provided electronic data in response to the Coordinator's Handbook, Attachment C. Attachment C requested private passenger automobile losses closed during the examination period. The examiners reviewed random samples of claim files from each of the following seven categories:

1st Party Total Losses Paid
1st Party Partial Losses Paid
1st Party Claims Closed Without Payment
Subrogated Claims Against 3rd Parties
3rd Party Total Losses Paid
3rd Party Partial Losses Paid
3rd Party Claims Closed Without Payment

From a population of claim forms and claim letters provided by the Company in response to Attachment A, and from the examiners' review of files, the examiners identified 16 exceptions.

CLAIM FORMS

Failed to provide a fraud warning statement on ten claim forms and/or claim letters in violation of A.R.S. § 20-466.03.

Population	Sample	# of Exceptions	Exception Ratio*
N/A	N/A	10	N/A

***Any claim form violation does not meet the Standard.**

Finding No. 1

The Company failed Claim Standard No. 3 because the Company failed to provide a fraud warning on ten claim forms and/or letters used in correspondence with parties associated with a claim. The following table identifies the claim forms and/or claim letters cited. [PF 9]

1	Authorization for Release of Health Information	2	Total loss 3rd Party settlement letters
3	3rd Party contact letter	4	Unsuccessful contact letter
5	Letter to claimant about ongoing investigation	6	3rd Party unsuccessful contact letter
7	1st Party unsuccessful contact letter	8	1st Party contact letter
9	3rd Party Denial letter	10	Notification of Unrepaired Damages

Recommendation No. 1

Within 90 days of the filed date of this Report, the Company conduct a self-audit of all claim forms and/or claim letters used in correspondence to gather information in the claim handling process. The Company should provide the Department sufficient documentation to verify a thorough review was conducted and appropriate actions taken to correct any claim forms and/or claim letters found non-compliant.

CLAIM AUTHORIZATION FORMS

Failed to specify on one authorization form, signed for the purpose of collecting other than claim related information, that the authorization remains valid for no longer than one year from the date signed in violation of A.R.S. § 20-2106(7)(b).

Population	Sample	# of Exceptions	Exception Ratio*
N/A	N/A	1	N/A

***Any claim form violation does not meet the Standard.**

Finding No. 2

The Company failed Claim Standard No. 3 because the Company failed to specify on one form, the *Authorization for Release of Information*, that an authorization signed for the purpose of collecting other than claim related information remains valid for no longer than one year from the date signed. [PF 2]

Failed to specify on one authorization form, signed for the purpose of collecting claim related information, that the authorization remains valid for no longer than the duration of the claim in violation of A.R.S. § 20-2106(8)(b).

Population	Sample	# of Exceptions	Exception Ratio*
N/A	N/A	1	N/A

***Any claim form violation does not meet the Standard.**

Finding No. 3

The Company failed Claim Standard No. 3 because the Company failed to specify on one form, the *Authorization for Release of Information*, that an authorization signed for the purpose of collecting claim related information remains valid for no longer than the duration of the claim. [PF 3]

Failed to specify on one authorization form the purpose for which the authorized information is collected in violation of A.R.S. § 20-2106(6).

Population	Sample	# of Exceptions	Exception Ratio*
N/A	N/A	1	N/A

***Any claim form violation does not meet the Standard.**

Finding No. 4

The Company failed Claim Standard No. 3 because the Company failed to specify on one authorization form, the *Authorization for Release of Health Information*, the purpose for which the information is collected. [PF 4]

Failed to advise, on three authorization forms, that the individual or persons authorized to act on behalf of the individual, are entitled to receive a copy of the authorization form in violation of A.R.S. § 20-2106(9).

Population	Sample	# of Exceptions	Exception Ratio*
N/A	N/A	3	N/A

***Any claim form violation does not meet the Standard.**

Finding No. 5

The Company failed Claim Standard No. 3 because the Company failed to specify on three authorization forms, the *Authorization for Release of Information,* the *Authorization for Release of Health Information*, and the *Authorization to Obtain Information*, that the individual or persons authorized to act on behalf of the individual are entitled to receive a copy of the authorization form. [PF 5]

Subsequent Event #1

During the course of the examination, the Company provided the examiners evidence that each authorization form had been reprinted with language suitable for its purpose and consistent with the statute.

CLAIM STANDARD 7

The following Claim 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(A)(6), 20-462(A), A.A.C. R20-6-801(H)(4)

Procedures Performed

During the Phase I Examination, the examiners reviewed a sample of 50 subrogation claims from a population of 4,875 and found three exceptions.

SUBROGATED CLAIMS RECOVERED

Failed, after recovery, to return to three first party claimants the proportionate share of their deductibles in violation of A.R.S. §§ 20-461(A)(6), 20-462(A), A.A.C. R20-6-801(H)(4).

Population	Sample	# of Exceptions	Exception Ratio*
4,875	50	3	6.0%

***A 6% exception ratio does not meet the Standard; therefore, a recommendation is warranted.**

Finding No. 6

The Company failed Claim Standard No. 7 because the Company failed, after recovery from the adverse carrier, to return to three first party claimants the proportionate amount of their deductibles. [PF 1]

Recommendation No. 2

Within 90 days after the filed date of this Report, the Company should implement procedures to assure, following successful subrogation, a return to the claimant of an amount proportionate with the amount recovered, consistent with state statutes and rules.

Subsequent Event #2

During the course of the examination, the Company resettled each claim, resulting in restitution of $189.48 plus $13.04 interest.

SUMMARY OF STANDARDS

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	

Claims 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, 20-462, A.A.C. R20-6-801)	X	
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, 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)(1), A.A.C. R20-6-801(D)(1)]	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.R.S. § 20-461, A.A.C. R20-6-801)	X	

#	STANDARD	PASS	FAIL
11	Claim handling practices do not compel insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X	