



THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION MARKET REGULATION

TARGETED MARKET CONDUCT FINAL EXAMINATION REPORT

OF

FEDNAT INSURANCE COMPANY

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EXECUTIVE SUMMARY

A targeted market conduct examination of FedNat Insurance Company (“FedNat” 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

FedNat Insurance Company is a domestic Property and Casualty insurer authorized to conduct business in Florida on March 1, 1984. On June 4, 2018, the Company’s name was changed from Federated National Insurance Company to FedNat Insurance Company. The Company is authorized to write Homeowners Multi-Peril and Commercial Multi-Peril coverage. The Company markets, distributes, and services insurance products through a network of independent agents.

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

Year	Total Direct Written Premiums in Florida (Per Schedule T of the Annual Statement)
2019	463,651,406
2018	\$472,046,775
2017	\$499,746,966

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 FedNat pursuant to Section 624.3161, F.S. The examination was performed by a contracted examination firm, Global Insurance Enterprises, Inc. 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 10, 2019 and ended November 24, 2020.

The last market conduct examinations of FedNat were completed on February 6, 2004, and December 14, 2004, under its former name, Federated National Insurance Company. The scopes of those targeted examinations reviewed the Company's claims handling practices and evaluated

the Company’s response to claims related to Hurricanes Charley, Frances, Ivan, and Jeanne. The Company’s last examinations yielded the following findings:

- In three instances of 100 claims filed by policyholders as a result of Hurricanes Charley, Frances, Ivan, and Jeanne, the Company failed to timely acknowledge claims communications within 14 calendar days, in violation of Rule 69O-166.024, Florida Administrative Code (“F.A.C.”).

FEDNAT AND HURRICANE MICHAEL COMPLAINT STATISTICS

As of October 25, 2019, in response to the Catastrophe Reporting data call, the Company reported receiving a total of 5,984 Hurricane Michael claims, or 4% 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 126 complaints related to Hurricane Michael from FedNat consumers. This represents 7.04% of the total number of complaints received from all consumers reporting Hurricane Michael complaints.

TOTAL REPORTED CLAIMS AND COMPLAINTS AS OF OCTOBER 2019			
FedNat Claims	Total Claims	FedNat Complaints	Total Complaints
5,984	149,773	126	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 2.11%.

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

- 67 complaints, or 53.2% of all complaints, were reported by consumers experiencing a claim handling delay;
- 15 complaints, or 12% of all complaints, were attributed to requests made by the Company or a policyholder to participate in mediation due to unresolved claim issues;
- 13 complaints, or 10.3% of all complaints, were made by consumers who:
 - Experienced a delay or no response from the Company;
 - Reported they did not receive payment for the usual and customary claim amount;
 - Experienced a delay receiving a premium refund;
 - Received a notice of cancellation or nonrenewal due to underwriting;
 - Reported the Company was not allowing coverage for Additional Living Expenses; or
 - Reported nonspecific issues related to a claim or to the Company, in general;

- 11 complaints, or 8.7% of all complaints, were made by consumers who reportedly received an unsatisfactory settlement offer;
- 10 complaints, or 7.9% of all complaints, were made by consumers who believed their claims were inappropriately denied; and
- 10 complaints, or 7.9% of all complaints, were reported by consumers who believed they were issued claim underpayments.

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;
- Usual and Customary as the amount paid based on the usual and customary charges for the services provided and not the amount billed for those services;
- Unsatisfactory Settlement Offer as a complaint that the amount offered to settle a claim is less than the amount requested by the insured; 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.

