REPORT OF THE TARGET MARKET CONDUCT EXAMINATION FOR THE MAINE BUREAU OF INSURANCE

OF

YORK INSURANCE COMPANY OF MAINE
PORTLAND, MAINE.
AS OF AUGUST 31, 2002

STATE OF MAINE
BUREAU OF INSURANCE
IT IS HEREBY CERTIFIED THAT THE ANNEXED REPORT OF A TARGET MARKET CONDUCT EXAMINATION FOR

YORK INSURANCE COMPANY OF MAINE

has been compared with the original on file in this bureau and that it is a correct transcript therefrom and of the whole of said original.

IN WITNESS WHEREOF,

I have hereunto set my hand and affixed the official seal of this Office at the City of Augusta this

8th day of November, 2004

____
Alessandro A. Iuppa
Superintendent
Bureau of Insurance

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May 29, 2004

Honorable Alessandro A. Iuppa, Superintendent
Department of Professional and Financial Regulation
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Dear Superintendent Iuppa:

Pursuant to your authority delegated under the provisions of 24-A M.R.S.A § 223 and in accordance with your instructions, a target market conduct examination of the business practices and affairs has been conducted on:

York Insurance Company of Maine

707 Sable Oaks Drive
South Portland, ME 04106

A Maine property and casualty insurance company hereinafter referred to as “York” or the “Company.” The examination was performed at the Company’s statutory home office located at 707 Sable Oaks Drive, South Portland, ME 04106.

The report of examination is herewith respectfully submitted.

SCOPE OF EXAMINATION

This target market conduct examination of the Company covered the 20 month period from January 1, 2001 through August 31, 2002 and did not include a review of material events which occurred subsequent to the examination cut-off date.

This examination was conducted pursuant to the provisions of 24-A M.R.S.A § 221 and 223 and in accordance with procedures and guidelines outlined in the Market Conduct Examiners Handbook as adopted by the National Association of Insurance Commissioners (NAIC) and/or agreed upon procedures approved by the Maine Bureau of Insurance (BOI).

The purpose of the market conduct examination was to determine the Company’s ability to fulfill and manner of fulfillment of its obligations, the nature of its operations, whether it has given proper treatment to policyholders, and its compliance with specified sections of the Maine Insurance Code, — 24-A, Maine Revised Statutes Annotated (M.R.S.A), and Bureau of Insurance Rules (Rules). Specifically, this target market conduct exam was undertaken in response to an increase in excess of 100% in the number of hearing requests pursuant to the Maine Property Insurance Cancellation and Control Act and the Maine Automobile Insurance Cancellation and Control Act. This report is primarily confined to comments on matters which involve departures from laws, rules or which are deemed to require special explanation or description.

A large percentage of the files sampled under this section involved the nonrenewal of homeowners' insurance policies. Utilizing the Bureau's historical interpretation of the standard for nonrenewal found in 24-A M.R.S.A. § 3051, the number of files failed for not meeting the statutory standard was higher than the error rate indicated in the tables below. Subsequent to the examination, the Maine Law Court rendered a decision, York Ins. Co. of Maine, Inc. v. Supt. of Insurance, 2004 ME 45 (April 7, 2004), that provided the first definitive guidance on how the statutory standard as it existed during the time of examination should be applied. The court's interpretation differed from the Bureau's historical interpretation. This decision prompted a second review of the sampled files applying the court's interpretation, and as a result, the Company's error rate for compliance with the standard for nonrenewal decreased substantially. The final results of this second review are reflected in the tables located under Complaint Handling Standard #5 and Cancellation and Nonrenewal Standard #1. Testing of the Company's underwriting practices did not indicate it acted in an unfairly discriminatory manner.

In order to determine the practices and procedures of the Company's operations, one or more of the following procedures were performed in each phase:

1. The Companies' policy and procedures manuals and/or memoranda were evaluated.
2. Samples of files were selected from various populations and each file was then reviewed with the results of testing for various attributes recorded in the examination workpapers.
3. The Companies responded to a series of memorandums requesting information or written inquiries regarding the results of the files being examined.

This examination was comprised of the following six phases:

Company Operations & Management
Complaint Handling
Producer Licensing
Policyholder Service
Underwriting & Rating
Claims Handling

SAMPLING PROCEDURES & DETAILS

COMPLAINT HANDLING

A judgmental sample size of 25 Bureau complaints was randomly selected from a total population of 210 complaints made during the period under examination. However, three files selected were also included in the sample of hearing files. These files were not replaced so a total of 22 Bureau compliant files were tested. A judgmental sample size of five internal complaints was randomly selected from a total population of 12 direct consumer complaints made during the period under examination. Therefore, a total of 27 complaint files were tested.

A sample size of 50 hearing files was randomly selected from a population of 107 hearing files.

PRODUCER LICENSING

No sample was selected. An analytical comparison was made between the biennial reports made to the Bureau and the Company appointment agent listings.

POLICYHOLDER SERVICE

With regard to premium and billings notices, the same 60 files selected for the underwriting standards below were utilized.

With regard to policy and endorsement issuance or renewal, a judgmental sample size of 75 Cancelled and Non-Renewed files was randomly selected. Insureds requested 19 of the cancellations of which six were mid-term cancellations.

UNDERWRITING & RATING

With regard to underwriting standards, a judgmental sample size of 50 in-force policies plus 10 new policies, a total of 60 files was randomly selected.

With regard to a complete rating review, ten files were judgmentally selected from the 60 policies in the above sample for underwriting standards. Five were homeowners policies and five were personal automobile policies.

CANCELLATIONS & NON-RENEWALS

A judgmental sample size of 75 cancelled and non-renewed policies during the period under examination was randomly selected as follows: 47 homeowners policies and 28 personal automobile policies.

CLAIMS HANDLING

With regard to paid claims, a judgmental sample size of 20 claims was randomly selected With regard to denied claims, a judgmental sample size of 30 claims was randomly selected.

COMPANY OPERATIONS AND MANAGEMENT

HISTORY & PROFILE

The Company became chartered December 28, 1987 subsequent to the demutualization of the former Maine Bar Association Mutual Title Insurance Company. The Company’s charter was acquired December 29, 1987 by York Holding Company. York Holding Company was a newly formed Delaware corporation. The Company was a member of a pooling agreement with York Mutual Insurance Company until June 30, 1993. Effective July 1, 1993, the pooling agreement was terminated as part of the plan of reorganization of the York Mutual Insurance Company.

Effective August 5, 1997, Commercial Union Insurance Company, a Massachusetts company, acquired the Company and changed its name to Commercial Union York Insurance Company. Commercial Union Insurance Company was a wholly owned subsidiary of CGU Corporation, a Delaware corporation, which in turn, was owned by CGNU plc, a United Kingdom company. On June 1, 2001, CGU Corporation was acquired from CGNU plc, by Bermuda-based White Mountains Group, Ltd. The Company continued to operate under the name of CU York of Maine until October 11, 2001 when the Company's name changed to York Insurance Company of Maine. All of the outstanding capital stock of the Company is owned by OneBeacon America Insurance Company, formerly Commercial Union Insurance Company, an indirect, wholly owned subsidiary of White Mountains Insurance Group Ltd. The Company, through common management and use of joint facilities, operates as a member of the OneBeacon Insurance Group.

The Company is licensed in Maine for the lines of Health, Fire, Allied Lines, Farmowners Multi Peril, Homeowners Multi Peril, Commercial Multi Peril, Ocean Marine, Inland Marine, Earthquake, Workers' Compensation, Other Liability, Products Liability, Auto Liability, Auto Physical Damage, Fidelity, Surety, Glass, Burglary and Theft, Boiler and Machinery, and Credit. Currently the Company only writes Property and Casualty insurance business in Maine.

