



THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION MARKET REGULATION

TARGETED MARKET CONDUCT FINAL EXAMINATION REPORT

OF

AMERICAN INTEGRITY INSURANCE COMPANY OF FLORIDA

NAIC COMPANY CODE: 12841

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EXECUTIVE SUMMARY

A targeted market conduct examination of American Integrity Insurance Company of Florida (“American Integrity” or “the Company”) was performed to review and analyze specific aspects of the Company’s handling of claims generated by Hurricane Michael. This examination report includes significant findings of fact, as described in Section 624.3161, Florida Statutes (“F.S.”), and general information about the insurer to ascertain its compliance with applicable provisions of the Florida Insurance Code and its own claim handling procedures.

COMPANY OPERATIONS

American Integrity Insurance Company of Florida is a domestic Property and Casualty insurer authorized to conduct business in Florida on September 13, 2006. The Company is authorized to write Homeowners Multi-Peril, Mobile Home Multi-Peril, and Mobile Home Physical Damage coverage.

Total Direct Written Premiums in Florida for all lines of business was as follows:

Year	Total Direct Written Premium in Florida (Per Schedule T of the Annual Statement)
2019	\$341,514,383
2018	\$316,880,059
2017	\$292,351,744

PURPOSE AND SCOPE OF THE EXAMINATION

The Florida Office of Insurance Regulation (“Office”) has primary responsibility for the regulation, compliance and enforcement of statutes related to the business of insurance and the monitoring of industry markets. Due to this responsibility, the Office conducted a targeted market conduct examination of American Integrity pursuant to Section 624.3161, F.S. The examination was performed by a contracted examination firm, Examination Resources, LLC and members of the Office’s Property and Casualty Market Regulation business unit under the supervision of INS Regulatory Insurance Services, Inc. The purpose of a market conduct examination is to review an insurer’s operating practices to determine if they comply with the Florida Insurance Code, rules related to the business of insurance, procedures adopted by the Company, the provisions contained within a contract of insurance issued by the Company, or orders issued by the Office. A common element of all market conduct examinations is to evaluate an insurer’s business practices to promote the protection of insurance-buying consumers and to hold insurers accountable when issues or violations are found.

On October 10, 2018, Hurricane Michael, a Category 5 storm, made landfall in the Florida Panhandle near Tyndall Air Force Base. Since Hurricane Michael made landfall and as of October 2019, the Office has completed 44 data calls, and conducted analyses of the claims data

reported by 400 insurance companies.

On October 10, 2019, the Office released a report entitled One Year Later: Hurricane Michael's Impact of Florida. The report stated that as of that date, Hurricane Michael had resulted in the filing of more than 149,448 claims by policyholders at an estimated cost of \$6.7 billion. As of the September 27, 2019 reporting date, insurers classified the status of those claims as follows:

- 110,979 claims closed with payment;
- 21,122 claims closed without payment; and
- 17,347 claims remained open at the time of the reporting.

Approximately 12,000 of the open claims reported were claims for damage to personal and commercial residential properties, with the majority of the remaining claims, or approximately 5,000 claims, for damage to commercial properties.

On December 19, 2018 and on July 25, 2019, the Office issued two Informational Memorandums, OIR-18-01M (attached as Addendum B) and OIR-19-04M (attached as Addendum C), directing insurers adjusting Hurricane Michael claims “to do everything possible to respond to the needs of affected Floridians, restore a sense of normalcy, and facilitate restoration and recovery of impacted communities.” All insurers were instructed to redouble efforts to resolve all open claims, using whatever resources necessary, to provide policyholders with the tools to rebuild their lives and property. Insurers were also reminded that policyholders have the right to expect prompt, efficient and fair claims adjustment service, especially after a catastrophic loss. Insurers were urged to concentrate their resources and energy on reaching out to policyholders with open Hurricane Michael claims and take all actions necessary to bring the claims to closure as quickly as possible.

This targeted market conduct examination was initiated in the wake of Hurricane Michael to review and evaluate the Company's handling of Hurricane Michael claims reported to the Company by policyholders between October 10, 2018 and August 30, 2019. The targeted examination focused on compliance with the following specific key claims handling standards which directly impact policyholders and claimants:

- Timely communication with respect to claims;
- Timely payment of claims;
- Payment of statutory interest if instances of untimely payments occurred;
- Adjustment and payment of claims in accordance with the terms and conditions of the policy contract;
- Fair claim settlement practices;
- Use of licensed and appointed claims adjusters;
- Maintaining reasonable claims records; and
- Adherence to internal claims processing standards.

The examination began October 9, 2019 and ended October 23, 2020. This is the first market conduct examination of American Integrity.

AMERICAN INTEGRITY AND HURRICANE MICHAEL STATISTICS

As of October 25, 2019, in response to the Catastrophe Reporting data call, the Company reported receiving a total of 4,401 Hurricane Michael claims or 2.94% of the total number of Hurricane Michael claims reported by all insurers as of that reporting date. As of October 13, 2019, the Florida Department of Financial Services' Division of Consumer Services ("DFS") reported receiving a total of 80 complaints related to Hurricane Michael from American Integrity consumers. This represents 4.5% of the total number of complaints received from all consumers reporting Hurricane Michael complaints.

TOTAL REPORTED CLAIMS AND COMPLAINTS AS OF OCTOBER 2019			
American Integrity Claims	Total Claims	American Integrity Complaints	Total Complaints
4,401	149,773	80	1,791

An analysis comparing the total number of Hurricane Michael complaints received by DFS to the total number of Hurricane Michael claims reported by all insurers determined that the average complaint to claims percentage was 1.44%, as of the October 2019 reporting. The Company's complaint to claims comparison percentage was 1.82%.