FEDNAT CONSUMER COMPLAINTS BY REASON	
Claim Handling Delay	67
Mediation	15
Unsatisfactory Settlement Offer	11
Claim Denial	10
Claim Underpayment	10
Company Delay or No Response	7
Usual & Customary	1
Premium Refund	1
Other Claim Issue	1
Cancellation or Nonrenewal due to Underwriting	1
Additional Living Expense Issue	1
Other Company Issue	1
Total	126

At the time of the October 2019 reporting by DFS:

- Five complaints were open pending resolution;
- 91 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;

- After DFS determined that the Company’s position was based on a contractual provision contained within the insurance policy;
 - Because the insurer extended coverage to the consumer; or
 - When DFS found the policyholders’ issue to be regulated by a provision of the Florida Insurance Code;
- 12 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;
 - After the Company issued the policyholder a reservation of rights letter; or
 - After the consumer retained legal representation;
 - One consumer complaint was referred to mediation; and
 - Two 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 15 mediation complaints were resolved in accordance with DFS’ mediation program.

FEDNAT COMPLAINT RESOLUTION CATEGORIES	
Open – Pending Resolution	5
Company Position Explained	42
Claim Settled	38
Resolved Through DFS’ Mediation Program	15
Question of Fact	10
Issue Resolved	6
Notice Issued – Relief	2
Contractual Provision	2
Coverage Extended	2
Referred to Mediation	1
Reservation of Rights	1
Attorney Retained	1
Statutory Provisions	1
Total	126

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 6,162 Hurricane Michael claims, an increase of 178 claims from the October 25, 2019 data call. Of the 6,162 claims reported, the Company recorded that 5,748 claims, or

93.3%, were closed and 414 claims, or 6.7%, remain open as of the reporting date. Of the 5,748 closed claims, 5,125 claims or 89.2%, were closed with payment and 623 claims, or 10.8%, 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 6,004 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:

- 1,791 claims closed with payment;
- 425 claims closed without payment;
- 2,818 reopened claims; and
- 970 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 403 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 FedNat claims subject to this examination, the total sample size required to achieve a 95% confidence level for all four categories was determined to be 403 claims.

The 403 randomly selected claims consisted of:

- 107 claims closed with payment;
- 83 claims closed without payment;
- 108 reopened claims; and
- 105 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(5)(a), 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 403 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 403 randomly selected Hurricane Michael claims by category: 107 claims closed with payment; 83 claims closed without payment; 108 reopened claims; and 105 open claims as of August 30, 2019.

After reviewing 107 **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 107 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	75
31 – 60 days	19
61 – 90 days	13
Over 90 days	0
Total Claims Reviewed	107

The results of the examination determined that 107 of the 107 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 initial claim to the date the claim was denied or closed, the Company denied or closed 82 claims, or 98.8% of the claims

closed without payment, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. One claim was denied or closed after 90 days.

CLAIMS CLOSED WITHOUT PAYMENT	
Closed Within	Number of Claims
0 – 30 days	63
31 – 60 days	14
61 – 90 days	5
Over 90 days	1
Total Claims Reviewed	83

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

The results of the examination determined that 82 of the 83 claims reviewed, or 98.8% of the Company’s claims closed without payment, complied with Section 627.70131(5)(a), F.S.

After reviewing 108 **Reopened Claims**, the examiners determined that when measuring from the date the Company received a first or initial reopened or supplemental claim to the date the claim was paid or denied, the Company paid or denied 102 claims, or 94.4% of the reopened claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Six claims were paid or denied after 90 days.

REOPENED CLAIMS	
Paid Within	Number of Claims
0 – 30 days	75
31 – 60 days	21
61 – 90 days	6
Over 90 days	6
Total Claims Reviewed	108

The examiners determined that the six claims in the over 90 days category are not 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 involved in the appraisal process. 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 108 of the 108 claims reviewed, or 100% of the Company’s reopened claims, complied with Section 627.70131(5)(a), F.S.

After reviewing 105 **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 54 claims in an “open”

status as of August 30, 2019, or 51.4% of the claims, in 90 days or less, in accordance with Section 627.70131(5)(a), F.S. Fifty-one claims were paid or denied after 90 days.

OPEN CLAIMS AS OF AUGUST 30, 2019	
Paid Within	Number of Claims
0 – 30 days	29
31 – 60 days	16
61 – 90 days	9
Over 90 days	51
Total Claims Reviewed	105

The examiners determined that all 51 claims in the over 90 days category are not 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 involved in litigation or the appraisal process. 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 105 of the 105 claims reviewed, or 100% 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 determination contained in this report may have been made based on subsequent events that occurred during the course of this examination.

