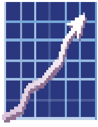
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DATE

AN INSURANCE GROUP
ADDRESS
CITY, STATE ZIP

Attn. NAME
Vice President, Claims

Dear NAME:

As we had discussed, a review of TITLE and TITLE work was conducted the weeks of and DATE with the files materials having been shipped to your CITY, STATE Branch. The review was conducted by NAME and NAME of the INSURANCE COMPANY Corporate Claims Audit Department and AUDITOR of RMG Consulting, LLC. The following report is of our findings, conclusions, and recommendations.

Introduction:

RMG Consulting was provided with a run of 485 files that were closed the last 3 months of 2003 and the first 2 months of 2004 of TYPE losses handled by your TITLE. The total paid for these losses was $30,684,345.95. We sorted them by specialist and selected a representative sample for each based on their volume totaling 86 claims. We were then also provided with a run of commercial losses handled by TITLE from which we selected an additional four claims, and with a listing of eight additional claims to review. We ended up reviewing and grading a total of 89 claims. Some we did not review because they were handled by a staff adjuster other than the COVERAGE specialist the file was coded to, some were adjusted by independents, some were actively supervised by the Home Office and you were already familiar with them, and some time did not permit us to review (although we were satisfied we had a good representative sample of work).

We added a second page to the review sheet we have used in the past to capture more detail with respect to the handling of the building, TYPE and time element features of these large losses. In addition we increased the emphasis on investigation and subrogation since these are predominantly fire losses, and also commented on file organization since it is necessary to work with large, complex losses.

File components were rated "A" or "Excellent", "B" or "Good", "C" or "Satisfactory, With Room for Improvement", "D" or "Poor" and "F" or "Failed." Tab 3 of this report includes the aggregate grade calculation for all 89 losses, Tab 4 has the claim and performance broken down by adjuster, and Tab 5 has the grade sheets in that same order. Following are the results and analysis of that review.

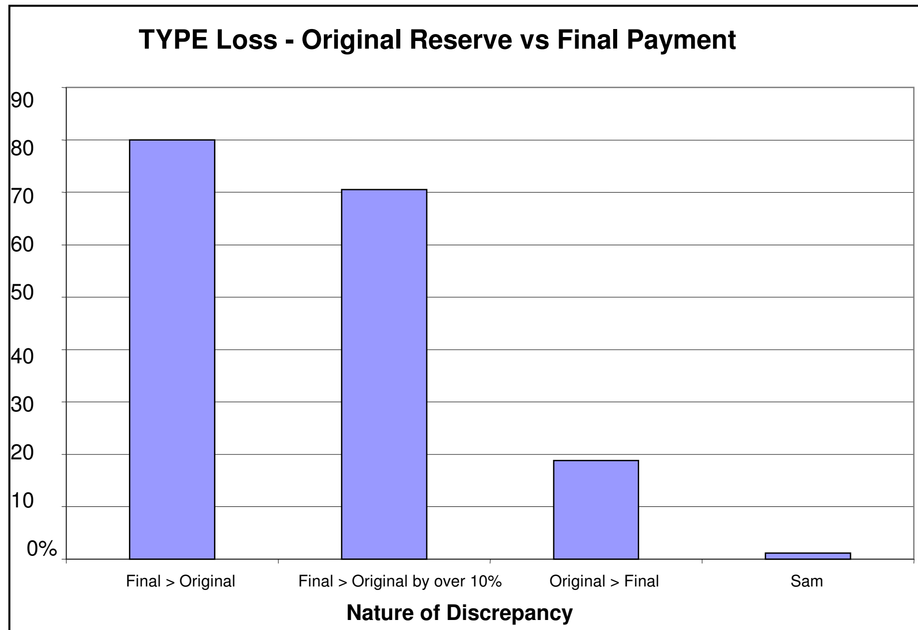
NOTE Sometimes a client looks for a grade, however, most like a dollar amount.

