STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

MARKET CONDUCT EXAMINATION

NUMBER 2012C-0022

August 31, 2012

TARGETED MARKET CONDUCT EXAMINATION REPORT

OF

FARM BUREAU GENERAL INSURANCE COMPANY

LANSING, MICHIGAN

NAIC COMPANY CODE 21547

For the Period January 1, 2010 through December 31, 2011

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I. EXECUTIVE SUMMARY

Farm Bureau General Insurance Company (the Company) is an authorized Michigan domiciled company. This examination was conducted by the Michigan Office of Financial and Insurance Regulation (OFIR) in conformance with the National Association of Insurance Commissioners (NAIC) *Market Regulation Handbook* (2012) (*Handbook*) and the Michigan Insurance Code, MCL 500.100 et seq. The scope of market conduct examination has been limited to the Company's activities related to the handling of Claims, Complaints Analysis and Cancellation / Non-Renewals in the Private Passenger Auto (PPA) and Homeowners (HO) lines of business. The examination covers the period January 1, 2010 to December 31, 2011.

The summary of this targeted market conduct examination of the Company is intended to provide a high-level overview of the examination results. The body of the report provides details of the scope of the examination, findings, Company responses, and OFIR recommendations.

OFIR considers a substantive issue one in which a "finding" or violation of Michigan Insurance Code was found to have occurred, or one in which corrective action on the part of the Company is deemed advisable. This examination has prompted two recommendations for Farm Bureau General Insurance Company.

Finding and Recommendation:
The review of the complaint files showed a trend that a number of Farm Bureau's insurance clients do not understand the billing process and what they are actually paying for when they submit their premium. It is therefore recommended that Farm Bureau, through their producer field force, company mailings or another method of Farm Bureau's choosing, clarify how the billing cycle works for their policyholders. This confusion was the root cause of approximately 30 percent of Farm Bureau's complaints and eliminating this confusion would ease Farm Bureau's complaint handling burden and lower their complaint ratio.

Finding and Recommendation:
The second recommendation involves the reasons for cancelling or non-renewing a Homeowners policy. When the examination team reviewed Complaints and Cancellation / Non-Renewal files, both indicated a clear problem with Farm Bureau insurance customers understanding why their Homeowners policy had been cancelled or non-renewed. In approximately 12.5% of the files, the reason for cancellation or non-renewal notice was, "Home doesn't meet the definition of an insurable dwelling", with no further clarification as to what that means. When this occurs, the insured is forced to either accept the decision without complete information or to obtain clarification by additional contact. OFIR requests that the actual reason as to how the home doesn't meet the definition of an insurable dwelling simply be included in the cancellation / non-renewal letter. This would eliminate a significant number of complaints and would help the insurance consumers of Michigan to better care for their homes.

Significant Findings:
No significant deficiencies were found in the Claims Handling, Complaint Handling, or Cancellation / Non-Renewal Handling Practices of Farm Bureau General Insurance Company.

II. PURPOSE, SCOPE AND METHODOLOGY OF EXAMINATION

This report is based on a targeted market conduct examination of Farm Bureau General Insurance Company. The examination was conducted at the Company's home offices located at 7373 W. Saginaw Highway, Lansing, Michigan 48909. OFIR conducted this examination in accordance with statutory authority of the Michigan Insurance Code, MCL 500.222 et seq. All Michigan laws, regulations and bulletins cited in this report may be viewed on OFIR's website at www.michigan.gov/ofir.

The examination covers the period January 1, 2010 to December 31, 2011. This examination was conducted under the supervision of Regan Johnson, Director of the Market Conduct Section, and Sherry J. Bass-Pohl, Manager of the Market Conduct Unit. The Examiner-In-Charge for this examination was Zachary J. Dillinger, and the on-site team consisted of EIC Dillinger and Examiner Lynella Cauther. Examiner Sherry Barrett assisted with the on-site sampling process.

The examiners evaluated the Company's market conduct procedures and treatment of policyholders in the State of Michigan. This examination focused on the specific areas of Customer Complaints, Claims Handling Practices, and Cancellation / Non-Renewal Practices for the Private Passenger Auto and Homeowners lines of business.

The examination team reviewed company records in the areas of: (1) Complaint Handling; (2) Claims Handling; and (3) Cancellations / Non-Renewals. The analysis and examination of these areas were conducted and measured according to the standards and practices in the NAIC *Handbook* and the applicable statutes in the Michigan Insurance Code.