During the examination period the Directors and Officers of York were as follows:

Name	Position
Alex Archimedes	Director
Andrew Carnase	Director
John Cavoores	COO & Director
Charles Chokel	Chairman of the Bd. & Chief Admin. Officer
Richard Howard	Director
Michael McSafly	President, CEO & Director
James Ritchie	Director
Roger Singer	Director
Beverly Gammon	Clerk
Dennis Smith	Secretary
Richard Hirtle	Treasurer

ANTIFRAUD PLAN

Company Operations and Management Standard #2*— The Company has an anti-fraud plan in place. 24-A M.R.S.A. § 2186.*

The Company has implemented an Antifraud Plan in compliance with 24-A M.R.S.A. § 2186.

ADEQUACY OF RECORDS

***Company Operations and Management Standard #3** — Records are adequate, accessible, consistent, and orderly and comply with state record retention requirements. 24-A M.R.S.A. §§ 3408 (1) and 3410.*

The Company was unable to supply 2 hearing files and 1 complaint file out the 77 files requested. Not retaining and maintaining records is a violation of 24-A M.R.S.A. § 3408 (1). To destroy the records prior to the examination would be a violation of 24-A M.R.S.A. § 3410.

The Company was requested to prepare listings of: (1) all internal and Bureau complaints during the period under examination (including hearing files), (2) Maine producers licensed and appointed on January 1, 2001 through August 31, 2002, (3) in-force policies for the period January 1, 2001 through December 31, 2001, reconciled to the 2001 annual statement and January 1, 2002 through August 31, 2002, (4) policies non-renewed or canceled during the examination period, (5) claims paid from January 1, 2001 through December 31, 2001, reconciled to the 2001 Annual Statement, and claims paid from January 1, 2002 through August 31, 2002, (6) claims denied from January 1, 2001 through August 31, 2002. The Company agreed to prepare the above listings prior to the beginning of the examination fieldwork.

The only listing that was complete and available for sampling at the beginning of fieldwork was the hearing files. All other listings had to be reprocessed a second time to derive an accurate population for sampling which extended the examination.

COMPANY COOPERATION

***Company Operations and Management Standard #4** — Records are adequate, accessible, consistent, and orderly and comply with state record retention requirements. 24-A M.R.S.A. §§ 223, 3408 and 3410].*

The Company signed a Records Availability Letter agreeing to a 96-hour turn-around on written requests for information. If the request could not be responded to within the 96- hour time frame, it was agreed the Company would notify the examiners within 24 hours of receiving the request, for an extension. The Company did not meet the 96-hour turnaround for 66 out of 78 (85%) requests. The Company never requested an extension or submitted an explanation for why the documents and/or files were not available in the agreed upon time frame. The Company average time frame for returning requests was 19 calendar days. The longest time to return a request was 57 calendar days.

When an inquiry was submitted to the Company, the form requests a response within five work days. The Company did not meet this standard for 42 out of 53 (79%) of the inquiries. The Company's average response time to inquiries was 25 calendar days. The longest time was 52 calendar days.

Other than unacceptable response time to inquiries and requests, the Company personnel in the Portland office were very helpful. The employees were timely in supplying manuals, hardware

for access to the Company systems, training for gathering information from the systems, answers to questions about information in the system and manuals, and help when systems problems arose.

REVIEW OTHER STATES' MARKET CONDUCT REPORTS

***Company Operations and Management Standard #5** — Review copies of all market conduct examination reports from any state issued or conducted on the Companies within the examination period.*

A copy of the only external market conduct examination completed during the examination period, by the New Hampshire Department of Insurance, was reviewed. The examination was completed for commercial lines and two comments were noted: (1) inadequate documentation to support workers compensation class codes and general liability risks; and, (2) and misclassification of workers compensation and general liability risks. It was noted there had been improvement in these areas since the prior examination by the New Hampshire Department of Insurance.

INTERNAL AUDITS

***Company Operations and Management Standard #6** — Review copies of all internal audits conducted by the Company within the examination period.*

Three internal claim audits and one underwriting internal audit were performed by the Company on personal lines business during the examination period and were reviewed.

Issues contained in the reports regarding claims were as follows: performance issues due to under staffing, communication lag-times and timely follow ups, timely settlement discussions, deterioration in timely reserving, and insufficient documentation.

Issues contained in the underwriting report were as follows: the restrictive regulatory environment as respects non-renewals and exceptions to the acceptance standards should be done selectively, the combined unsatisfactory and marginal risk quality percentage should be 5%, not 11%, and closer attention should be paid to post-loss underwriting, 30% of the sample was found unsatisfactory.

CERTITICATES OF AUTHORITY

***Company Operations and Management Standard #7**— The Company is licensed for the lines of business being written. 24-A M.R.S.A. § 404.*

The Company is licensed for the lines of business being written in Maine.

COMPLAINT HANDLING

SUPERINTENDENT AND INTERNAL COMPLAINTS

Complaint Handling Standard #1*— The Company's handling system has been approved by the Board of Directors.*

Verification that the Board of Directors had endorsed the complaint handling and hearing procedures was not provided. However, the Company did provide its procedures in place during the examination period. Complaint procedures were changed and implemented during the examination.

Complaint Handling Standard #2*— The Company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, regulations and contract language. 24-A M.R.S.A. § 220.*

In one response to an inquiry (insured complaint) from the BOI, the Company provided inaccurate information about its Platinum Customer Credit scoring procedure, which does not take the loss history of an insured into consideration.

In a second file, the Company provided an insured with 29-days advance notice of cancellation therefore the Company was in violation of 24-A M.R.S.A § 2916-A. In a third file, the Company issued a notice of cancellation, stating the property was vacant. The property was not vacant, therefore the Company was in violation of 24-A M.R.S.A. § 3049.

The results are summarized below:

	Complaint Standard No. 2	
Result	Number	Percent
Passed	24	89%
Failed	3	11%
	27	100%

Complaint Handling Standard #3*— The time frame within which the Company responds to Bureau complaints is in accordance with applicable statutes, rules and regulations. 24-A M.R.S.A. §§ 220 and 3408.*

In testing the personal lines hearing files, two files were failed. One file did not document receipt of the complaint; therefore the receipt date could not be confirmed and the file was failed. In addition, the Company could not provide one complaint file, which was either not logged properly, or it did not retain the formal complaint from the BOI. Failure to retain and maintain records is a violation of 24-A M.R.S.A. § 3408 (1).

The results are summarized below:

Result	Complaint Standard No. 3 Insufficient Documentation Number	Percent
Passed	48	96%
Failed	2	4%
	50	100%

OneBeacon provided its first complaint listing with four of the Portland office complaints missing from the listing. Therefore, the OneBeacon listing was not complete and did not include all the complaints from all Maine locations. The Company failed to maintain its complaint log as indicated in its procedures. An updated listing was provided prior to complaint file sampling.

The Company's Complaint Handling Procedures do not specify the time frame within which a complaint should be addressed. Two files tested indicated the Company did not timely respond to BOI inquiries. For one file, the initial response was made 35 days after receipt of the inquiry and in the other 19 days after receipt. The Company was not in compliance with 24-A M.R.S.A. § 220 when it did not respond within 14 days of receipt of the inquiry. The Company agreed in both instances that it had not replied timely.

The results are summarized below:

Result	Complaint Standard No. 3 Untimely Response Number	Percent
Passed	25	93%
Failed	2	7%
	27	100%

Complaint Handling Standard #4 *— The Company has adequate complaint handling procedures in place. 24-A M.R.S.A. § 3408.*

The complaint procedures include methods for distribution and recording of complaints. However, the Company's response to complaints did not mention either analysis of complaints to identify areas developing complaints or communication of complaint procedures to policyholders. For one file tested, it was not possible to estimate a time- frame for resolution of the complaint because the file documentation was inadequate, therefore, the file was failed.

The results are summarized below:

Complaint Standard No. 4		
Result	Number	Percent
Passed	26	96%
Failed	1	4%
	27	100%

The Company stated it only recognizes complaints that are in writing (other than BOI calls to its office). Therefore, the Company does not provide a telephone number or address for consumer inquiries and complaints. The Company stated most insured's contact their agent prior to attempting to contact the Company and does not log phone calls and does not record them as complaints.