Reserving:

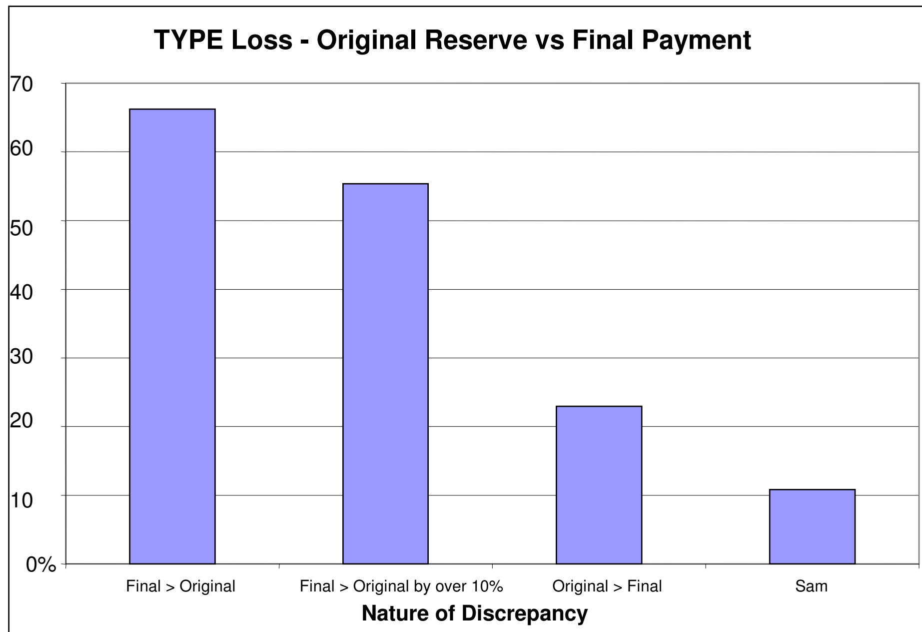
Reserving graded as ***satisfactory, with room for improvement (2.36)****,* generally because they are set up promptly and adjusted as necessary, although further comment is required on that point.

In reviewing the actual reserve development from the initial reserves, particularly on the building feature, through to final payment, in general the initial reserves are significantly inadequate. From an industry standpoint, COVERAGE losses have traditionally small loss development through time. This should be particularly true with large losses where the adjusting level is more experienced. It has also been my experience with both staff and independent adjusters that they tend to be somewhat conservative with their reserve recommendations on large losses because there is a perception (with some merit) that if the final settlement is brought in within the reserve, a good job was done in evaluating and adjusting the loss.

On the TYPE features of the 89 losses reviewed initial reserves of $6,318,700 developed into final payouts of $9,807,786.94, or a 55% increase of $3,489,086.94. In 80% of the losses (see exhibit below), the final amounts paid exceeded the initial reserve. In 70% of the losses the final amounts paid exceeded the initial reserve by 10% or more. In only 19% of the cases the final paid amount was less than the original reserve, an in one case it was the same amount (total to the policy limit). A review of the schedule showing reserve and paid points out several striking examples of this phenomenon.



The same is true with TYPE reserves, although to a lesser extent. TYPE OF CLAIM initial reserves of $3,319,650 developed into final payments of $4,525,439.64, or a 36% increase. As the next exhibit shows, in 66% of the cases the final payments exceeded the reserve; in 55% of the cases the payments exceeded the reserves by more than 10%. In 23% of the cases the final payments were within the initial reserve, and in 11% of the cases they were the same – likely total losses, again.



While some reserve increases are expected and normal, these claims showed a consistent pattern of stair-step reserving. Chronically low initial reserves are the result of adjusters failing to recognize the severity of the loss in the first instance and/or losing control of the adjustment process during its course and the supervisors failing to recognize and address this pattern.

In addition there were some inconsistencies in the way line reserve features were set up. Sometimes the TYPE claims in fire losses were set up as FEATURE. Also, sometimes the loss of use feature had a separate line reserve as FEATURE or FEATURE, or sometimes as another FEATURE line, and sometimes it was included in the building reserve. We realize your system does not have a major peril/cause of loss code for TYPE loss of use claims and we would recommend you consider adding one to assist your actuaries in tracking this exposure – which is significant in these large losses.

Diary Control:

Overall, diary control was ***satisfactory, with room for improvement (2.25).*** Consistent with the INSURANCE COMPANY's claims practices, claims are generally assigned to the handling adjuster quickly, contact with the policyholder is prompt and inspections are also done quickly. To a lesser degree estimates are done on a timely basis in some files, and good control of the adjustment process is evident in some cases.

However, control is an area where significant improvement is needed generally, resulting in long periods of time to close claims and severity problems with loss of use. In many instances adjusters are not preparing their building estimates promptly and/or not obtaining building estimates from their or the insured's contractors promptly. In some cases of total losses, the actual cash value loss is not quickly being calculated and paid. In other total loss cases, the policy limit or replacement cost is being quickly paid, with no rebuild contract or estimate and no documentation of what expenditure the insured experienced or committed to.