Three types of review were utilized for the above standards. Certain standards were examined with a single review, and others were examined using one or more type of review. This statistical sample applies to the Company as follows:

1. Generic Review: A standard test was applied using analysis of general information provided as a response to examiner questions;
2. Sample Review: A "sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC *Handbook*, Chapter 14. For statistical purposes, an error tolerance of 2.3% was used when reviewing Claims samples. An error tolerance of 5.5% was used for Cancellation / Non-Renewal file samples. The sampling techniques used are based on a 95% confidence level, meaning there is 95% confidence that the error percentages shown in the various standards so tested are representative of the entire set of records from which it was drawn. An error rate in excess of the tolerance level in these sections of the report is indicative of a general business practice of engaging

in that type of conduct. Note that the statistical error tolerance is not indicative of OFIR's actual tolerance for deliberate or systematic error.

3. Census Review: Complaint files were not subject to the sampling procedure, as the number of complaints did not warrant taking a sample. Therefore, every complaint file for the examination period was reviewed by the examination team for compliance with applicable statutes, regulations and internal company guidelines.

This examination report is a report by test. The report contains a summary of pertinent information about the lines of business examined. This includes each standard, Michigan Insurance Code citation, and NAIC *Handbook* source; any examination findings detailing the non-compliant or problematic activities that were discovered during the course of the exam; the Company response proposing methods for correcting the deficiencies; and recommendation for any further action by OFIR.

III. COMPANY OPERATIONS AND PROFILE

Farm Bureau General Insurance Company began operations on July 13, 1962, as a Michigan domiciled company. They are currently licensed to market and write new insurance business only in Michigan. The Company markets and sells property and casualty lines of business. The Company's top lines of business are: Homeowners, Private Passenger Auto, and Commercial.

The Company markets and sells its products through its more than 450 producers, direct mail marketing, and public advertising. Currently, Farm Bureau General Insurance Company is rated B++ by the AM Best Company.

To be eligible to purchase insurance from the Company, a person must also be a member of Michigan Farm Bureau, the farmer's trade association for Michigan. Both organizations share a corporate headquarters at 7373 W. Saginaw, Lansing, Michigan 48909, with County Farm Bureau offices in all 83 Michigan counties. No insurance is sold from those offices; it is sold only through licensed producers.

IV. EXAMINATION FINDINGS

A. Complaint Handling

Standard 1: All complaints are recorded in the required format on the regulated entity's complaint register. NAIC *Handbook*, Chapter 16. MCL 500.2026(2).

Findings:
The examiners requested and reviewed the Company complaint register for OFIR and in-house complaints. These complaints consisted of 44 complaints for the year 2010 and 50 for the year 2011, giving a total of 94 complaints for the examination period.

After a census review of all 94 complaint files, examiners found no complaints which were not reflected on the complaint register, as required by MCL 500.2026(2). Further, examiners reviewed all OFIR complaints for the examination period and found none that were not reflected on the complaint register.

Recommendation:
No further action is required at this time. The Company appears to be in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Summary of Company Response:
There was none provided.

Standard 2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. NAIC *Handbook,* Chapter 16.

Findings:
Computerized systems automatically generate complaint response letters, and the complaint is forwarded to the relevant manager, as well as the producer responsible for that policyholder. The average file open time, from receipt of complaint to closing the complaint, is 17.4 days. This is in compliance with the Company's complaint handling timeline of 30 days. These letters automatically include the information on how to complain to OFIR, unless the complaint itself was referred to the Company from OFIR.

Recommendation:
No further action is required at this time. The Company appears to be in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Summary of Company Response:
There was none provided.

Standard 3: The Company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. NAIC *Handbook,* Chapter 16.

Findings:
After reviewing 94 complaint files (a census of all HO and PPA claims received during the examination period), examiners found no instance in which the company failed to properly address the complainant's concern. In at least three instances, when prompted by complaint, the Company appears to have paid claims for which it had no liability, in an attempt to help the complainant and to maintain a positive business relationship.

Of the 94 complaints during the exam period, the most common complaint was a misunderstanding of the Farm Bureau billing procedure. In 27 of the 94 complaints, the complainant was cancelled for non-payment of premium, despite the assertion that the complainant had paid the bill. With the way Farm Bureau bills are done (coverage is provided in advance of premium payment, resulting in a premium owed for coverage already provided), it is easy for an insured to think they are current, but in reality the account is past due for coverage already provided.