No exceptions were noted during the Adherence Review.

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 1,791 Hurricane Michael claims that were closed with payment during the examination scope period. A random sample of 107 claims was selected for review and the findings of the review are as follows:

FINDING 1: In four instances of the 107 claims reviewed, an error percentage of 3.7%, 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.

CLAIMS CLOSED WITHOUT PAYMENT

The Company reported a universe of 425 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 2: In one instance out of 83 claims reviewed, an error percentage of 1.2%, 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 violation.

FINDING 3: In one instance out of 83 claims reviewed, an error percentage of 1.2%, the Company failed to maintain reasonable claims records, in violation of Section 627.318, F.S.

COMPANY RESPONSE: The Company agreed with the violation.

REOPENED CLAIMS

The Company identified a universe of 2,818 Hurricane Michael claims that were reopened as an additional claim that had previously been adjusted pursuant to the initial claim. A random sample of 108 claims was selected for review and the findings of the review are as follows:

FINDING 4: In one instance out of 108 claims reviewed, an error percentage of 0.9%, 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 violation.

FINDING 5: In one instance of the 108 claims reviewed, an error percentage of 0.9%, 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 violation.

FINDING 6: 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.

OPEN CLAIMS AS OF AUGUST 30, 2019

The Company reported a universe of Hurricane Michael claims that were open as of August 30, 2019. A random sample of 105 claims was selected for review and the findings of the review are as follows:

FINDING 7: In seven instances of the 105 claims reviewed, an error percentage of 6.7%, 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.

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; 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; and
- Eliminate the ability for unlicensed or un-appointed claims adjusters to participate in claims activities.

CONCLUSION

This targeted market conduct examination of FedNat 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 403 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 FINAL REPORT SUBMISSION

The Office hereby issues this Final Report based upon information from the examiner's 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 staff's adherence with processes and procedures.

The Company uses an automated policy and claims administration application. All related documents are scanned and housed in ImageWrite software.

In anticipation of a pending catastrophic weather event, the Company's Catastrophe Operations Center begins preparations based on the anticipated location and severity of the storm. Immediate action is taken to ensure that sufficient resources are in place to maximize a timely response to agents and policyholders and to process claims as quickly as possible following an event. The Company has an Agent Advocate Team that makes outbound calls to agents in the forecasted impact zones in advance of landfall to open a line of communication and address any urgent needs of agents and policyholders. Additional team members are added to the First Notice of Loss (FNOL) group in anticipation of an increased number of reported claims. Insureds can report a claim by using an online portal or by calling and speaking to a FNOL team member. All claim details are entered into a claim database by desk adjusters, management, and customer service staff.

Based on the anticipated severity and the expected volume of claims received, the Company ensures a sufficient number of desk adjusters are on site at landfall to maximize outbound calls to insureds on newly reported claims. All desk adjusters used for CAT events have been trained to ensure compliance with the Company's protocols for timely processing of claims. On an annual basis and as a part of the certification process, the Company trains the adjusters on current or updated claims handling procedures. The Company's protocol is to have desk adjusters make contact with insureds within 24-hours after every reported claim. The Company was determined to have met this standard in 98% of the claim files reviewed. The Company primarily utilizes independent adjusting firms during catastrophic events to provide timely inspections and to provide detailed loss reports. The field assignments are monitored by management using XactAnalysis software which tracks the progress of all claims in real time. The Company monitors the performance of vendor partners to ensure they are meeting the Company's timelines of contact with the insured within one day, conducting the inspection within three days, and submission of a final report to the Company within five days. The Company was determined to have met the three-day inspection standard in 95% of the claim files reviewed. In several instances, insureds requested to delay the inspection due to scheduling conflicts. All independent adjusting firms attend annual FedNat-specific training courses in addition to event-specific training prior to field deployment.