We saw a few instances where the loss of use claim was actually overpaid through advances. We saw *no* cases where the time to rebuild was estimated, the loss of use calculated for that period, agreed upon, and paid as a final payment. We saw many instances where the insured delayed construction for one reason or another and the COVERAGE specialist just paid for the additional time element loss without any attempt to control that feature. In many total loss cases the loss of use feature was paid for the entire year.

As for the TYPE losses, the COVERAGE specialists are not following up for the insureds' claims, and when they do receive them they are sometimes slow to react to them. TYPE claims are often received piecemeal and paid in the form of many checks, with the timing under the insured's control.

Generally speaking, although these were large losses, they took too long to conclude. The COVERAGE specialists are not controlling them – they are reacting to them.

Coverage:

Overall, the verification, interpretation, and application of your policies' terms and conditions were considered to be ***good (2.72)***, as you would expect from specialists handling large fire losses. There were not many issues as to whether a loss was covered, or not, so most times if the coverage was properly applied that was considered to be "good." This should not mask, however, that there were a larger number of errors in applying the proper coverage to these losses than one should expect or accept from people of this experience level. Most of the positive and negative findings were over some of the finer points of coverage application (with the exception of deductibles, which we will discuss in further detail below).

In the HomeProtector line coverage was confirmed in every case. We saw seven instances where risk reports were warranted and issued. Most times building depreciation was calculated and withheld. Sub-limits were applied in some cases (and missed in others) and additional extensions of coverage were granted in some cases (and missed in others).

Even thought the overall rating was *good* there were a large number (25, or 28%) of claims that were rated with improvement needed, or poor or failing. Since specialists should be held to a higher standard, this is disappointing. Errors resulted in both underpayments to your policyholders, as well as overpayments. Besides missing sub-limits and extensions, examples of additional errors are:

- Building items paid under the TYPE feature (010110465256).
- A risk report was issued because the insured was selling the home, but not because the home was unoccupied and un-watched during the winter (010180614771. Power apparently went off allowing the pipes to freeze, water damage go undetected, and mold to develop).
- Did not address or apply sub-limits for stamps and coins (010150456166).
- Did not consider sub-limit for boat until 9 months into adjustment (010710165280).
- Under an Ultracover the building limit was substantially increased to cover the cost to rebuild but the additional percentages for debris removal and trees, shrubs, plants and lawns were not correspondingly increased (010170616967).
- Additional limits calculated prior to application of inflation guard (010180584612).
- Coverage for personal COVERAGE of others on the premises improperly denied (010170669310).
- Coinsurance waived (010410212626) "due to MSB broad band connection."
- Not verifying insured's interest in improvements and betterments (010210468990).
- Paying for trees not down on the buildings (commercial loss 010210475459).
- Failure to address possible arson defense (010510185799).

Coverage notes on commercial claims were not as complete and informative as those on HomeProtector losses (010960024300, 010710185442 and 010610132191).

We noted four instances where deductibles apparently were not taken (010210398625, 010190138815, 010620087152 and 010810018010) and two where it was taken on a total dwelling loss (010740165551 and 010930058263). The correct application of a policy deductible is one of the first things an adjuster is taught. This improper application is a function of the COVERAGE specialists' work product being unorganized and not clearly documenting the basis of the payments, making it difficult for the supervisors to review them. Requiring partial and final statements of loss to outline the adjustment would correct this, or make it easier to spot.

File Documentation:

File documentation was ***barely satisfactory, with substantial room for improvement (1.88).*** Of the 89 files graded 57 were "C" (2.00) or worse, while only 23 were "B" ("good" 3.00) or better. Most adjusters were consistent, i.e. they were either good or bad or fair; however, some ranged from poor to good.

In file documentation we looked for scopes of damage, diagrams, photographs being mounted, dated, labeled and the person who took them identified estimates, contracts, receipts, and any other evidence of ownership, existence, cost and quality of TYPE. We also looked for recorded interviews or signed statements where warranted, and looked at the quality of the CMS notes to the file.

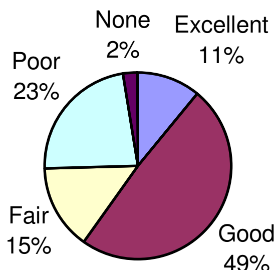
As can be seen in the accompanying charts (in the "Adjustments" section) for building losses the specialists scoped the damages over 70% of the time, but did their own estimate in only 50% of the losses. Scopes and estimates were done by a contractor on behalf of the insured just over 60% of the time. Diagrams of the footprint of the building on total losses and of the room layouts in partial or total losses were scarce, and when they were done were generally of poor quality. Photograph quality and quantity of building damages was considered good to excellent in 60% of the losses, and fair, poor or non-existent in 40% of them.