Complaint Handling Standard #5 *— If hearing was for cancellation/non-renewal, determine if the notice and the cancellation/non-renewal reason is in accordance with applicable statutes, rules and regulations. 24-A M.R.S.A. §§ 2908, 3049, 3051, 3054, 3007, 3050, 2914, 2915, 2916-A, 2917 and 2920.*

A hearing file is one in which a policyholder has requested a hearing before the Bureau about a proposed cancellation or non-renewal and as a result the Bureau held an administrative hearing on the matter.

In testing the Personal Lines Hearing files, 10 of the 50 files were failed for violating one or more laws.

One of the 10 files failed above, also failed to comply with the requirements of the hearing officer. The Company re-tiered the insured at renewal after the Officer had instructed the Company to renew coverage on the same terms and conditions, therefore the Company was in violation of 24-A M.R.S.A. § 3054. For the fifty files tested, the Company lost the hearing in 10 cases, it won in 12 cases, the hearing was canceled by the insured in 11 cases (insured usually replaced coverage) and in 17 cases the Company agreed to reinstate the coverage prior to a hearing. Of the 17 cases reinstated, there are times when the Company reinstated because the insured agreed to changes in the property (homeowners) and times when it reinstated because it had determined internally that it would lose the hearing. The files were failed for violations of 24-A M.R.S.A. §§ 2914, 3051, and 3054.

The results are summarized below:

Complaint Standard No. 5		
Result	Number	Percent
Passed	40	80%
Failed	10	20%
	50	100%

PRODUCER LICENSING

Producer Licensing Standard #1 *— The Company 's policy of producer appointments and terminations does not result in unfair discrimination against policyholders. 24-A M.R.S.A. §§1420-M, 1420-N 1420-0, 2162, 3049, 3007, 2914 and 2916-A.*

When an agency is terminated the Company procedures state in part, "... the Company will issue a legal notice to the policyholder advising that the agency no longer represents OneBeacon. We must notify the customer that they have the option to continue coverage through another One Beacon agency; however we will encourage the customer to contact the existing agency to make arrangements with another carrier." The written Company procedures comply with the standards indicated in Bulletin 316.

No exceptions were noted during the testing of Producer Licensing.

POLICYHOLDER SERVICE

Policyholder Service Standard #1 *— Premium and billing notices are sent out with an adequate amount of advance notice.*

The Company issued premium and billing notices timely for all renewal business and endorsements.

Policyholder Service Standard #2 *— Policies and endorsements are issued or renewed accurately, timely and completely and insured requested cancellations are made timely.*

Ten of the 60 underwriting files reviewed were not renewals and therefore were not included in the testing of this standard.

Six policies were processed in 30 days or less, therefore the Company failed to process six of the 50 in-force policies at renewal in a timely manner in accordance with Company standards.

The results are summarized below:

Policyholder Service Standard No. 2
Timely Policy Issuance

Result	Number	Percent
Passed	44	88%
Failed	6	12%
	50	100%

There were 16 policies in the sample of 60 underwriting files which contained endorsements, The Company standard used to determine timeliness of issuance was 12 calendar days. Four files containing five endorsements failed to meet the timeliness standard.

The results are summarized below:

Policyholder Service Standard No. 2 Timely Endorsement Issuance		
Result	Number	Percent
Passed	11	73%
Failed	4	27%
	15	100%

Insureds requested 19 of the cancellations of which six were mid-term cancellations. The Company averaged nine calendar days to process a mid-term cancellation which was an average of 20 calendar days from the date the insured signed his/her request. The longest number of days from the date of the insured's signature was 48.

One of the six insured requested mid-term cancellations was failed for processing over seven days from the date the Company received the request and, therefore, not in accordance with Company standards. Another was failed for un-timeliness created by the agent for causing more than 13 calendar days from the date the insured's signature was received until the request was processed by the Company. Two of the files contained both of the above failures. Therefore, a total of four files contained six failures for untimely processing of mid-term cancellations and did not comply with Company standards.

The results are summarized below:

Policyholder Service Standard No. 2 Mid-Term Cancellations		
Result	Number	Percent
Passed	2	33%
Failed	4	67%
	6	100%

Four of the remaining 13 insured requested cancellation files were at the end of a policy period of coverage and were failed for not being timely in accordance with Company guidelines when agents failed to provide the insured's cancellation request to the Company within 13 calendar days of the insured's signature. The longest number of days from the date of the insured's signature was 74.

The results are summarized below:

Policyholder Service Standard No. 2 End-of-Coverage Cancellations		
Result	Number	Percent
Passed	9	69%
Failed	4	31%
	13	100%

UNDERWRITING AND RATING

RATING PRACTICES

Rating Practices Standard #1 *— The rates charged for the policy coverage are in accordance with filed rates or the company-rating plan. 24-A M.R.S.A. §§ 2162, 2303 and 2304-A.*

Ten files were judgmentally selected from the 60 files in the underwriting sample to perform a complete rating review. Of these ten files tested, none were failed. However, four of the five automobile files tested had one-dollar miscalculations for medical payments when the passive restraint discount was applied. Each one-dollar difference in rating was determined to lower the insured's premium. In addition, the collision coverage premium calculation for one policy was $2 less than the amount calculated with manual rules. The Company could not determine the reason for the incorrect calculation. Because these errors lowered the insureds' premium, they were not considered failures.

The Company has filed and received approval for its manual homeowner guidelines for rule 501 which is for Replacement Cost on Coverage "A" of the dwelling. When the Company filed for Rule 501 it did not file how or where the computation would be applied to the base premium. The Company is applying the percentage applicable (1.01) under sequence "d." The Company was not found in error for the files rated with this endorsement because it is the same sequence location applied to Replacement Cost for Personal Property and appears to be appropriate.

It is recommended the Company make an additional filing for its Personal Lines Manual *(Procedures for Determining Policy Premium)* to clarify the sequence for computation when Rule 501 is to be applied.

Rating Practices Standard #2*— File documentation adequately supports decisions made. 24-A M.R.S.A. §§ 223, 3408 and 3410.*

The ten in-force policy files tested contained adequate documentation for rating purposes.

UNDERWRITING PRACTICES

Underwriting Practices Standard #1 *— The Company 's underwriting practices are not unfairly discriminatory. The Company adheres to applicable statutes, rules and regulations and Company guidelines in selection of risks. 24-A M.R.S.A. §§ 2152 and 2162.*

The Company re-tiered five insureds, out of the 60 files tested, when its underwriting guidelines clearly indicated the insured qualified for another rating tier. Therefore, the Company was not in compliance with its filed and approved rating guidelines which is in violation of 24-A M.R.S.A. § 2316.

The results are summarized below:

Underwriting Standard No. 1 Company Adheres To Guidelines		
Result	Number	Percent
Passed	55	92%
Failed	5	8%
	60	100%

The same five files were also failed for unfair discrimination by not applying the same treatment among all insureds having like insuring or risk characteristics, which is a violation of 24-A M.R.S.A. § 2162 (2).

The results are summarized below:

Underwriting Standard No. 1 Unfair Discrimination		
Result	Number	Percent
Passed	55	92%
Failed	5	8%
	60	100%

- The application of the Platinum Credit program, which is based on credit scoring, was determined to be applied fairly (credit score of over 750) to all insureds that applied. However, from notes in files and answers to requests, it appears the agents do not always pursue the consent form from all applicants. The Company stated that some agents were reluctant to ask some applicants. The credit check and the Platinum Credit should be available to all applicants and qualified insureds at renewal. When it is not made consistently available to all potentially qualifying applicants, this could result in unfair discrimination pursuant to 24-A M.R.S.A. § 2162 (2). The agents should not predetermine who is asked for a credit check based on a “supposed knowledge” of the applicant. It appears the application should contain an area to acknowledge an offer for a credit check and the availability of the Platinum Credit program.

It also appears that a credit check should be offered at renewal if the insured did not qualify when applying, because the financial position of the insured may have changed and therefore be eligible for the credit at renewal, when not eligible at policy issuance.