A review of the Company's consumer complaints by reason category, as assigned by DFS, reflects that:

- 50 complaints, or 62.5% of all complaints, were reported by consumers experiencing a claim handling delay;
- 19 complaints, or 23.8% of all complaints, were made by consumers who reportedly:
 - Received unsatisfactory settlement offers;
 - Were issued claim underpayments;
 - Believed their claims were inappropriately denied;
 - Experienced a delay or lack of response from the Company;
 - Experienced a contract dispute with the Company;
 - Were concerned with the amount of the deductible applied to their claim;
 - Believed their policy was cancelled or nonrenewed due to their claims history; or
 - Experienced an unspecified claims issue.
- 11 complaints, or 13.8% of all complaints, were attributed to requests made by the Company or a policyholder to participate in mediation due to unresolved claim issues.

DFS defines:

- Claim Handling Delay as a complaint regarding the Company's or the adjuster's delay in contacting the claimant, processing the claim, or issuing a payment; and

- Claim Underpayment as an issue involving a claim that has been paid, but in an amount that is less than deemed appropriate by the person receiving the payment or on whose behalf payment is made.

CONSUMER COMPLAINTS BY REASON	
Claim Handling Delay	50
Mediation	11
Unsatisfactory Settlement Offer	6
Claim Underpayment	4
Claim Denial	3
Company Delay or No Response	2
Contract Dispute	1
Deductible Issue	1
Cancellation or Nonrenewal Claims	1
Other Claim Issue	1
Total	80

At the time of the October 2019 reporting by DFS:

- Two complaints were open pending resolution;
- 58 complaints were closed:
 - After DFS explained the Company’s position to the consumer;
 - Because DFS determined the claim was settled;
 - Because DFS resolved the consumer’s issue;
 - Because the insurer extended coverage to the consumer;
 - Because DFS explained coverage to the consumer;
 - When the consumer retained legal representation; or
 - When DFS found the policyholders’ issue to be regulated by a provision of the Florida Insurance Code.
- Four complaints were closed because DFS determined that a question of fact existed wherein DFS was unable to make a determination in favor of either the policyholder or the Company;
- One consumer complaint was referred to mediation; and
- Four notices were issued to the Office of alleged violations of the Florida Insurance Code after the consumers’ issues were satisfactorily resolved by the Company.

The notices issued to the Office were reviewed based on the scope of this examination.

The remaining 11 mediation complaints were resolved in accordance with DFS’ mediation program.

AMERICAN INTEGRITY COMPLAINT RESOLUTION CATEGORIES	
Open – Pending Resolution	2
Company Position Explained	37
Resolved Through DFS’ Mediation Program	11
Claim Settled	14
Question of Fact	4
Notice Issued – Relief	4
Issue Resolved	3
Referred to Mediation	1
Coverage Explained	1
Coverage Extended	1
Attorney Retained	1
Statutory Provisions	1
Total	80

The examination was conducted in light of the Company’s complaint statistics and was designed to analyze the adherence of the Company to specific key claims handling standards and the adherence of the Company to its own claims processing standards.

On November 2, 2020, in response to a new Catastrophe Reporting data call, the Company reported receiving a total of 4,463 Hurricane Michael claims, an increase of 62 claims from the October 25, 2019 data call. Of the 4,463 total claims reported, the Company recorded that 4,355 claims, or 97.6%, were closed and 108 claims, or 2.4%, remained open as of the reporting date. Of the 4,355 closed claims, 3,866 claims, or 88.8%, were closed with payment, and 489 claims, or 11.2%, were closed without payment.

EXAMINATION PROCEDURES

The conduct of this examination and the procedures, statistical sampling and examination processes used were consistent with and in accordance with those standards and procedures contained in the *Market Regulation Handbook* promulgated by the National Association of Insurance Commissioners (“NAIC”).

In preparation for the examination, the Company was requested to provide the total number, or universe, of Hurricane Michael claims reported with a Florida exposure during the examination’s scope period of October 10, 2018 to August 30, 2019. The Company reported receiving a total of 4,394 Hurricane Michael claims during the scope period. To facilitate a thorough review of the Company’s claims files and to address with particularity the specific key claims handling standards discussed previously in this report, the claims universe was divided into four categories: claims closed with payment, claims closed without payment, reopened claims, and claims open as of August 30, 2019. Each of the four categories were evaluated for compliance with the specific key claims handling standards.

The Company reported the universe of claims for each category as follows:

- 2,199 claims closed with payment;
- 467 claims closed without payment;
- 1,389 reopened claims; and
- 339 claims open as of August 30, 2019.

For purposes of this examination, the selection of claims reviewed for each of the four categories was defined as follows:

- Claims Closed With Payment: The first or initial Hurricane Michael claim filed by the named insured, policyholder, or legal representative during the scope period due to a loss occurring to a personal residential or commercial residential risk that was closed with payment during the examination's scope period.
- Claims Closed Without Payment: The first or initial Hurricane Michael claim filed by the named insured, policyholder, or legal representative during the scope period due to a loss occurring to a personal residential or commercial residential risk that was closed without payment for any reason during the examination's scope period. Reasons for closing a claim without payment could include but are not limited to claims valued at less than the policy's hurricane deductible, claims determined not to be covered by the policy, or claims that were voluntarily withdrawn by the named insured or policyholder.
- Reopened Claims: The first or initial Hurricane Michael claim filed by the named insured, policyholder, or legal representative during the scope period due to a loss occurring to a personal residential or commercial residential risk that was closed for any reason and subsequently reopened upon receipt of the first supplemental claim. Section 627.70132, F.S. defines the term "supplemental claim" or "reopened claim" as any additional claim for recovery from the insurer for losses from the same hurricane or windstorm which the insurer has previously adjusted pursuant to the initial claim.
- Claims Open as of August 30, 2019: A claim filed during the scope period by the named insured, policyholder, or legal representative due to a loss occurring to a personal residential or commercial residential risk that was in an "open" status as of August 30, 2019.