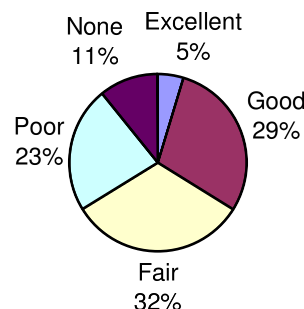
For the TYPE claims the insureds prepared the inventory in almost 70% of the losses, while the specialist did it in 3%. Inventories were prepared by others on INSURANCE COMPANY'S behalf 16% of the time and by public adjusters 5%. Verification of original purchases existed in only 8% of the losses; replacements were verified in just over 30% of the losses. For the overall TYPE losses, supporting receipts for 0-5% of the COVERAGE involved were present in 31% of the cases (see accompanying chart in "Adjustments" section) – the most of any range measured, even though it was the smallest. Photo quantity and quality of the TYPE losses was considerably worse than of the building damages – being excellent or good 34% of the time, but fair, poor or non-existent 66% of the time.

Receipts for additional living expenses were present, but often unorganized, kept in envelopes and not totaled or apparently analyzed. Insureds' normal living expenses were rarely documented.

Best Practices prompts are not being used to any significant extent to report on these losses. Generally, the CMS notes do not thoroughly report on the facts, activities, a game plan for the adjustment, or an organized explanation of the settlement and payments made. Sometimes the notes misstated what was contained in experts' reports. The tone of the notes was professional, i.e. they did not contain unsubstantiated opinions or remarks that would be harmful if exposed in litigation (with one exception – claim number 010920038126. The well intended remarks of the inexperienced adjuster attempting to assist on this loss, while very likely accurately relating conversations she had with the insured, might be used to show the insured was distressed and the COVERAGE specialist did not adequately communicate with him. See printouts of notes with review sheet).

The following charts measure the quantity and quality of photographs of the building losses and TYPE losses.





Finally, check issuance is sloppy with many not naming the insureds correctly as they appear on the policy, and many not including all the required payees.

File Organization:

This file component was added to the review sheet for these large losses because it was felt that file organization is an important aspect of the specialists' ability to keep the various features of the claim, i.e. building, other structures, TYPE and loss of use well organized so they could be evaluated each on their own merits, while recognizing the inter-relationships they have. For example, the amount of the building loss and time to rebuild affects the loss of use claim. The rebuild schedule also affects the timing of the insureds' needs to replace destroyed TYPE. We also saw items included in both the building estimate and TYPE claim (usually kitchen appliances).

Merely because of the size of these losses it is necessary to organize the files to properly evaluate and document them. Organizing the file material helps the specialist take an organized approach to the adjustment process. Obviously, by their very nature large COVERAGE losses should generate large volumes of file material in scopes, estimates, photographs, diagrams, receipts, cause and origin reports, other expert reports, official reports, tax lien information, title searches and recorded interviews. Organizing this material also facilitates its review and cuts down on the chances for mistakes to be made.

Overall, the rating was between ***satisfactory, with room for improvement*** to ***good (2.49).*** On a by-file basis, it ranged from failing to excellent, depending on the particular specialist's recognition of the importance of file organization and ability to do so. We have already mentioned we found loss of use receipts in envelopes unorganized and apparently not evaluated. The same was true in some instances of TYPE receipts. While recognizing that the COVERAGE specialists do not put the documents in the claim folders, we would expect them to send them in, in an organized fashion.

For these large losses, consideration should be given to using compartmentalized files such as is done for files in litigation in the Harrisburg Branch. Compartments could be used to separate the building loss, TYPE claim, loss of use, correspondence, policy forms if needed, origin and cause investigations (including official reports), and other or miscellaneous. The specialist could color code the material's cover sheet, similar to how the litigated file material is done in Harrisburg.

Another option would be for the COVERAGE specialists to send the hard copy file materials to their supervisor to review and place in the file. Presumably, if it comes in to the supervisor in a neat and orderly fashion, it will go to the file that way.

Investigation/Cause of Loss Determined:

We added the "Cause of Loss Determined" description to this file component for this review because the preponderance of the losses were large fires and we wanted to be especially mindful of preparing files for potential subrogation opportunities. Overall, the investigations were considered to be ***satisfactory, with room for improvement (2.27)*****.**

Cause and origin investigators were used in 52 of the 72 fire losses we looked at. Of the twenty where no professional C&O expert was used, only two should have had one. While we understand and agree with the valid approach to err on the side of caution, we did note seven instances when a C&O expert was assigned and was not needed or effective. These were cases where the cause and origin was well known and documented, or, had the specialist inspected the loss first, he or she would have seen the damage was so extensive the cause and origin could not be determined, or that the site was so altered (demolished) an investigation could not be conducted. We also noted instances where the COVERAGE specialist approved the expert's fee bill for payment when it should have been adjusted.