Recommendation:
The examination of the complaints showed that a number of Farm Bureau's insurance clients do not understand the billing process, and what they are actually paying for when they submit their premiums. It is therefore recommended that Farm Bureau, through their producer field force or through Company mailings, seek to clarify how the billing cycle works. This confusion was the root cause of approximately 29% of the Company's complaints from the examination period. If this were cleared up, it would eliminate many of these complaints and lessen Farm Bureau's complaint load.

Company Response:
"For many years, Farm Bureau has offered a Multi-Policy Account Billing Option to our customers. This was made available on a monthly, direct billed mode, to make premium payments as flexible and easy as possible for our policyholders. The availability of having all policies billed together on a monthly basis is appreciated by our customers. However, the mere combination of multiple policy due dates and amounts, especially when mid-term changes are made, is complex. A component of the account bill option, was the practice of "spreading" past due premiums over the remaining months of a policy term whenever a customer missed a monthly payment. This practice was also implemented to make premium payments as flexible and easy as possible for our policyholders. We know that the spread of past premiums compounded the complexity of our bills and made it difficult for policyholders to understand. To address this we implemented a change to our billing system effective September 14, 2012. This change eliminates the "spreading" of past due payments and replaces it with the practice that most consumers are accustomed to. This means that past due premiums are billed in full during the next billing period, identified as a past due amount, added to the current amount due for a billed amount total. We are confident that this recent change will produce billing documents that are clearer to our customers while remaining as flexible as possible. We continually look for ways to service and communicate with our policyholders and will be offering on-line current and historical bill presentment options in the near future."

Standard 4: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations. NAIC *Handbook,* Chapter 16.

Findings:
The Company has a response average of 17.4 days. In four complaint files, the Company's 30 day standard for closing the file was not met, but each of those files demonstrated that the delay was caused by the insured failing to submit a required document or response, not by the Company's failure to act. There are no findings.

Recommendation:
No further action is required at this time. The Company appears to be in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Summary of Company Response:
There was none provided.

B. Cancellations / Non-Renewals

Cancellation / Non-Renewal Practices Work Programs were executed on the following samples:

Type	Population	Sample Size	Max Failures	Failures
Private Passenger Auto Policies Cancelled or Non-Renewed	32805	129	7	0
Homeowners Policies Cancelled or Non-Renewed	6353	128	7	0

The following Standards and statutory citations formed the basis for the analysis of the data.

Standard 8: Cancellation/Nonrenewal, discontinuance and declination notices comply with policy provisions, state laws and regulated entity guidelines. NAIC *Handbook* Chapter 16. MCL 500.2104(6), 500.2119, MCL 500.2122, MCL 500.2123.

Findings:
From a population of 32,805 cancelled or non-renewed Private Passenger Auto policies from the examination period, a random sample of 129 files was reviewed for compliance with State of Michigan statute, rules and regulations, as well as Company guidelines. From this sample, the following information was obtained:

- 72 policies were cancelled at the insured's request.
- 43 policies were cancelled for non-payment.
- Five policies were replaced internally by the Company.
- Five policies were cancelled for not being current Farm Bureau members, which is a requirement to have a Farm Bureau policy.
- Four policies were cancelled because the policyholder did not have a valid Michigan Motor Vehicle Operators License.

All cancellations in the sample were done for statutory reasons and were in compliance with Company policy. All notices sent to Private Passenger Auto policyholders complied with the applicable statute and Company regulation. There are no findings.

From a population of 6,353 cancelled or non-renewed Homeowners policies from the examination period, a sample of 128 files was reviewed for compliance with State of Michigan statute, rules and regulations, as well as Company guidelines. From this sample, the following information was obtained:

- 63 policies were cancelled or non-renewed because the home was not owner-occupied. Many of these files specifically noted that the home was a foreclosure.
- Eight policies were ended due to the poor physical condition or substandard maintenance of the home.
- Two policies were cancelled or non-renewed for excessive claims history.
- The remaining policies, except the 16 described below, were cancelled or non-renewed for one of the following reasons: non-payment of premium, incomplete application or for having an undeclared solid fuel heating system (unacceptable increase of risk).