The examiners reviewed a total of 380 randomly selected Hurricane Michael claims. The number of randomly selected claims in each sample is consistent with the recommended sample size for claims in the NAIC's *Market Regulation Handbook's* Acceptance Samples Table. Examination results with a 95% confidence level permit those results to be extrapolated to the population of claims in each of the four claim categories. Based on the total universe of American Integrity claims subject to this examination, the total sample size required to achieve a 95% confidence level for all four categories was determined to be 380 claims.

The 380 randomly selected claims consisted of:

- 108 claims closed with payment;
- 83 claims closed without payment;
- 107 reopened claims; and
- 82 claims open as of August 30, 2019.

In reviewing materials for this report, the examiners relied on records provided by the Company, including catastrophe claims information provided to the Office in its Catastrophe Reporting data calls.

REVIEW FOR COMPLIANCE WITH SECTION 627.70131, F.S.

This portion of the examination focused on the Company's compliance, with respect to its Hurricane Michael claims, with statutory requirements and timeframes found in Section 627.70131, F.S. The review evaluated the specific key claims handling standards of timely payment of claims; timely communication with respect to a filed claim; and payment of statutory interest, if required. Other specific key claims handling standards which were evaluated are discussed in the Findings section of this report.

Section 627.70131, F. S., provides in pertinent part:

(5)(a) Within 90 days after an insurer receives notice of an initial, reopened, or supplemental property insurance claim from a policyholder, the insurer shall pay or deny such claim or a portion of the claim unless the failure to pay is caused by factors beyond the control of the insurer which reasonably prevent such payment. Any payment of an initial or supplemental claim or portion of such claim made 90 days after the insurer receives notice of the claim, or made more than 15 days after there are no longer factors beyond the control of the insurer which reasonably prevented such payment, whichever is later, bears interest at the rate set forth in s. 55.03. Interest begins to accrue from the date the insurer receives notice of the claim. The provisions of this subsection may not be waived, voided, or nullified by the terms of the insurance policy. If there is a right to prejudgment interest, the insured shall select whether to receive prejudgment interest or interest under this subsection. Interest is payable when the claim or portion of the claim is paid. Failure to comply with this subsection constitutes a violation of this code. However, failure to comply with this subsection does not form the sole basis for a private cause of action.

To determine the Company's adherence to these statutory requirements and timeframes, the examiners conducted detailed analyses of 380 claims. The examiners reviewed and analyzed each of the claims to determine if the claims were paid or denied within 90 days after the Company received notice of the initial, reopened, or supplemental claim. In accordance with the statute, the examiners also analyzed whether factors reasonably beyond the control of the Company may have prevented payment of that claim within 90 days. In instances where factors reasonably beyond the control of the Company existed, the claims were determined to have met the 90-day

standard, as provided in Section 627.70131(5)(a), F.S. The examiners applied those statutory requirements and timeframes to each of the 380 randomly selected Hurricane Michael claims by category: 108 claims closed with payment; 83 claims closed without payment; 107 reopened claims; and 82 open claims as of August 30, 2019.

After reviewing 108 **Claims Closed with Payment**, the examiners determined that when measuring from the date the Company received notice of the first or the initial claim to the date the claim payment was made to the policyholder, the Company paid 108 claims, or 100% of the claims closed with payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S.

CLAIMS CLOSED WITH PAYMENT	
Paid Within	Number of Claims
0-30 days	91
31-60 days	13
61-90 days	4
Over 90 days	0
Total Claims Reviewed	108

The results of the examination determined that 108 of the 108 claims reviewed, or 100% of the Company's claims closed with payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 83 **Claims Closed Without Payment**, the examiners determined that when measuring from the date the Company received notice of the first or the initial claim to the date the claim was denied, the Company denied 81 claims, or 97.6% of the claims closed without payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Two claims were denied after 90 days.

CLAIMS CLOSED WITHOUT PAYMENT	
Closed Within	Number of Claims
0-30 days	68
31-60 days	10
61-90 days	3
Over 90 days	2
Total Claims Reviewed	83

The examiners determined that two claims closed without payment in the over 90 days category are in violation of Section 627.70131(5)(a), F.S. because no factors existed beyond the control of the Company to reasonably prevent paying or denying the claim within 90 days.

The results of the examination determined that 81 of the 83 claims reviewed, or 97.6% of the Company’s claims closed without payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 107 **Reopened Claims**, the examiners determined that when measuring from the date the Company received the first or initial reopened or supplemental claim to the date the claim was paid or denied, the Company paid or denied 97 claims, or 90.7% of the reopened claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Ten claims were paid or denied after 90 days.

REOPENED CLAIMS	
Paid Within	Number of Claims
0-30 days	51
31-60 days	32
61-90 days	14
Over 90 days	10
Total Claims Reviewed	107

The examiners determined that four reopened claims in the over 90 days category are in violation of Section 627.70131(5)(a), F.S. because no factors existed beyond the control of the Company to reasonably prevent paying or denying the claims within 90 days.