The real improvement opportunity in this area is with the quality of the C&O experts' work and the COVERAGE specialists' and/or supervisors' reaction to it. In 19 of the 52 assignments either the expert did a poor or incomplete job that went unrecognized, or the specialist and/or supervisor apparently did not read the report, or did not understand it, or did not interpret it correctly, or did not take further action that was warranted. These problems are resulting in substantial missed subrogation opportunities and possible incorrect coverage decisions.

On causes of loss other than fire appropriate experts were also used where warranted, however similar problems were evident. If the loss is serious enough to warrant the expense of an independent expert, their reports should be thoroughly reviewed, understood and appropriate action taken. In fact, whenever possible it is desirable for the COVERAGE specialist to attend at the loss site with the expert and get first hand knowledge of what the findings and opinions are so additional direction can be given at that time, if needed. This requires planning and time, but so does the adjustment of large losses in general.

We did see a number of recorded interviews and signed statements taken, however we also saw several that were warranted but not taken. Sometimes the need for a recorded interview was dismissed in a Best Practices note before the specialist inspected the loss or interviewed the insured in person.

Adjustments:

The measurement of this file component considers the COVERAGE specialists' activities in scoping the damages, quantifying the losses, applying coverage correctly and negotiating settlements fair and equitable to all – i.e. the policyholder and the insurer. Unfortunately, this critical component of our review attained the lowest grade of all – ***barely satisfactory, with room for substantial improvement (1.67).*** The breakdown of the grades is:

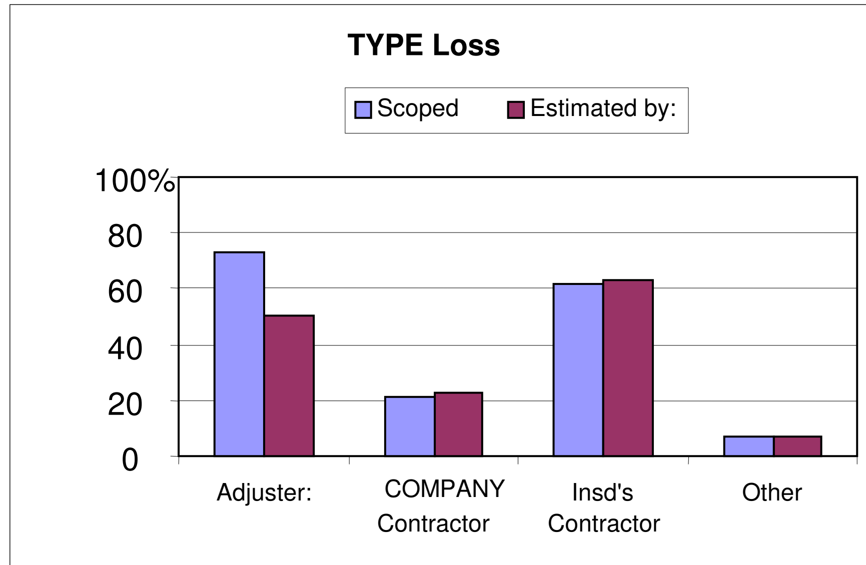
Excellent:	8
Good:	16
Satisfactory, with room for improvement:	23
Poor:	26
Failed:	16
Total:	89

To better understand how these results came about it is useful to examine the three distinct but interrelated components of the losses, i.e. the building, TYPE and time element features.

Building:

As previously discussed under "File Documentation" your COVERAGE specialists are scoping 72% but writing their own estimates on only 50%. There has been substantial improvement in this area since Jan. 1, 2003 when we understand this was made a requirement. Prior to 1/1/03 the specialists prepared their own building loss estimate in 13 cases (34.2%) and did not in 25 cases (65.8%). Many of those where they did were in late 2002. Since 1/1/03 the specialists have prepared their own estimates in 32 cases (69.6%, although three of those were total losses estimated on a square foot basis) and did not 14 times (30.4%).