In addition, once an insured has qualified for the Platinum credit and it is applied to his/her policy, it is never removed. The Company does not complete another credit score check at each renewal. Therefore, the insured may no longer qualify for the credit and he/she continues to have it applied to his/her policy premium. This could also be construed as unfairly discriminatory, and therefore, a violation of 24-A M.R.S.A. 2162 (2).

- The Company has a non-smoker credit it allows for homeowner policies. It does not appear to be applied fairly to all applicants, when it is not, the Company is in violation of 24-A M.R.S.A. 2162 (2). If the applicant checks the box on the application that there are no smokers living in the household it would appear the credit should be applied. However, it is mandatory for the insured to fill out a "non-smoking statement." If the agent fails to recognize the insured has checked the non-smoking box on the application and does not provide the applicant the "non-smoking statement," the applicant does not receive the credit he/she is entitled.
- During testing of CustomPac files (automobile policy, homeowner policy and can add an umbrella policy) (all file review for rating, underwriting, cancellations/non- renewals and complaints/hearings), it was noted the Company (in non-renewal and cancellation notices) had differing statements to its insureds on how to continue with the policy that was not canceled as part of the multi-policy CustomPac. Some notices stated the insured must re-apply, others stated coverage would be granted for the other policy and one notice canceled both policies incorrectly.

The Company stated it was advised by the BOI not to require a new application. The Company implemented its new procedures after the end of the examination period. Therefore, testing was not performed to determine if the current CustomPac cancellation and non-renewal notices contain BOI compliant language.

Company employees know that some agents do not allow the practice of issuing policies without a down payment. When some agents don't allow applicant's to bind coverage without a down payment, it appears those applicants are being unfairly discriminated against and therefore a violation of 24-A M.R.S.A § 2162. The Company stated, "All agents are given the option of submitting a new business application without a deposit premium.

- The Company filings for increases in base rates state in part, "For New and Renewal business "processed" on or after. . ." The Company uses the base rate effective when the policy is issued or renewed. Therefore, two applicants (new business) or insureds (renewals) could have the same policy effective date and different base rates used for rating purposes. If this actually occurred, the Company would be in violation of 24-A M.R.S.A. § 2162(2).

Base rates should be changed (according to filing dates) and implemented based on policy effective dates; only in this manner can the Company ensure that all base rates will be fair and not unfairly discriminatory.

Underwriting Practices Standard #2*— File documentation adequately supports decisions made. 24-A M.R.S.A. §§ 223, 3408 and 3410.*

The Company failed to maintain adequate documentation (endorsement missing) to support the underwriting decisions made in one file. Therefore, the Company was in violation of 24-A M.R.S.A. § 3408.

The results are summarized below:

Underwriting Standard No. 2		
Result	Number	Percent
Passed	59	98%
Failed	1	2%
	60	100%

Underwriting Practices Standard #3*— Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near the expiration, or following a claim. 24-A M.R.S.A. §§ 2162, 2304-A, 2421, 2901 and 3001.*

Underwriting decisions are generally based on information that was developed during the initial underwriting and not after the policy expired or following a claim. However, in some instances the Company has non-renewed policies based on changes in the Company's underwriting criteria when the underlying risk has not changed.

Underwriting Practices Standard #4 *— The Company does not engage in collusive or anti-competitive underwriting practices. 24-A M.R.S.A. §2152*

During the testing of files and Company practices and procedures, nothing was found to indicate the Company was engaging in collusive or anticompetitive underwriting practices.

CANCELLATION AND NON-RENEWALS

Cancellation and Non-Renewal Standard #1 *— Cancellation/non-renewal and declination notices and procedures comply with policy provisions and state laws and Company guidelines, including the amount of advance notice provided to the insured and other parties to the contract. 24-A M.R.S.A. §§ 2908, 3049, 3051, 3054, 3007, 3050, 2914, 2915, 2916-A, 2917, 2920 and 2921.*

Five files were failed because the Company failed to follow Maine statutes when canceling or non-renewing a personal lines policy.

The results are summarized below:

Cancellation/Non-Renewal Standard No. 1 Company Adheres To guidelines		
Result	Number	Percent
Passed	70	93%
Failed	5	7%
	75	100%

One file was failed when the Company unfairly discriminated in favor of an insured during cancellation/non-renewal, which is a violation of 24-A M.R.S.A. § 2162. The Company

indicated it had intentionally allowed an individual to terminate auto coverage and receive a pro-rata return of unearned premium which is not allowed for the type of automobile policy issued for one of the insured's vehicles.

The results are summarized below:

Cancellation/Non-Renewal Standard No. 1
Unfair Discrimination

Result	Number	Percent
Passed	74	99%
Failed	1	1%
	75	100%

Twenty two of the 75 cancellation files were insured requested cancellations. Two of these files were failed when the Company could not produce either a signed policy release, or the policy returned by the insured in compliance with contractual cancellation language in its monoline homeowner and automobile policies.

The results are summarized below:

Cancellation/Non-Renewal Standard No. 1
Policy Release Documentation

Result	Number	Percent
Passed	20	91%
Failed	2	9%
	22	100%

Cancellation and Non-Renewal Standard #2*— File documentation adequately supports decisions made. 24-A M.R.S.A. §§ 223, 3408 and 3410.*

Each file tested contained adequate information to support the decisions made, therefore no exceptions were noted.

Cancellation and Non-Renewal Standard #3 *— Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner. 24-A M.R.S.A. §§ 1449 and 2174.*

Only 41 of the 75 cancellation files were subject to return of unearned premium.

One file was failed when the Company provided a pro-rata calculation of unearned premium for a personal lines monoline automobile policy. The Company's filed and approved guidelines state the Company should short-rate (90% of pro-rata). When the Company is not consistent in applying its guidelines for unearned premium among all its insureds, it is unfairly discriminatory and a violation of 24-A M.R.S.A § 2162 (2) and § 2316. In addition, the pro-rate calculation was not consistent with its policy provisions.

In another file, the Company issued a notice of cancellation for a personal line automobile policy effective October 3, 2001. However, the actual cancellation date in the Company system was effective October 1, 2001. Therefore, the return of unearned premium was calculated incorrectly as referenced to the date on the notice to the insured.

The results are summarized below:

Cancellation/Non-Renewal Standard No. 3

Result	Number	Percent
Passed	39	95%
Failed	2	5%
	41	100%

CLAIMS HANDLING PRACTICES

PAID CLAIMS

Paid Claims Standard #1 *— Initial acknowledgement or contact by the Company with the claimant is within the required time frame. 24-A M.R.S.A. § 2164-D.*

The 20 paid claim files were reviewed for compliance with the requirements for timeliness of initial acknowledgement or contact with the insured, No errors were noted in the files tested.

Paid Claims Standard #2 *— Claims are resolved or paid in a timely manner in accordance with Maine statutes and/or regulations. 24-A M.R.S.A. §§ 2436, 2164-D and 3002.*

Two of the 20 paid claims files indicated claims payments were not timely according to the Company's standards or 24-A M.R.S.A. § 2436. One claim was not paid for 54 days after it was approved for payment and one claim was not paid for 68 days after authorization of payment. The length of time was greater than the 30-days allowed from receipt of a clean claim.

The results are summarized below:

Paid Claims Standard No. 2

Result	Number	Percent
Passed	18	90%
Failed	2	10%
	20	100%

Paid Claims Standard #3*— Claim files are adequately documented. 24-A M.R.S.A. §§ 2201 thru 2212, 3408, 3409 and 2164-D.*

Of the 20 paid claims files, two were not adequately documented and therefore did not comply with 24-A M.R.S.A. § 2164-D, which requires the maintenance of documented claim files

supporting decisions made regarding liability. The Company agreed. One file did not document the justification for the amount of the claim payment and one file did not document payment of supplementary damages and car rental expenses which had been approved for payment.