The remaining six reopened claims in the over 90 days category were determined not to be in violation of Section 627.70131(5)(a), F.S. because the Company was pending receipt of documentation or communication needed from the policyholder or the policyholder’s representative to resolve the claim or the claim was in litigation. These factors were reasonably beyond the control of the Company and the claims were determined to have met the 90-day standard.

The results of the examination determined that 103 of the 107 claims reviewed, or 96.3% of the Company’s reopened claims, complied with Section 627.70131(5)(a), F.S.

After reviewing 82 **Open Claims as of August 30, 2019**, the examiners determined that when calculating from the date the Company received notice of the initial, reopened, or supplemental claim to the date the claim was paid or denied, the Company paid or denied 29 claims in an “open” status as of August 30, 2019, or 35.4% of the claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Fifty-three claims were paid or denied after 90 days.

OPEN CLAIMS AS OF AUGUST 30, 2019	
Paid Within	Number of Claims
0-30 days	10
31-60 days	16
61-90 days	3
Over 90 days	53
Total Claims Reviewed	82

The examiners determined that two of the 53 open claims as of August 30, 2019 in the over 90 days category are in violation of Section 627.70131(5)(a), F.S. because no factors existed beyond the control of the Company to reasonably prevent paying or denying the claims within 90 days.

The remaining 51 open claims as of August 30, 2019 in the over 90 days category were determined not to be in violation of Section 627.70131(5)(a), F.S. because the Company was pending receipt of documentation or communication needed from the policyholder or the policyholder's representative to resolve the claim or the claim was in litigation or mediation. These factors were reasonably beyond the control of the Company and the claims were determined to have met the 90-day standard.

The results of the examination determined that 80 of the 82 claims reviewed, or 97.6% of the Company's claims open as of August 30, 2019, complied with Section 627.70131(5)(a), F.S.

ADHERENCE REVIEW

In addition to reviewing the Company's claims practices to determine compliance with specific key claims handling standards, the examiners evaluated the Company's compliance with its own internal claims procedures.

To determine the Company's adherence to its own claims processing standards, the examiners reviewed materials and information provided by the Company and compared them to the information and data contained within the claims files. The full review is contained in Addendum A of this report. Additional adherence determinations contained within this report may have been made based on subsequent events that occurred during the course of this examination.

The results of the adherence review determined that one area substantially deviated from the Company's internal standards. The Company's written procedures require field adjusters to attempt to make contact with policyholders within 24 hours of receiving notice of a claim. The examiners' review of the Company's written agreements with independent adjusting firms revealed that each of the agreements contained provisions requiring timely contact

with policyholders. The Company stated that, based on reports received from its independent adjusting firms, the 24-hour contact standard was met 66% of the time for Hurricane Michael claims because downed power and telephone lines and damaged cell towers located in the affected areas made it difficult to meet the standard.

FINDINGS

The following Findings, or violations, are compiled from the Office's and the contracted examiners' analysis of the Company's adherence to specific key claims handling standards and the Company's adherence to its own claims processing standards. Each Finding includes the Company's response to each violation, and, in certain cases, additional conclusions made, when necessary.

The statutory standards that were reviewed are Section 627.70131(1)(a), F.S., requiring the timely acknowledgement of claims communications, Section 626.112, F.S., requiring the use of licensed and appointed claims adjusters, Section 626.877, F.S., requiring the adjustment of claims in accordance with the terms and conditions of the insurance contract, and Section 626.9541, F.S., that defines unfair trade practices.

CLAIMS CLOSED WITH PAYMENT

The Company reported a universe of 2,199 Hurricane Michael claims that were closed with payment during the examination scope period. A random sample of 108 claims was selected for review and the findings of the review are as follows:

Finding 1: In two instances out of 108 claims reviewed, an error percentage of 1.9%, the Company's adjusters made a material misrepresentation to the policyholder by issuing proceeds payable under the policies that effected the settlement of the claims on less favorable terms than those provided by the insurance policies, in violation of Section 626.9541(1)(i)2., F.S.

COMPANY RESPONSE: The Company agreed with the violations stating the issues would be remedied.

Finding 2: In four instances out of 108 claims reviewed, an error percentage of 3.7%, the Company or the Company's independent adjusting firm did not submit an Emergency Adjuster Application form to the Department within seven calendar days after adjusting work began, in violation of Rule 69B-220.001(5)(a), Florida Administrative Code ("F.A.C.")

COMPANY RESPONSE: The Company agreed with the violations and stated its independent adjusting firm experienced a merger. Since the merger, a new system was put into place to ensure this does not happen again.

Finding 3: In one instance out of 108 claims reviewed, an error percentage of 0.9%, the Company failed to maintain reasonable claims records, in violation of Section 627.318, F.S.

COMPANY RESPONSE: The Company agreed with the violation.

CLAIMS CLOSED WITHOUT PAYMENT

The Company reported a universe of 467 Hurricane Michael claims that were closed without payment during the examination scope period. A random sample of 83 claims was selected for review and the findings of the review are as follows:

Finding 4: In two instances out of 83 claims reviewed, an error percentage of 2.4%, the Company did not deny or close the claims within 90 days after receiving notice of the claim from the policyholder, in violation of Section 627.70131(5)(a), F.S.

COMPANY RESPONSE: The Company agreed with the violations.