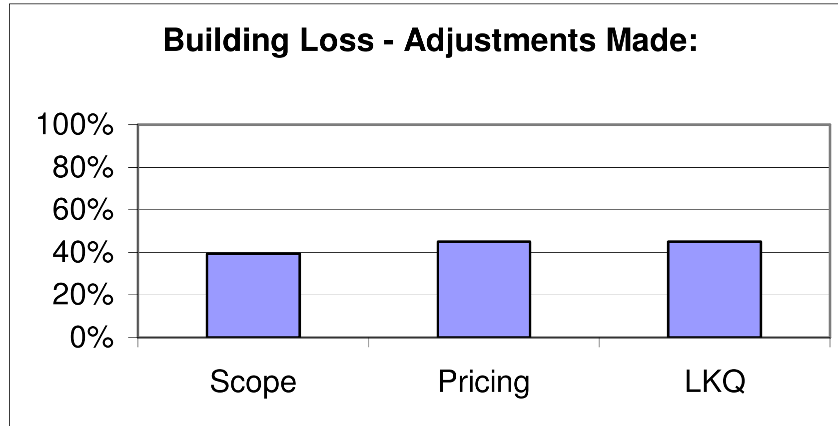
The following chart shows the percentage of building losses scoped and estimated by the specialist, and contractor on your behalf or a contractor on the insured's behalf.



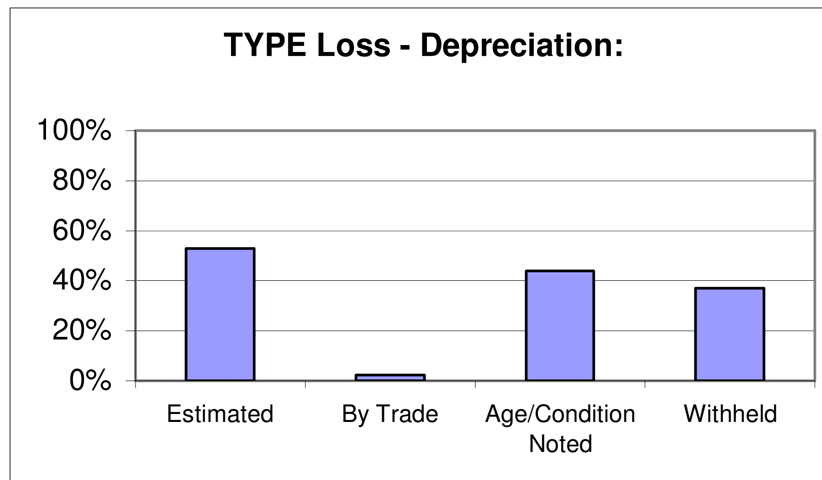
The positive impact of the COVERAGE specialist preparing his/her own estimate is both expected and somewhat astounding. We calculated the grades for "Reserving", "File Documentation", "Adjustment" and "Overall" separately for those claims where the specialist prepared a building estimate and those where he/she did not, with the following results:

Specialist Prepared Own Estimate	Reserving	File Documentation	Adjustment	Overall
Yes	2.67	2.12	2.02	2.25
No	1.99	1.58	1.29	1.63

Although one might expect the performance in files where the specialist did prepare a building estimate to be even better, several things prevented that. First, the quality of the specialist's estimate was not always good (see for example claim # 010150521273 where the specialist calculated the square footage of the dwelling incorrectly). Secondly, the specialists estimate was rarely used to settle the loss. Finally, the specialist often did not use his/her estimate to adjust the insured's contractor's estimate. Please see the following graph for the number of times the specialists made adjustments for scope, pricing or like kind and quality of materials used:



While depreciation is taken to establish an actual cash value loss, it is always taken on a lump sum basis which is often an arbitrary and low percentage. Although we recognize the year the dwelling was built is indicated on the policy declaration page for the COVERAGE line, rarely is there a discussion of the age of the building, its condition or the basis for the percentage of depreciation chosen in the claim file. Lump sum depreciation is appropriate on total losses in states where the proper measure of actual cash value is replacement cost, less depreciation. However, on partial losses, different building trades depreciate at different rates and there even can be different rates within a trade (e.g. One room was recently painted; another is in bad need of decoration. Home may have a more recent addition on it). Some trades do not depreciate, such as demolition and debris removal.