The results are summarized below:

Paid Claims Standard No. 3		
Result	Number	Percent
Passed	18	90%
Failed	2	10%
	20	100%

Paid Claims Standard #4*-- Claim files are properly handled in accordance with policy provisions and state statues. 24-A M.R.S.A. §§ 2436 and 2164-D.*

Three of 20 paid claims were not correctly paid as follows: (1) One claim was overpaid and, therefore, did not comply with 24-A M.R.S.A. § 2164-D, which requires fair and equitable settlement of claims; (2) One claim that was paid late did not receive interest on overdue amounts, and, therefore, did not comply with 24-A M.R.S.A. § 2436. The Company stated incorrectly that 24-A M.R.S.A. § 2436 applied only to health care coverage; and, (3) One claim for supplemental damages and car rental charges was not paid, and the Company is therefore not in compliance with 24-A M.R.S.A. § 2164-D, which requires prompt, fair, and equitable settlement of claims in which liability has become reasonably clear. As this claim was not paid, interest at the rate of 1 ½% per month after the due date, should be paid when the claim is paid, as required by 24-A M.R.S.A. § 2436.

The results are summarized below:

Paid Claims Standard No. 4		
Result	Number	Percent
Passed	17	85%
Failed	3	15%
	20	100%

DENIED CLAIMS

Denied Claims Standard #1 *— Initial acknowledgement or contact by the Company with the claimant is within the required time frame. 24-A M.R.S.A. § 2164-D.*

A review of the 30 denied claims files indicated that in two cases the Company did not make initial contact with the claimant within the time frame required by the Company's standards or 24-A M.R.S.A, § 2164-D, which requires acknowledgement of claims within a reasonable time following receipt of written notice by the insurer of a claim by an insured. The acknowledgements were made 31 and 61 days respectively after receipt of the claim. The Company provided evidence that it had developed an initiative to correct this problem.

The results are summarized below:

Denied Claims Standard No. 1		
Result	Number	Percent
Passed	28	93%
Failed	2	7%
	30	100%

***Denied Claims Standard #2** — Claims are resolved and denied in a timely manner in accordance with Maine statutes and/or regulations. 24-A M.R.S.A. §§ 2436, 2164-D and 3002.*

In the following denied claims, it was noted the Company did not meet the time standards of 24-A M.R.S.A. § 2164-D which requires review of claims, which may include payment or denial of a claim, within a reasonable time following receipt of written notice of claim. (1) Two claims took 123 days and 69 days respectively to process, without justifiable reason for the delay. The Company agreed. (2) One file reflected that the Company had all the documentation necessary to make the decision but did not do so for 29 days. The Company incorrectly stated that this claim was outside the scope of the examination. (3) Two files reflected that the Company did not timely notify the policyholder of the decision to deny the claim. The claims were denied 14 days and 17 days respectively after the decision to deny was made.

The results are summarized below:

Denied Claims Standard No. 2		
Result	Number	Percent
Passed	25	83%
Failed	5	17%
	30	100%

***Denied Claims Standard #3** — Claim files are adequately documented. 24-A M.R.S.A. §§ 2201 thru 2212, 3408, 3409 and 2164-D.*

Of the 30 denied claims files, one did not contain documentation adequate to determine whether the claim was appropriately processed.

The results are summarized below:

Denied Claims Standard No. 3		
Result	Number	Percent
Passed	29	97%
Failed	1	3%
	30	100%

***Denied Claims Standard #4** — Claim files are properly handled in accordance with policy provisions and state statues. 24-A M.R.S.A. §§ 2436 and 2164-D.*

The Company handling of the denied claim files tested was in accordance with policy provisions and state statutes.

Denied Claims Standard #5*— Denied and closed-without-payment claims are handled in accordance with policy provisions and state law and not with such frequency as to indicate a general business practice to engage in such activity. 24-A M.R.S.A. §§ 2164-D.*

In one denied claim file, the denial and notice of denial did not provide a reasonable basis for the action taken and, therefore, did not comply with 24-A M.R.S.A. § 2164-D.

The results are summarized below:

Denied Claims Standard No. 5

Result	Number	Percent
Passed	29	97%
Failed	1	3%
	30	100%

SUMMARY OF FINDINGS

1. The Company was unable to locate three files. See *Management and Operations Standard #3* on page 6.
2. Timeliness of preparing sampling extended the examination. See *Management and Operations Standard #3* on page 6.
3. The Company response time to inquiries and memorandum requests was not timely. See *Management and Operations Standard #4* on page 7.
4. The Company was unable to provide adequate documentation during a recent market conduct examination by the New Hampshire Department of insurance. See *Management and Operations Standard #5* on page 7.
5. Various issues were raised during internal audits of claims and underwriting. See *Management and Operations Standard #6* on pages 7 and 8.
6. The Company provided inaccurate information to the BOI in response to a complaint. See *Complaint Handling Standard #2* on page 8.
7. The Company issued a cancellation notice with only 29-days advance notice, a violation of state law and not in accordance with its procedures to mail notices 35 days in advance. See *Complaint Handling Standard #2* on page 8.
8. The Company canceled property coverage, stating it was vacant, when it was not. Vacancy should be confirmed prior to non-renewal or cancellation. See *Complaint Handling Standard #2* on page 8.
9. The Company failed to maintain its complaint log in compliance with its procedures. The Company implemented new procedures for logging complaints during the examination. See *Complaint Handling Standard #3* on page 9.
10. The Company did not respond timely to two BOI consumer complaint inquiries. It should respond in compliance with 24-A M.R.S.A. § 220. See *Complaint Handling Standard #3* on page 9.

11. The Company re-tiered one hearing file at renewal after it had lost at hearing. After receiving instructions from the Hearing Officer, the Company has discontinued this practice. See *Complaint Handling Standard #5* on pages 10 and 11.
12. Ten of the 50 hearing files were failed for violations of cancellation and non-renewal state statutes. See *Complaint Handling Standard #5* on pages 10 and 11.
13. The Company failed to process 6 of the 50 renewal policies in a timely manner pursuant to Company standards. See *Policyholder Service Standard #2* on page 12.
14. Five of the 16 files contained six endorsements which failed to meet the timeliness standard of 12 calendar days pursuant to Company standards. See *Policyholder Service Standard #2* on page 12.
15. Four files contained six failures for untimely processing of mid-term cancellations pursuant to Company standards. See *Policyholder Service Standard #2* on pages 12 and 13.
16. Four insured requested cancellation files tested were failed when the agency did not notify the Company of the insured's request in a timely manner pursuant to Company standards. See *Policyholder Service Standard #2* on page 13.
17. The Company should amend its filed underwriting and rating guidelines for Rule 501 (Property Replacement Cost), to clarify the sequence for computation. See *Rating Practices Standard #1* on page 14.
18. Five of the in force 60 files tested were failed for re-tiering an insured when the underwriting and rating guidelines did not support the new tier and each was failed again for unfair discrimination. See *Underwriting Standard #1* on pages 14 and 15.
19. The Company should develop an agency verification process in the application for insurance to ensure that all applicants are provided an opportunity to apply for the Platinum Credit program. See *Underwriting Standard #1* on page 15.
20. All non-smokers are not provided the homeowner non-smoking credit because of the non-smoking statement requirement. The Company should determine how the credit is available and apply it to all non-smoking applicants and insureds. See *Underwriting Standard #1* on page 16.
21. The Company stated its CustomPac policy cancellation and non-renewal notices have been changed to comply with BOI requirements where the insured does not have to apply again for the coverage that is not canceled or non-renewed. See *Underwriting Standard #1* on page 16.
22. The Company application of base rates after a filing should be applied by the policy effective or renewal date; currently the Company applies base rates in affect as of the processing date (unfairly discriminatory). See *Underwriting Standard #1* on page 16.
23. The documentation in one policy file was inadequate. See *Underwriting Standard #2* on pages l6 and 17.
24. In some instances the Company has non-renewed policies based on changes in the Company's underwriting criteria when the underlying risk has not changed.
25. Six 75 files tested were failed for failure to follow its own guidelines and state law when canceling or non-renewing insureds. See *Cancellation and Non-Renewal Standard # 1* on pages 17 and 18.
26. One file was failed when the Company unfairly discriminated against an insured during cancellation/non-renewal, which is a violation of 24-A M.R.S.A. § 2162. See *Cancellation and Non-Renewal Standard #1* on page 18.