Finding 5: In six instances out of 83 claims reviewed, an error percentage of 7.2%, the Company utilized persons who were either not licensed or appointed by an appropriate appointing entity or person as insurance adjusters at the time the claims were adjudicated, in violation of Section 626.112(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with three of the violations but disagreed with three violations and requested the Office review a corrected license number for an adjuster that was listed on all three claims.

The violations were retained in this report because the review of the corrected license number determined that the adjuster did not have an active appointment at the time the claims were adjudicated.

Finding 6: In six instances out of 83 claims reviewed, an error percentage of 7.2%, the Company or the Company's independent adjusting firm did not submit an Emergency Adjuster Application form to the Department within seven calendar days after adjusting work began, in violation of Rule 69B-220.001(5)(a), F.A.C.

COMPANY RESPONSE: The Company agreed with the violations.

Finding 7: In four instances out of 83 claims reviewed, an error percentage of 4.8%, the Company failed to maintain reasonable claims records, in violation of Section 627.318, F.S.

COMPANY RESPONSE: The Company agreed with the violations.

REOPENED CLAIMS

The Company identified a universe of 1,389 Hurricane Michael claims that were reopened as an additional claim that had previously been adjusted pursuant to the initial claim. A random sample of 107 claims was selected for review and the findings of the review are as follows:

Finding 8: In four instances out of 107 claims reviewed, an error percentage of 3.7%, the Company did not pay or deny the claims within 90 days after receiving notice of the claim from the policyholder, in violation of Section 627.70131(5)(a), F.S.

COMPANY RESPONSE: The Company agreed with the violations.

Finding 9: In six instances out of 107 claims reviewed, an error percentage of 5.6%, the Company did not timely acknowledge receipt of claims communications within 14 calendar days, in violation of Section 627.70131(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with the violations.

Finding 10: In three instances out of 107 claims reviewed, an error percentage of 2.8%, the Company's adjusters made a material misrepresentation to the policyholder by issuing proceeds payable under the policies that effected the settlement of the claims on less favorable terms than those provided by the insurance policies, in violation of Section 626.9541(1)(i)2., F.S.

COMPANY RESPONSE: The Company agreed with the violations stating the issues would be remedied.

Finding 11: In 15 instances out of 107 claims reviewed, an error percentage of 14.0%, the Company utilized persons who were either not licensed or appointed by an appropriate appointing entity or person as insurance adjusters at the time the claim was adjudicated, in violation of Section 626.112(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with nine of the violations but disagreed with six violations and requested the Office review corrected license numbers for two adjusters that were listed on three claims each.

The violations were retained in this report because the review of the corrected license numbers determined that neither adjuster had an active appointment at the time the claims were adjudicated.

Finding 12: In one instance out of 107 claims reviewed, an error percentage of 1.1%, the Company or the Company's independent adjusting firm did not submit an Emergency Adjuster Application form to the Department within seven calendar days after adjusting work began, in violation of Rule 69B-220.001(5)(a), F.A.C.

COMPANY RESPONSE: The Company agreed with the violation.

OPEN CLAIMS AS OF AUGUST 30, 2019

The Company reported a universe of 339 Hurricane Michael claims that were open as of August 30, 2019. A random sample of 82 claims was selected for review and the findings of the review are as follows:

Finding 13: In two instances out of 82 claims reviewed, an error percentage of 2.4%, the Company did not pay or deny the claims within 90 days after receiving notice of the claim from the policyholder, in violation of Section 627.70131(5)(a), F.S.

COMPANY RESPONSE: The Company agreed with the violations.

Finding 14: In eight instances out of 82 claims reviewed, an error percentage of 9.8%, the Company did not timely acknowledge receipt of claims communications within 14 calendar days, in violation of Section 627.70131(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with the violations and stated measures have been put into place to ensure follow-up with these types of issues.

Finding 15: In five instances out of 82 claims reviewed, an error percentage of 6.1%, the Company utilized persons who were either not licensed or appointed by an appropriate appointing entity or person as insurance adjusters at the time the claim was adjudicated, in violation of Section 626.112(1)(a), F.S.

COMPANY RESPONSE: The Company agreed with the violations.

Finding 16: In two instances out of 82 claims reviewed, an error percentage of 2.4%, the Company or the Company's independent adjusting firm did not submit an Emergency Adjuster Application form to the Department within seven calendar days after adjusting work began, in violation of Rule 69B-220.001(5)(a), F.A.C.

COMPANY RESPONSE: The Company agreed with the violations.

ADHERENCE REVIEW

Finding 17: The Company did not consistently adhere to its own claims processing standards that require field adjusters to attempt to contact policyholders within 24 hours of receiving notice of a claim.

COMPANY RESPONSE: The Company stated that downed power and telephone lines and damaged cell towers located in the affected areas made it difficult to meet the standard.

RECOMMENDATIONS

The following Recommendations were compiled from the Findings contained within this report. The Company is to provide a written report to the Office of actions taken on each Recommendation within 60 days of the Company's receipt of the Office's Final Examination Report.

It is recommended that the Company:

- Ensure that all initial, supplemental or reopened claims will be paid or denied, in whole

or in part, within 90 days; that the acknowledgement of all claims communications will occur within statutorily mandated timeframes; that claims proceeds payable under the policies are issued in accordance with those provided by the insurance policy; and that all claims files will contain reasonable records in order for the Office or its examiners to determine the Company's compliance with the applicable provisions of the insurance code;

- Ensure that statutorily required interest is automatically included in claims payments to policyholders when claims are not paid within statutory timeframes and no factors exist beyond the control of the Company to reasonably prevent paying or denying the claims within 90 days;
- Eliminate the ability for unlicensed or un-appointed independent or emergency claims adjusters to participate in claims activities; and
- Ensure field adjusters consistently adhere to its own claims processing standards that require documented attempts to contact policyholders within 24 hours of receiving notice of a claim.