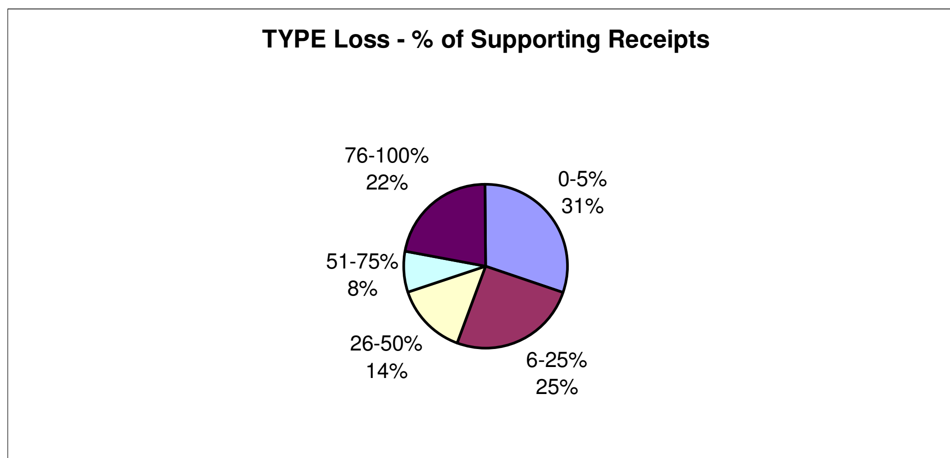
We also noted that your estimating program is adding sales tax on materials after the unit pricing estimate and before overhead and profit. Thus, the contractor would be getting overhead and profit on the sales tax, which he is not entitled to. In some of these large losses, this is a significant amount (we saw one where it was over $700).

Finally, diagrams of building losses are often poor. The footprint of the building should be diagramed for total losses, as should the room layout for total and substantial partial losses.

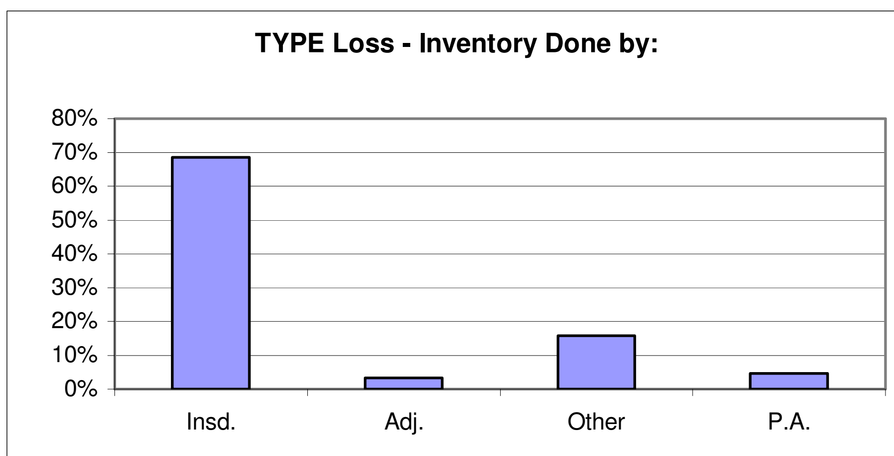
TYPE:

The handling of TYPE losses on large claims may be more of a problem then the building feature. Generally, the insured's inventory is accepted without checking or adjusting quantities or values. Descriptions of the items are vague, lacking sufficient detail to verify the price claimed. Claims are presented, accepted and paid on a piecemeal basis, with numerous partial payments being made. Depreciation is sometimes applied on a lump sum basis, and often appears too low. We noted several times the specialist offered to split the difference between the ACV and RC loss amounts as a "buy out."

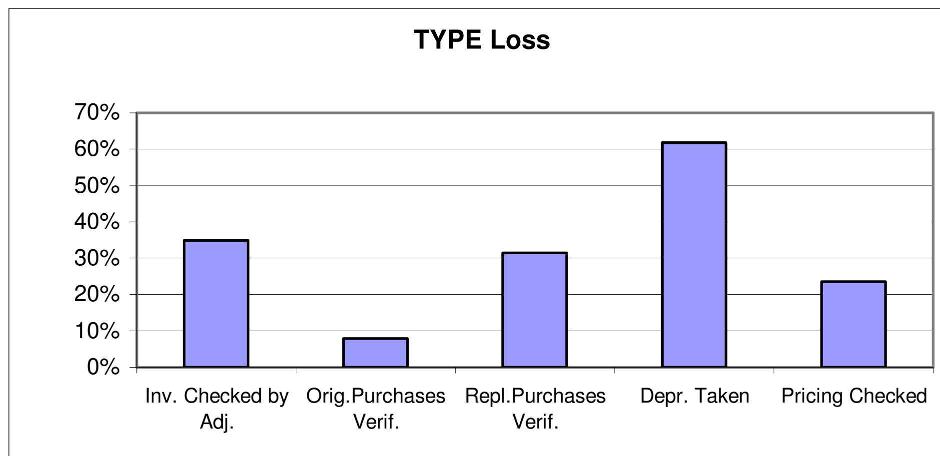
We attempted to estimate the percentage of TYPE loss items that were supported by receipts of any kind and as the following chart shows by far the largest grouping was 0-5% - the smallest range and the least amount. In 56% of the cases supporting receipts existed for less than 25% of the items.