27. Two files were failed when the Company could not supply evidence of a signed policy release or return of the insured's policy. See *Cancellation and Non-Renewal Standard # 1* on page 18.
28. The Company should follow the contract language and its filed and approved guidelines when calculating unearned premium refunds. See *Cancellation and Non-Renewal Standard # 3* on page 19.
29. The Company should use the correct date on cancellations/non-renewals and for calculating unearned premium refunds. See *Cancellation and Non-Renewal Standard #3* on page 19.
30. Two of the 20 paid claim files, were not paid timely after a meeting of the minds with the insured. See *Paid Claim Standard #2* on pages 19 and 20.
31. Two of the 50 paid and denied claim files did not contain adequate documentation to support the decisions made. See *Paid Standard #3* on page 20.
32. Three of the 20 paid claims were not paid correctly. See *Paid Claim Standard #4* on page 20.
33. The Company did not recognize 24-A M.R.S.A. § 2436 as applying to property and casualty lines of insurance. See *Paid Claim Standard #4* on pages 20 and 21.
34. In two of the 30 denied claim files, the Company initial contact time did not meet its standards. See *Denied Claim Standard #1* on page 21.
35. Three of the 30 denied claims were not processed timely and two of the 30 denied claimants were not notified in a timely manner. See *Denied Claim Standard #2* on pages 21 and 22.
36. One file did not contain adequate documentation to determine whether it was properly processed. See *Denied Claim Standard #3* on page 22.
37. The notice of denial in one of the 30 denied claim files did not provide a reasonable basis for the Company actions. See *Denied Claim Standard #5* on pages 22 and 23.

ACKNOWLEDGEMENT

In addition to the undersigned Yvonne Sainsbury, AIE, AIRC and Terrence J. Meagher, CIE, CFE, CPA participated in this examination.

Respectfully submitted,

____

Thomas D. McIntyre, CIE, CPCU, FLMI, APA
Examiner-In-Charge
For the State of Maine
Bureau of Insurance

HUFFTHOMAS

AFFIDAVIT

STATE OF Ohio

COUNTY OF Franklin

Thomas D. McIntyre, being duly sworn, deposes and says that the foregoing Target Market Conduct Report of Examination of York Insurance Company of Maine, as of August 31, 2002, subscribed by him is true to the best of his knowledge and belief.

____

Thomas D. McIntyre, CIE, CPCU, FLMI, APA
Examiner-In-Charge
For the State of Maine
Bureau of Insurance

Subscribed and sworn to before me on the 14 day of October, 2004.

____

Notary Public for the State of Ohio
My Commission Expires:

In and For that State of Ohio
My Commission Expires
May 14, 2007

STATE OF MAINE
COUNTY OF KENNEBEC, SS

Eric A. Cioppa, being duly sworn according to law, deposes and says that in accordance with the authority vested in him by Alessandro A. Iuppa, Superintendent of Insurance, pursuant to the Insurance Laws of the State of Maine, he has made a target market conduct examination on the condition and affairs of the

York Insurance Company of Maine

of South Portland, Maine as of August 31, 2002, and that the foregoing report of examination, subscribed to by him, is true to the best of his knowledge and belief.

____

Eric A. Cioppa
Deputy Superintendent of Insurance

Subscribed and sworn to before me
This 5th day of November, 2004

____
Debra L. Tozier
Notary Public
My commission expires:

DEBRA L. TOZIER
NOTARY PUBLIC • MAINE
MY COMMISSION EXPIRES JULY 29, 2010

APPENDIX A - MANAGEMENT LETTER OF REPRESENTATION

One Beacon
INSURANCE

April 14, 2003

Thomas McIntyre, CIE, APA, CPCU
For: Maine Bureau of Insurance
Huff, Thomas & Company
4700 Belleview, Suite 208
Kansas City, MO 64112

Re: Letter of Representation

This letter is in connection with the market conduct examination of York Insurance Company of Maine, as of August 31, 2002, for the purpose of determining the Company's compliance with policy provisions and the Maine Insurance Code and Rules and Regulations in regard to all phases of property and casualty personal lines. I hereby certify, to the best of my knowledge and belief, the following representations made to you during your examination.

The transactions and business affairs of York Insurance Company of Maine are conducted in compliance with the statutes, rules and regulations, and procedures of the State of Maine in all material respects, except in the instances specifically described as follows (insert NONE if there are no exceptions): None

All corporate powers are exercised by or under the authority of the duly qualified and constituted Board of Directors of the Company and the business affairs and transactions of the Company are managed under the direction of such Board of Directors, all in accordance with the duties and responsibilities conferred upon the Board of Directors by the Articles of Incorporation, By Laws, and Maine Law.

Pursuant to Title 24-A§223, we have made available to you in their entirety:

All books, records, accounts, papers, documents, and computer and other recordings in the Company's possession and relating to personal lines policies, compliance with the Maine Insurance Code and Rules and Regulations, and to all matters relating to the period under examination.

April 11,2003
To: Tom Mcintyre, CIE, APA, CPCU
Letter of Representation

There have been no:

Irregularities involving management or employees who have significant roles in the internal control structure;

Irregularities involving other employees who have a material effect on the record keeping system; or

Communications from regulatory agencies concerning noncompliance with applicable requirements, or other deficiencies therein that could have a material effect in the treatment of policyholders or other applicable persons.

Violations or possible violations of laws or regulations whose effects should be considered for disclosure in the resultant market conduct report of examination.

There is no litigation against the Company that is considered material in relation to Maine cancellations/non-renewals during the examination period.

The Company is not aware of any events occurring subsequent to of August 31, 2002, which may have a material effect on any of the above representations.

You have represented to us that this market conduct examination was made in accordance with examination standards established by the Maine Bureau of Insurance, and procedures established by the National Association of Insurance Commissioners, and accordingly included such tests of the accounting records and such other examination procedures as were considered necessary under the circumstances.

York Insurance Company of Maine

Michael J. McSally, NE President 4-14-03
(type name), (title of executive officer), Date

____
(signature)

EXHIBIT B

OneBeacon
INSURANCE

September 24, 2004

SENT VIA EMAIL & U.S. MAIL

Eric Cioppa
Department of Professional and Financial Regulation
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333

Re: Target Market Conduct Examination
York Insurance Company of Maine

Dear Mr. Cioppa,

We have reviewed the final draft of the targeted market conduct Report of Examination. The Company outlined its objections to the first draft of the Report in its response to the Bureau on February 2, 2004, and the Bureau responded to those objections in its letter dated February 18, 2004. The Company also noted objections in its letter dated August 13, 2004. The Company is reserving the original objections as set out below with respect to the final draft Report.

COMPANY OPERATIONS AND MANAGEMENT

ADEQUACY OF RECORDS

Company Operations and Management Standard #3

The Report (p.6) notes that company was unable to supply 2 hearing files and 1 complaint file, and "to destroy the records prior to the examination would be a violation of 24-A M.R.S.A. § 3410". The Company takes exception to the reference to destruction of records. These records were not destroyed prior to the examination. The Company was not able to locate the records. Therefore, we requested that the reference to destruction of records be removed from the Report. In addition, we requested that the Report reflect that the company did communicate with the examiner regarding delays in locating listings.

The Report (p. 6) notes that the only listing that was complete and available for sampling at the beginning of the fieldwork was the list of hearing files. The Company takes exception to this reference in the Report. The Company was notified of the examination via a phone call on February 10, 2003 from the contract examiner. The Company had no prior record of notice. The examiner then sent a formal letter on February 10, 2003 via email following the phone conversation. This letter was addressed to an individual that was no longer with the Company.

The start date of the exam was only 14 days after the Company received notice. Two weeks was not a sufficient period of time to properly prepare listings for the exam, and the Company expressed its concerns at the outset. Therefore, the Company requested that these statements be removed from the Report.