CONCLUSION

This targeted market conduct examination of American Integrity was designed to review and evaluate whether the Company's handling of Hurricane Michael claims was in compliance with the specific key claims handling standards required by statute, the provisions of the insurance policy issued by the Company, or the Company's own claims processing standards. During the examination, the Office and the Office's contracted examiners identified findings and made recommendations for remediation to be implemented by the Company. The examination identified no improper general business practices related to claims and determined that the Company was diligent when investigating Hurricane Michael claims and when accurately paying such claims.

This examination report and the Findings contained therein are the result of a factual, data-driven analysis of the claims handling practices of the Company, as reflected in its handling of 380 Hurricane Michael claims. This report contains a number of recommendations for improvement and remediation that should be implemented by the Company. It does not document what regulatory or administrative action may be taken by the Office. Any such action taken as a result of this targeted market conduct examination will be the subject of a separate Order issued by the Office.

EXAMINATION DRAFT REPORT SUBMISSION

The Office hereby issues this Final Report based upon information from the examiners' draft report, additional research conducted by the Office, and additional information provided by the Company.

ADDENDUM A

CLAIMS OVERVIEW

The examination included a review of the Company’s claims handling procedures, catastrophe preparedness, adjuster training, system resources, and the types of monitoring used by the Company to ensure its claims staffs’ adherence with processes and procedures.

As the storm approached, the Company was prepared with 139 adjusters, a combination of staff and independent adjusters, from three contracted independent adjusting firms. Once the storm hit, the claims staff was reduced to three teams totaling 99 adjusters as the original claim volume, anticipated to be approximately 3,000 to 4,000 claims, was lower than expected. The Company maintained 99 claims adjusters on staff until March 14, 2019, when the staff was reduced again to approximately 30 claims adjusters working to resolve Hurricane Michael claims.

During the examination, the examiners noted, in certain circumstances, multiple adjusters were assigned to a single claim. The Company was requested to provide data to show the total number of claims adjusters that were assigned to 289 claims files reviewed for this purpose during the examination. Based on the Company’s response, 99 claims, or 34% of the claims reviewed, had one adjuster assigned throughout the lifecycle of the claim; 91 claims, or 31% of the claims reviewed, had two to three adjusters assigned; and 57 claims, or 20% of the claims reviewed, had four to five adjusters assigned throughout the lifecycle of the claim. In one case, the Company reported 11 claims adjusters were assigned to a single claim.

Number of Adjusters Assigned	Number of Claim Files	Percentage
1	99	34.3%
2	35	12.1%
3	56	19.4%
4	29	10.0%
5	28	9.7%
6	15	5.2%
7	17	5.9%
8	4	1.4%
9	4	1.4%
10	1	0.3%
11	1	0.3%
Total	289	100%

The Company stated the same adjuster is retained on a claim file throughout the lifecycle of the claim unless the adjuster leaves, the claim file is moved to litigation, or the file moves into a “staging box” while it is awaiting assignment. During a catastrophe, one primary exemption

exists to the Company's protocol because catastrophes require a significant ramp up of adjusting resources at the onset of a storm and those resources decrease over time. The Company consolidates staff based on claim needs and releases independent adjusters and temporary staff as deemed appropriate. Claims can be moved from adjuster to adjuster as consolidations occur. When consolidating staff, the Company retains staff based on exemplary performance while ensuring the retained adjusters' pending workloads are based on the complexity of the assigned claims.

The Company's claims records also include documentation of many "touches" by call center staff, managers, other adjusters assisting with cold calls from customers or administrative staff. The Company's goal is to ensure that each customer is taken care of as quickly as possible and for employees to act as a team looking up claims information and assisting the customer, as necessary.

Policyholders were able to report claims 24-hours a day by calling a toll-free telephone number, via the Company's website or by contacting their agent. Once a claim was opened, policyholders were able to verify the status of their claims using the Company's web portal. Policyholders in need of emergency water mitigation services or other temporary repairs were directed to contact the Company's preferred vendor for assistance. The Company's field adjusters utilized Xactimate software to write and upload initial estimates which were then stored in the Company's claims system.

Once a policyholder filed a claim, it was assigned to a desk adjuster. If an inspection of the damage was needed, the claim was assigned to a field adjuster. The Company's written procedures required field adjusters to attempt to make contact with the insured within 24 hours of the claim assignment. The Company stated that, based on reports received from its independent adjusting firms, this standard was met 66% of the time for Hurricane Michael claims. The Company indicated that downed power and telephone lines and damaged cell towers located in the affected areas made meeting the 24-hour contact standard with insureds difficult.

Desk adjusters were responsible for gathering facts about the loss, reviewing, and explaining policy coverage, including the deductible, and discussing next steps with the insured. If needed, the desk adjuster scheduled in-person appointments with the insured or sent an expert, such as an engineer, to inspect the damaged property. The field adjusters created and uploaded initial estimates into the Company's claims system and desk adjusters issued claims checks for covered losses based on the approved initial estimate. Once the Company paid the initial claim, it was considered resolved and closed. The Company notified insureds to report additional expenses or damages not previously presented immediately. Once received, the insured's claim was reopened for additional review.