The above reasons are allowed under Michigan's Essential Insurance Act, MCL 500. 2101 et seq., and were properly described on the notice sent to the policyholder. The reasons were appropriate and well documented, as verified by the examination team utilizing the Company's computerized data storage systems. There are no findings with these files.

Sixteen notices from the sample listed the reason for policy discontinuance as, "Home doesn't meet the definition of an eligible dwelling". According to MCL 500.2104(6), all cancellation notices must be written in such a way that a person of "ordinary intelligence" must be able to understand the specific reason why the policy was ended. See Recommendation.

Recommendation:
When the examination team reviewed Complaints and Cancellation / Non-Renewal files, both indicated a clear problem with the Company's policyholders' understanding of why their Homeowners policies had been cancelled or non-renewed. In approximately 12.5% of the sampled Cancellation / Non-Renewal files, the reason for cancellation or non-renewal notice was, "Home doesn't meet the definition of an insurable dwelling", with no further clarification as to what that means. When this occurs, the insured is forced to either accept the decision without complete information or to obtain clarification by additional contact. OFIR requests that the actual reason as to how the home doesn't meet the definition of an insurable dwelling simply be included in the cancellation / non-renewal letter. The examination team feels this is warranted under MCL 500.2104(6), to clarify the reason for the policy's discontinuance.

Summary of Company Response:
"We believe that earlier this year we addressed this concern with our underwriting staff as a whole after individual cases were brought to our attention by the OFIR Consumer Services section. We have counseled individual underwriter in the specific cases and have scheduled an additional group meeting to reinforce this requirement. The actual reason a home doesn't meet the definition of an insurable dwelling is now included in our cancellation and non-renewal letters."

C. Claims Handling Practices

Claims Handling Practices Work Programs were executed on the following samples:

Type	Population	Sample Size	Max failures	Failures
Private Passenger Auto (PPA) Comprehensive (Comp) and Collision (Coll) with Payment	61470	88	2	0
PPA Comp and Coll Without Payment	7364	88	2	0
PPA PIP With Payment	3539	88	2	0
PPA PIP Without Payment	2692	88	2	0
Homeowners First Party Losses With Payment	20737	88	2	0
Homeowners First Party Losses Without Payment	10750	88	2	0

The following Standards and statute citations formed the basis for the analysis.

Standard 2: Timely investigations are conducted. NAIC *Handbook*, Chapter 16. MCL 500.2026(c).

Findings:
MCL 500.2026(c) requires that all claims investigations be completed within one calendar year of being notified of the loss. In all sampled files that warranted a Company investigation, said investigation was completed within one year. There are no findings.

Recommendation:
No further action is required at this time. The Company appears to be in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Summary of Company Response:
There was none provided.

Standard 3: Claims are resolved in a timely manner. NAIC *Handbook,* Chapter 16. MCL 500.2006.

Findings:
MCL 500.2006, and Company internal guidelines, require that claims with adequate proof of loss be paid within 60 days of receipt of the proof of loss, unless the claim is reasonably in dispute. The following information was obtained during the on-site examination:

- Of the 88 sampled files, nine Homeowners files closed with payment showed payments later than 60 days, but in each of these nine files, the policyholder failed to provide adequate proof of loss on time. The Company files show that the Company did notify the policyholder of their duties after a loss, including the timeline for providing proof of loss. In no case was the Company liable to pay 12% interest for late payments. There are no findings.
- Of the 88 sampled Private Passenger Auto Comp and Collision files closed with payment, four were paid later than 60 days. In three of these files, the policyholder failed to

provide required information that would constitute a satisfactory proof of loss quickly enough. The fourth was an error made by the policyholder, who mistakenly submitted two claims, which should have been only one. There are no findings.

- Of the 88 sampled Private Passenger Auto PIP files closed with payment, none were paid later than 60 days. Claim documentation was received by the provider, or the insured, and the claim was paid. There are no findings.