Once the Company's adjuster completes the Final Inspection Report the Company's goal is to review and process the reports as quickly as possible. Many are finished within 24 to 48 hours post submission. The desk adjuster processes the claim, issues claims payments due, and contacts the insured to explain the settlement amount. The insured is sent a settlement letter with a copy of the estimate created by the field adjuster. Supplemental claim procedures are explained to the

policyholder at that time so they are aware of what to do should they find additional damages that exceed the field adjuster’s initial estimate.

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 314 claims files reviewed for this purpose during the examination. Based on the Company’s response, 38 claims, or 12.1% of the claims reviewed, had one adjuster assigned throughout the lifecycle of the claim; 146 claims, or 46.5% of the claims reviewed, had two to three adjusters assigned; and 75 claims, or 23.9% of the claims reviewed, had four to five adjusters assigned throughout the lifecycle of the claim. In two cases, the Company reported 9 claims adjusters were assigned to a single claim.

Number of Adjusters Assigned	Number of Claim Files	Percentage
1	38	12.1%
2	72	22.9%
3	74	23.6%
4	38	12.1%
5	37	11.8%
6	29	9.2%
7	12	3.8%
8	12	3.8%
9	2	0.6%
Total	314	100%

During any catastrophic event, the Company’s Customer Service Team is staffed to ensure policyholders experience minimal wait times. During the past several events, insured’s experienced wait times of less than 30 seconds in order to speak with a live representative. In January 2019, the Company changed the phone routing protocol for desk adjusters to ensure calls are automatically forwarded to the Customer Service Queue should a desk adjuster be on the phone or away from their desk and unable to take the call. Calls are then routed to supervisors and others to assist. This reduced the number of complaints related to an insured’s inability to speak a desk adjuster. The Company’s main focus during any catastrophic event is to provide the policyholder with timely claim processing with a high level of customer service.

To complete the examination, the examiners accessed the Company’s claims system to review claims files and other pertinent documentation.

Notice of Loss and Acknowledgement Letter

The majority of claims files reviewed contained an Acknowledgement Letter (“Letter”) which was mailed or emailed to the claimant to inform them that the Company was in receipt of their notice of loss. This is noted as the beginning of the claims process. Included in the Letter is an explanation of the overall claims process and an introduction by the Company to the internal adjuster assigned to the claim who is responsible for initial contact with the insured and who processes the claim

once the estimate or report is received by the independent adjusting firm. The Letter names the independent adjusting firm who is responsible for contacting the claimant to set up an appointment to inspect the damages.

The Letter provides claimants with information concerning their rights to fair and timely handling of their residential property insurance claim and the right to attend a mediation conference with the insurer in order to settle any claim disputes that may arise with the insurer. If the claimant and insurer fail to agree on the amount of the loss, either may demand mediation or demand an appraisal of loss. If the claimant chooses to have an appraisal, each party will choose a competent appraiser within 20 days after receiving a written request from the other.

Supplemental Claims

Certain claim files reviewed were reopened to consider the payment of supplemental claims after the insured or a third-party vendor submitted information to the Company in addition to the original loss. Litigation of the initial claim was another reason noted for the Company reopening claims.

If the insured presented a supplemental claim after the Company made an initial claim payment, another 90-days would begin upon receipt of the supplemental information, not the original claim submission.

It was noted that the Company was responsive to policyholders during the claims process. In 99% of the claim files reviewed, the Company maintained adequate and appropriate claims documents; however, it was noted that in some instances the files contained duplicate copies of the same documents.

FedNat's Response: FedNat utilizes two main systems to adjust claims. Our transactional system of record, PTS, contains the notes input by adjusters, policyholder information and transactional data. Our other system, ImageRight, is utilized to "house" documentation on the file. ImageRight is also used for workflow purposes and communication between adjusters and their management team. This can cause some documents to be duplicated, as the proposed letter would be sent to the manager within ImageRight on one date and then the final copy would also be in ImageRight, after the approval. This process does cause some duplication, but those familiar with the system are able to navigate and handle appropriately.

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@flor.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.