COMPANY COOPERATION

Company Operations and Management Standard #4

The Report (p.7) notes that the Company's response time to inquiries and memorandum requests was not timely. The Company did communicate with the examiner regarding delays or extended response times. The delay was due in part to the fact that the examiner was including hearing files in the examination that had already been reviewed by the Department. As a result, the Company needed to clarify with the Department how to respond to these requests. This required additional time to filter these questions through the Department. In addition, the statutes cited in this section do not require a specific time frame for responses during an examination. Therefore, we do not believe that this is a violation, and we requested that it be removed from the Report.

REVIEW OTHER STATES' MARKET CONDUCT REPORTS

Company Operations and Management Standard #5

The Report (p.7) makes reference to the results of a New Hampshire Market Conduct Examination, and the comments noted regarding commercial lines business. The Company objects to the inclusion of this information in the Report, as it is inappropriate for the results of another state's market conduct examination to be part of the Report. In addition, the results regarding commercial lines are not relevant to this personal lines target examination. For the above reasons, we requested that this reference be removed from the Report.

INTERNAL AUDITS

Company Operations and Management Standard #6

The Report (p.7) makes reference to issues raised during internal audits. Internal audits are conducted as a means for identifying and correcting procedures and practices relating to the day to day operations. If any deficiencies are discovered, this should not influence the findings of a regulatory examination. Therefore, we do not believe that this constitutes a violation, and we requested that this reference be removed from the Report.

SUPERINTENDENT AND INTERNAL COMPLAINTS

Complaint Handling Standard #1

The Report (p8) notes that verification that the Board of Directors had endorsed the complaint handling and hearing procedures was not provided. There was no statute or regulation cited as authority for this requirement. Therefore, we do not believe that this a violation, and we

requested that it be removed from the Report. Further, the written complaint procedures provided to the examiner were not changed during the examination, and we requested that the statement be removed from the Report.

Complaint Handling Standard #2

The Report (p.8) notes that the Company provided inaccurate information about its Platinum Customer Credit scoring procedure. The Company takes exception to this statement. This was an unintentional error as the result of a misunderstanding on the part of the individual responding, and we requested that the Report reflect this.

With regard to the statements made in the Report with respect to the alleged inaccurate information and late notice, these are not complaint handling issues but errors in the execution of cancellations. Therefore, the Company requested that these errors be removed from the complaint handling section of this Report.

Complaint Handling Standard #3

The Report (p.9) notes that certain items were missing from the listing. With respect to the complaint items missing from the initial log provided to the examiner, coordination of the recording of complaints and reconciliation at year-end with home office is now the responsibility of each office and function area and not the sole responsibility of the Portland office. This is the only procedural change that occurred.

The Report (p.9) states that the company's complaint handling procedures do not specify the time frame within which a complaint should be addressed. The company does business in a number of states and the time frame varies considerably from state to state. The company's complaint handling procedures state that "in those situations where the complaint has been sent to the company by an insurance department, adherence to that state's regulatory requirements with respect to response time is critical". Therefore, this is not a violation, and the company requested that this item be removed from the Report.

Complaint Handling Standard #4

The Report (p.10) notes that the Company's response to complaints did not mention either analysis of complaints to identify areas of developing complaints or communication of complaint procedures to policyholders. There is nothing in the law cited indicated to suggest that this is a requirement of the Maine Insurance Code. Therefore, this is not a violation, and the Company requested that this item be deleted from the Report.

The Report (p. 10) also states that the Company only recognizes complaints that are in writing (other than Department calls to its office). The Company takes exception to this general statement as it is incorrect and contradicted by the examiner's statement on page 9 that the company did not produce both telephone complaints. Therefore, this is not a violation, and the Company requested that this item be eliminated from the Report.

Complaint Handling Standard #5

The Report (p. 10) notes that the Company violated one or more laws with respect to issues that went before the Bureau for hearing. Again these alleged violations had nothing to do with complaint handling procedures and any violations involving the execution of cancellations, renewals or non-renewals should be addressed in the Underwriting and Rating portion of the Report. Therefore, we requested that these items be removed from this section of the Report.

The Report (p.11) notes that the Company retiered one hearing file at renewal after it had lost at hearing. However, after receiving instructions from the Hearing Officer, the Company had reissued the policy correctly. As this violation was corrected prior to this examination, we requested that it be removed from the Report.

POLICYHOLDER SERVICE

Policyholder Service Standard #2

The Report (p. 12) states that "There were 16 policies in the sample of 60 underwriting, files which contained endorsements." However, the chart which summarizes the results notes that there were a total of 15 policies with endorsements (11 Passed, 4 Failed) in the sample. The chart should reflect that there were a total of 16 policies in the sample (12 Passed, 4 Failed). The Company requests that this section be corrected accordingly.

UNDERWRITING AND RATING

RATING PRACTICES

Rating Practices Standard #1

The Report (p. 13-14) recommends that the Company make an additional filing for its Personal Lines Manual to clarify the sequence for computation. The Company takes exception to this recommendation. Rule 501 in the Manual indicates that the rating factor of 1.03 is applied to the BASE premium. Therefore, the company disagreed that the rule needs to be amended for clarification and requested that this statement be removed from the Report.

UNDERWRITING PRACTICES

Underwriting Standard #1

The Report (p. 15) recommends that the Company develop an agency verification process in the application to ensure that all applicants are provided an opportunity to apply for the Platinum Credit program. The Company would like to clarify that when this discount was introduced in 2000, the Company notified existing policyholders that this new discount was available and instructed the policyholders to contact their agent to determine whether or not they qualified. The Company issued another message to all renewal policyholders notifying them that this discount was available in 2003. In addition, all agents were provided training regarding the criteria for the

applicant of Platinum Credit. Therefore, the Company requested that the above information be included in the Report. The examiner was provided with this information during the examination.

The Report (p.16) notes that the nonsmoker credit for homeowner policies is not applied fairly to all applicants. The Company disagreed as it provides the nonsmoking discount to any insured providing a signed statement confirming that no member of the household smokes or has smoked during the past year. This procedure is in accordance with the manual rule filed. Therefore, this is not a violation and Company requested that it be removed from the Report.

The Report (p. 16) notes that some agents do not allow the practice of issuing policies without a down payment, and it appears that those applicants are being unfairly discriminated against. The Company disagreed with this finding as all agents are given the option of submitting a new business application without a deposit premium. If an application is issued without a deposit premium, the system generates a bill directly to the insured for the premium due. The premium is billed in accordance with filed options. As all agents are given this opportunity, this is not a violation, and the Company requested that this be removed from the Report.

The Report (p. 16) notes that base rates should be changed and implemented based on policy effective dates. The Company disagrees as it operated in accordance with the filings approved by the Maine Department. The approved filings clearly state "process date". Therefore, this is not violation and Company requested that it be removed from the Report. Notwithstanding its objection, the Company will include a new business and renewal effective date in any future filing.

SUMMARY OF FINDINGS

The Report (p. 24-27) lists a Summary of Findings. The Company hereby incorporates the objections noted in the statements above and takes exception to those findings as outlined in this response.

Please do not hesitate to contact me at _________ if you have any questions or if you would like to discuss this further. Thank you.

Very Truly Yours,
Meredith K. Mangan
Counsel

EXHIBIT C

Attached as Exhibit C is the Bureau's response to most of the issues raised in the Company's September 24, 2004 letter. In most instances, the Bureau did not agree with the Company's perspective and the exam report was not changed. However, an error in the exam report relative to Policyholder Service Standard #2 chart was revised as requested by the Company.

February 18, 2004

Meredith K. Mangan, Counsel
OneBeacon Insurance Group
One Beacon Street
Boston, Massachusetts 02108-3100

Re: Target Market Conduct Examination
York Insurance Company of Maine

Dear Ms. Mangan:

The Bureau has reviewed your response dated February 2, 2004, in reference to the above-captioned draft examination report. We have considered your concerns relative to some of the statements made in the draft report and offer the comments below in response to these concerns. In addition, you have asked for information in help you identify specifically what files are referenced as having been "failed" in various parts of the report. All of the aforementioned files were the subject of inquiries during the examination. Attached to this letter is documentation relating to the subject files identifying policyholder name and number based on the information in the examiners' notes.