The claims files closed without payment, without exception, provided sufficient evidence to prove that not paying the claim was the proper response according to the policy language. The statistics on why the claims were denied is as follows:

- Private Passenger Auto Comp and Collision: 26 were claims lower than the deductible, 19 were claims in which the policyholder wasn't at fault and the other insurance paid the claim, 15 were claims made on parking lot damage for which no cause can be ascertained. The other claims closed without payment were not statistically significant, but were made for the following reasons: policyholder hit their own insured vehicle, the vehicle was not on the policy at loss, no response or documentation from policyholder. All files contained adequate documentation to support the Company's position. There are no findings.
- Private Passenger Auto PIP: Of the 88 claims, 71 were not paid because the injured party didn't submit any medical bills to be paid or because no medical treatment was sought. The other claims closed without payment were not statistically significant, but were made for the following reasons: mail returned, rental vehicle, coordination of benefits with health insurance. All files featured adequate documentation to support the Company's position. There are no findings.
- Homeowners: Of the 88 claims closed without payment, 35 were not paid because the policyholder withdrew the claim after learning the damage is less than the deductible. Nine were not paid because policyholder never submitted sufficient proof of loss. Seventeen were not paid because the damaged property was poorly maintained and damage was result of poor maintenance. The other claims closed without payment were not statistically significant, but were made for the following reasons: stolen property which was recovered, loss to non-scheduled personal property exceeded coverage limit, intentional fire loss. There are no findings.

Recommendation:
No further action is required at this time. The Company appears to be in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Summary of Company Response:
There was none provided.

Standard 4: The regulated entity responds to claims in a timely manner. NAIC *Handbook*, Chapter 16.

Findings:
Company policy requires initial contact with claimant within 48 hours. In all sampled files, with no exceptions, the Company met or exceeded this requirement. There are no findings.

Recommendation:
No further action is required at this time. The Company appears to be in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Summary of Company Response:
There was none provided.

Standard 5: Claim files are adequately documented. NAIC *Handbook,* Chapter 16.

Findings:
Examiners reviewed a mix of both paper Claims files and Electronic-Only Claims files. In all sampled files, the Claims file documentation was more than adequate to support the claim determination. Company should be commended for the completeness of their record keeping requirements and for their efforts to digitize their records. All internal Company document requirements were met without exception. There are no findings.

Recommendation:
No further action is required at this time. The Company appears to be in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Summary of Company Response:
There was none provided.

Standard 6: Claims are properly handled in accordance with policy provisions and applicable statutes. NAIC *Handbook,* Chapter 16. MCL 500.2026, MCL 500.4507.

Findings:
MCL 500.2026 prohibits the following: Failing to promptly act on claims communications, refusing to pay claims without a reasonable investigation, failing to affirm or deny coverage within a reasonable time after proof of loss is received, and compelling policyholders to institute litigation to recover a proper settlement by offering a substantially lower amount than what is due to the policyholder. Without exception, the sampled Homeowners and Private Passenger Auto files show the Company to be in compliance with all aspects of this statute. There are no findings.

Standard 6 requires that the Company have a policy for reporting suspected fraudulent claims to the relevant authorities. Further, MCL 500.4507 requires that the Company provide this information at the request of the Commissioner of Insurance. The Company reports all suspected fraudulent activity to the National Insurance Crime Bureau (NICB). There are no findings.

In all of the sampled files, the proper deductible, according to policy provisions, was applied. There are no findings.

In all sampled files, Farm Bureau met or exceeded all internal and state requirements for salvage, release of claims payments and referral of suspicious claims to the NICB. Total losses were excluded from the sample and so none were reviewed. There are no findings.

Recommendation:
No further action is required at this time. The Company appears to be in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Summary of Company Response:
There was none provided.

Standard 9: Denied and closed without payment claims are handled in accordance with policy provisions and state law. NAIC *Handbook,* Chapter 16. MCL 500.2100 et seq.

Findings:
In all sampled closed with payment claims files, the Company has acted according to all applicable statutes and internal regulations. Further, the Company has maintained proper claims file documentation to support closing the claim without payment. There are no findings.

Recommendation:
No further action is required at this time. The Company appears to be in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Summary of Company Response:
There was none provided.

V. ACKNOWLEDGEMENT

This examination report of Farm Bureau General Insurance Company is respectfully submitted to the Commissioner of the Office of Financial and Insurance Regulation, State of Michigan.

The courtesy and cooperation of the officers and employees of Farm Bureau General Insurance Company, especially the managers and staff of the Internal Audit Department, during the course of this examination is hereby acknowledged.

In addition to the undersigned Examiner in Charge, Lynella Cauther and Sherry Barrett, Examiners, also participated in the examination and preparation of this report.

Zachary Dillinger
Examiner-In-Charge
Office of Financial and Insurance Regulation
Market Conduct Section
August 31, 2012