The Company has several internal claims processes that ensure adjuster adherence with claims procedural guidelines and estimating practices. The Company has created three primary sets of standards; Leader Standard Work, Claims Handler Standard Work; and Estimating Guidelines. The Leader Standard Work is a set of standards, which outlines step-by-step guidelines on how managers should supervise their staff to ensure adherence to the claims processes. Leader Standard Work is built to ensure that managers are measuring and monitoring how adjusters are following

the guidance provided in the Claim Handler Standard Work. Claims Handler Standard Work is an extensive set of processes for adjusters on how to handle claims peril by peril. The Estimating Guidelines are step-by-step instructions provided to ensure that essential processes are not missed and that all essential steps are taken to ensure compliance.

The Company uses a multi-layered approach to ensure that internal processes are followed. Within the Catastrophe and Staff Operations departments, there are managers who oversee the adjusting teams with an 8:1 or 10:1 adjuster-to-manager ratio depending on the complexity of the storm or claims they receive. The Company has a tiered approach for maintaining adjuster oversight during catastrophes. During a storm, the Head of Catastrophe activates the catastrophe team and takes responsibility for managing storm related claims. The Head of Catastrophe runs the operation and is responsible for ensuring completion of necessary operations, processes, and procedures. The Head of Catastrophe oversees representatives from each organizational department during the event such as training, customer care, underwriting, sales, and IT. Those resources are responsible for preparing the systems and their staff in response to the storm. The catastrophe claims staff managers and all of the personnel from the contracted independent adjusting firms also report to the Head of Catastrophe.

During a storm, the Company reported that certain claims adjusters are reverted to a claims check approval authority of \$5,000 and confirmed that the check writing authority for non-catastrophe claims ranges from \$0 to \$15,000 based on the adjuster's level of experience, performance as assessed by the independent adjusting firm they work for, and feedback from the Company regarding their performance while handling past claims. The Company reported that most independent adjusters used during the "ramp up" and "ramp down" phases of a catastrophe claims operation retain a \$5,000 claims check approval authority level but some adjusters are granted additional authority if they have several years past claims experience or significant time in the industry when the Company will grant additional authority based on the independent adjusting firm's recommendation. The Company stated that its independent adjusters do not have authority to write physical checks but input data into the claims system where approval is generated within the system. The Company's accounting operation prints and mails the claims checks to policyholders. As Hurricane Michael persisted, the Company stated that adjuster claims check approval authority was increased based on the independent adjusting firms' recommendations and the overall performance of the claims adjusters.

The Company stated that the reason for reverting claims check approval authorities to \$5,000 was because the Company's past experience with other storms involved a high frequency of claims whereas Hurricane Michael claims were of a higher severity and like no other storm experienced before by the Company. During Hurricane Irma, the Company noticed that, in some cases, its adjusters made incorrect coverage decisions at the onset of a claim and that risk could grow due to the complexity of Hurricane Michael claims. To ensure that claims adjusters were prepared for handling the complex nature of the storm and the damages that ensued, the Company stated it created an automated management oversight trigger by modifying the check approval authority assigned to claims adjusters in its claims system and pushing the authority for setting the amount for claims reserves to the manager level. The Company stated the automated process was needed to ensure that claims adjusters made more accurate coverage determinations and created more accurate initial claims estimates.

The Company provided the check approval authorities for 118 adjusters that were assigned to the claims files reviewed during the examination. Sixty-one adjusters, or 51.7% of the total adjuster authorities reviewed, were assigned a \$5,000 check approval authority; and 30 adjusters, or 25.4% of the total adjuster authorities reviewed, were assigned a \$25,000 check approval authority. The remaining results of the analysis of the adjuster check approval authorities is provided in the table below:

Adjuster Check Approval Authorities		
Authority Amount	# of Adjusters	Percentage
\$,5000	61	51.7%
\$10,000	19	16.1%
\$15,000	2	1.7%
\$20,000	2	1.7%
\$25,000	30	25.4%
\$40,000	1	0.8%
\$50,000	3	2.5%
Total	118	99.9%

The Company was requested to provide a summary of measures taken as a result of Hurricane Michael to ensure proper resolution of claims. The Company stated it conducted an audit of 1,000 Hurricane Michael claims a few months after the storm, evaluated each claim individually and identified trends, opportunities, and successes. The Company stated that the information enabled it to outline process enhancements, collect details about claim adjuster skillsets and identify significant opportunities to increase the Company’s accuracy with administering indemnity and expense management. The Company stated it identified 10 components for improvement and have begun implementing them. The Company identified the need to improve dwelling coverage decisions, reduce the number of errors in the over utilization of roofing components when unnecessary and ensure proper, more frequent follow ups with customers as storms progress. The Company stated it has provided training for and implemented these improvements in its standard work process.

The examiners noted that the Company referred to “opportunities found in (Hurricane) Irma that caused the Company to reduce authority levels” and asked the Company to elaborate on what those opportunities were. The Company stated that the final report, completed by Accuracy Assurance, outlined significant findings for both Hurricanes Irma and Michael. While that report was done midway through Hurricane Michael it was an “in the rears” look at Hurricane Irma confirming what the Company noticed during quality reviews and spot checks throughout the storm. The Company stated that key findings, in both real-time reviews conducted during reserve reviews and payment reviews, found that claims adjusters were affording coverages for damages where coverage did not exist. For example, Ordinance and Law coverage (10% of policy limits) is not included in every policy type. The Company found that claims adjusters were applying Ordinance and Law coverage to dwelling policies where no coverage was provided by the policy. Other existing coverage issues that needed review was in regard to storm created openings and the application of actual cash value to policies that did not provide replacement cost coverage.