Under Company Operations and Management Standard # 3, you asked that the reference to destruction of records be removed from the report; This section of the report, however, does not state that the company in fact destroyed records. Instead, the report states that the company was unable to supply 3 files. While the report references two Maine laws pertaining to the maintenance and destruction of records, it does not state that the company violated either of these laws. For this reason, we believe this provision is factually correct and does not warrant a change. You also asked that this section reflect that the company communicated with the examiner about delays in locating listings. A sentence to this effect will be added in this section. Finally, you asked that statements about the lack of listings being available at the commencement of the examination be removed, as the company believes there was insufficient time to compile the requisite listings. Based on our records, the company was provided at least two weeks notice of the examination start date with a list of required records. We do not have any record that the company either objected to this timeframe or of the company indicating that there would be any difficulty in providing the required listings before the examination start date. Based on our records, it was not until the examiner was on site that there was an indication of difficulty in locating or providing the necessary listings. For this reason, we believe the current language in this section of the report is warranted. If the company has documentation dated prior to the examination start date indicating a communication that there would be difficulty in providing the requested listings, we may consider revising this section.

Under Company Operations and Management Standard # 4, you raised concerns with statements on the lack of timeliness in responding to inquiries and memorandum requests during the examination. Our understanding is that the timing for responses to such requests was agreed upon at the beginning of the examination. While we acknowledge there was some need for clarification in responding to inquiries relating to hearing files initially, we believe this was

resolved early on and only related to a rather small subset of the total inquiries sent during the examination. We do not believe, therefore, that the Bureau's agreement to review certain inquiries on hearing files had a material effect on the company's timeliness in responding to inquiries throughout the examination period. We believe this language should remain in this section of the report.

Under Company Operations and Management Standard # 5, you raised concerns about the reference to the results of a New Hampshire Market Conduct Examination. We believe the reference to this report and the two comments noted in the report are consistent with this Standard as outlined in the NAIC Examiners Handbook. Accordingly, we have not made any changes to this section.

Under Company Operations and Management Standard # 6, you raised concerns with the reference to issues raised during internal audits. We believe the reference to the internal audit and the findings of such audit are consistent with this Standard as outlined in the NAIC Examiners Handbook. Please note that the draft report does not treat the issues identified in the internal audit as "failures" for purposes of the report. We have not made any changes to this section.

Under Complaint Handling Standard # 1, you asked that the reference to a lack of verification of the Board of Directors endorsing the complaint handling and hearing procedures be removed, as you do not believe this is a violation of law. We believe this statement is factually accurate, and the report does not state this is a violation of law. You also assert that the complaint procedures were not changed during the examination period. Our records indicate that the complaint procedures were changed consistent with your statements in response to Complaint Handling Standard # 3 on page 3 of your letter dated February 2, 2004. This latter comment is not meant to imply a violation of law, but rather to note that a procedural change in complaint process occurred during the examination. For the foregoing reasons, we have not changed this section of the report.

Under Complaint Handling Standard # 2, we believe the statements on providing inaccurate information to the Bureau and relating to a cancellation notice are factually accurate based on the work papers in the examination. You stated that you believe these errors should be removed from the complaint handling section of the report. These errors were discovered in files within the sample pulled for this standard and involved violations of law detected in the complaint process. As such, we believe it is appropriate to list these errors under this standard, and we believe this is consistent with the procedures contemplated in the NAIC Examiners Handbook.

Under Complaint Handling Standard # 3, you raised a concern about the statement that the company's complaint handling procedures do not contain a specific time frame within which a complaint should be addressed. We believe this is factually accurate based on the information provided during the examination. Please note that this statement is an observation, and this is not listed as a violation of law. With respect to the failure to provide one of the two telephone complaint files, we believe this is factually accurate regardless of the reason for the inability to provide the requested files. For the foregoing reasons, we have not made changes to this section.

Under Complaint Handling Standard # 4, you stated that the referenced complaint handling processes are not specifically required by Maine law, and therefore, reference to the one failed file should be deleted from the report. We believe the processes identified here are consistent with insurers' practices generally, and 24-A M.R.S.A. § 3408 requires companies to maintain records in accordance with the usual and accepted principles and practices of record keeping applicable to the kinds of insurance transacted by the insurer. In addition, the NAIC Examiners Handbook contemplates an insurer having certain basic complaint handling processes in place. Please note, however, that the company was not failed under this section for not having complaint analysis and communication processes in place. Rather, the only file failed under this section was failed due to inadequacy of information in the file to determine the timeliness of resolution of the complaint. With respect to the statement that the company only recognizes written complaints as being "complaints" with the exception of Bureau telephone inquiries, we believe this information correctly reflects what company staff told examiners during the examination. Furthermore, we believe this statement does not contradict the reference to two telephone complaint logs on page 8 of the report, as the examiners notes indicate these files related to Bureau telephone inquiries. For the foregoing reasons, we have not made any changes to this section.

Under Complaint Handling Standard # 5, you raised a concern similar to that raised in connection with the findings under Complaint Handling Standard # 2. Our response to this comment is the same as provided above (Complaint Handling Standard # 2), and therefore, we believe these errors are correctly included in this section. With respect to the error on retiering a policy after hearing, we believe this error should be noted in this section; Although the error was corrected by the company at the direction of the hearing officer, the subsequent correction does not change the fact that the error occurred.

Under Policyholder Service Standard # 2, the report (p. 11) states that five files containing six endorsements failed to meet the timeliness standard. Upon further review of the examiner notes and work papers, it appears this statement should reflect that four files containing five endorsements failed to meet the timeliness standard. This section will be corrected accordingly.

Under Rating Practices Standard # 1, the examiners recommended that the company amend its filed manual homeowner guidelines to clarify the sequence for computation when Rule 501 is to be applied. You responded that you do not believe this requires clarification, as the rule states that a factor of 1.03 is applied to the base premium. The recommendation in the report reflects a desire to add clarification in the manual as to the sequence of computation (i.e. how or where) the factor would be applied to base premium, not whether the factor would be applied to base premium. The examiners note that the company is applying the factor under sequence "d" and did not find this to be in error. We believe the company should file a clarifying amendment to its filed guidelines to confirm the sequence of computation for this rule. If the company continues to object to the inclusion of this recommendation in the report, then we may be willing to consider incorporating this recommendation in a management comment letter in lieu of the report.

Under Underwriting Standard # 1, you asked that additional information be inserted in this section to reflect the company's efforts to notify policyholders of the availability of the Platinum Credit program. We will make note of these efforts in the report, but we remain concerned about

the apparent subjectivity associated with a producer's decision to mention the credit to applicants. For this reason, we do not intend to make further changes to this section. With respect to the statements relating to the nonsmoker credit and issuing policies without down payments, based on the information provided during the examination, we believe the processes associated with these issues are not sufficient to ensure uniformity of treatment among insureds with like insuring characteristics. Accordingly, we believe the statements in the report are warranted. With respect to the statements relating to the practice of increasing base rates on process dates of new or renewal business versus policy effective date, although we do not dispute the filing references policies "processed" after a certain date, the Bureau was not aware of the company's intentions when this filing was approved. The Bureau continues to believe that policies having the same effective date should have the same base premium applied. Otherwise, we believe the differing treatment would be considered unfairly discriminatory. We do not intend to change this section.

Under Cancellation and Nonrenewal Standard # 1, the report states that 18 of the 75 files tested were failed for not following state law and company guidelines. Upon further review of the examiner notes and work papers, we believe this section should be changed to state that 17 files were failed for violating both state law and company guidelines, and 1 file was failed for not following company guidelines only.

As stated above, attached to this letter is documentation to help identify the files referenced as having been "failed" in the various parts of the report. Please notify me within two weeks of receipt of this letter as to whether the company has any additional comments or concerns with the draft report and/or if you would like to meet to discuss these issues further.

Sincerely,

Eric A. Cioppa
Deputy Superintendent