The Company also stated that, outside of coverage issues, it also noticed estimating issues, including the incorrect application of labor minimums and overhead and profit. Based on these issues, the Company puts safeguards in place at the onset of storms to ensure claims adjusters are trained by their independent adjusting firms prior to expanding claims check approval authority beyond the Company's comfort level. The Company stated that it is estimated that more than 1/3 of the claims adjusters that processed claims for Hurricanes Irma and Harvey, industry wide, had never handled a property insurance claim prior to the storm. As large catastrophes bring new independent adjusters into the market, the Company stated it is critical for the Company to evaluate and manage claims check approval authority levels. The Company stated while claims managers may stay the same, changes in claims adjusters occur frequently in a catastrophe-type of environment many times requiring real-time training on the Company's best practices just prior to the claims adjusters' deployment to handling claims. The Company stated, as real-time training is a necessity for responding to catastrophes, it yields gaps in the independent adjuster's knowledge base and warrants lower limits in their claims check approval authority.

For Hurricane Michael, the Company stated its training sessions included but were not limited to the following topics: Legislative Agenda and Assignment of Benefit ("AOB") Reform, Coverage Forms, Endorsements and Exclusions, Systems Training, Special Investigative Unit ("SIU") Referrals and Best Practices, Estimating Guidelines and Claim Audit Sheet Review, and Claim Standards Work Review.

With respect to independent adjusters, the Company stated the independent adjusting companies are trained using the Company's guidelines. The independent adjusting firms' training teams place the Company's materials and guidelines into their own training programs to onboard people in a consistent manner. The managers at the independent adjusting companies conduct side-by-side reviews and audits to reinforce training. When a storm hits, if warranted, the Company deploys its Head of CAT, training teams and Directors to conduct onsite, real time training and overviews of the Company's guidelines, protocols and estimating practices. Training materials are updated as they change with copies provided to the independent adjusting firms. The Company provided a roster to the examiners to confirm that the training sessions were provided and the names of the staff that attended the training.

As part of the examination, the agreements with the independent adjusting firms were reviewed. All three agreements were similar in nature. Monetary compensation for claims activities is determined by the size of the loss. The greater the amount of damages, the greater the compensation amount. Each of the agreements contain provisions requiring timely contact with claimants.

ADDENDUM B



**INFORMATIONAL
MEMORANDUM OIR-18-01M
ISSUED**

December 19, 2018

Florida Office of Insurance Regulation
David Altmaier, Commissioner

**TO ALL PROPERTY AND CASUALTY INSURERS AUTHORIZED TO
DO BUSINESS IN FLORIDA**

HURRICANE MICHAEL CLAIMS RESPONSE

Hurricane Michael made landfall in the Florida Panhandle on October 10, 2018, causing estimated total insured losses of \$4.5 billion and generating more than 133,000 claims as of December 17, 2018. According to data filed with the Florida Office of Insurance Regulation, more than 90,000 claims have been closed. However, there are more than 42,000 claims that remain open. Insurers are reminded of Section 626.9541(1)(i)4., Florida Statutes, which requires that property insurers must pay:

...undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

To facilitate the payment of Hurricane Michael claims, it is important that insurers have sufficient claim adjustment and consumer service resources to provide policyholders with access to effective customer service. Insurers may need to augment available claim or customer service resources, establish mobile claims offices in the Florida Panhandle, initiate outbound calls to claimants, or take other action to provide quality policyholder service. The Office expects insurers not only to comply with the provisions of Florida law but also to do everything possible to respond to the needs of affected Floridians, restore a sense of normalcy, and facilitate restoration and recovery in impacted communities.

If you have any questions regarding this memorandum, please contact Virginia Christy at Virginia.Christy@floiir.com or (850) 413-5019.

ADDENDUM C



INFORMATIONAL MEMORANDUM OIR-19-04M ISSUED JULY 25, 2019

Florida Office of Insurance Regulation
David Altmaier, Commissioner

TO ALL PROPERTY AND CASUALTY INSURERS AUTHORIZED TO DO BUSINESS IN FLORIDA

HURRICANE MICHAEL CLAIMS RESPONSE

This Hurricane Michael Informational Memorandum supplements [Informational Memorandum OIR-18-01M](#), which was issued on December 19, 2018. That Informational Memorandum directed insurers adjusting Hurricane Michael claims to not only comply with required provisions of Florida law but also “to do everything possible to respond to the needs of affected Floridians, restore a sense of normalcy, and facilitate restoration and recovery in impacted communities.”

As of June 28, 2019, insurers reported that a total of 147,877 Hurricane Michael claims had been filed. While 126,208 claims were reported closed, 21,669 claims remained open.

More than 20,000 Floridians with open claims need assistance. Insurers should redouble efforts to resolve all open claims, using whatever resources are necessary, to provide policyholders with the tools to rebuild their lives and property.

The Office of Insurance Regulation (Office) will be issuing an enhanced data call to collect additional information from insurers regarding open Hurricane Michael claims. This information will assist the Office in evaluating claim payment trends and identifying potential impediments to the prompt closure of claims.

Policyholders have the right to expect prompt, efficient and fair claims adjustment service, especially after a catastrophic loss. The Office demands nothing less. Insurers should therefore concentrate their resources and energy on reaching out to policyholders with open Hurricane Michael claims and taking all actions necessary to bring the claim to closure as quickly as possible.

If you have any questions regarding this memorandum, please contact Susanne Murphy at Susanne.Murphy@flor.com or (850) 413-5083.