As we would expect, and as is the insured's duty, the insured provides the TYPE inventory in almost 70% of the losses. However, the specialists are only checking that inventory 34% of the time, and only checking pricing 23% of the time.



Original purchases are documented less than 10% of the time; replacement purchases are documented 31% of the time. Replacement services are rarely used usually dismissed with some excuse in a Best Practices note. Some specialists are depreciating each item appropriately; however some are estimating total lump sum depreciation on total losses. Again, depreciation percentages are low and rarely is the age or condition of the items commented on or questioned (one insured allegedly acquired all their personal COVERAGE in the last two years).



We noted several TYPE inventories were done by the insureds on Excel spreadsheets. It may be in the INSURANCE COMPANY's interest to develop a disc with a TYPE inventory format to provide to its policyholders for this purpose. It could be seen as an added value claim service, but also facilitate the specialists' analysis of the claim, categorizing groups of COVERAGE for control purposes, applying depreciation, checking the math, and becoming a precursor to a statement of loss to explain the adjustment. If the insured's personal computer is involved in the loss, this might be one of the first items considered in an advance, possibly though a replacement service.

Another added value service could be the use of debit cards for advances, rather then checks. Insureds don't normally go out and buy $50,000 worth of TYPE all at once. A debit card would slow the outlay of cash from the INSURANCE COMPANY, while also providing detailed records of the insured's replacement purchases, and be a convenience to the insured.

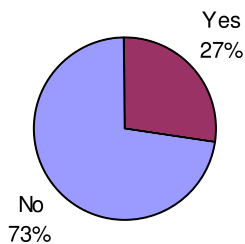
Loss of Use:

As mentioned in the section on Reserving we recommend a separate Major Peril/Cause of Loss code be developed to accurately track this feature within the Coverage line so it can be accurately measured as we believe it is a disproportionately larger amount than industry standards. We saw many claims where the period ran the full 12 months, which should be the exception rather then the rule. The specialists are not establishing a reasonable period of restoration, nor are they controlling it. Many times the insured or their contactor delayed restoration and the specialist paid for the additional time without making any effort to adjust it.

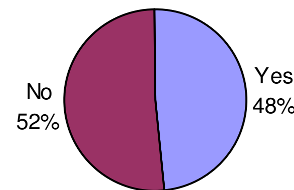
While good claim service entails advance payments to the policyholder for anticipated additional living expenses, your specialists are overdoing this and not utilizing the process to control the claim. In two instances (010180614771 and 010110437063) the advance payments actually exceeded the loss. Documentation to substantiate the amounts advanced was sorely lacking.

Normal expenses were not being verified or deducted.

Historical Expenses Verified



Normal Expenses Deducted



We did not see any instance where the loss of use claim was calculated early on, projected and settled on that basis. This adjusting technique establishes parameters for the insured and their contractor as to what a reasonable period of restoration is. Should that period be exceeded due to no fault of the policyholder, the payment period can be extended. The important point is to introduce some sense of control into the process.

On one of the commercial claims we saw including an income loss, the limit of liability was paid with no comment or documentation as to what the insured's actual monthly revenue and expenses were (010170706713).

Supervision:

Supervision was considered to be just ***satisfactory, with room for improvement (2.06).*** As with the "Coverage" file component some benefit of doubt was a factor in this grade since, if the final result was good even though no supervision may have been evident in the file, supervision was deemed to be good. There were, however, also some instances where the supervision was evident, active and effective.

Supervision needs the most improvement in cases where it is ineffective, i.e. it is present but either not picking up issues it should, or not changing the course of the adjustment for the better, and in cases where it is totally absent, but was needed. This is apparent in some files through the course of their development and in more files where it is evident the claim settlement was not reviewed. In both cases, hard copies of file materials are going into the file envelopes without the supervisor seeing them.

As we discussed briefly, there is also the chicken or egg issue, i.e. are the claims difficult to supervise because of the condition of the files? Or, is the condition of many of the files unorganized and difficult to follow because of the lack of supervision? The fact is, many files are disorganized and not properly documented and it is very difficult to review them and figure out how much was paid from the notes and TYPE and why.

CMS file notes often do not provide the reader with a plan of action that can be comprehended and commented on. To some degree, the Best Practices prompts are being used as excuses not to take a statement, pursue recovery, or use a replacement source.

Salvage and Subrogation:

The aggregate grade for salvage and subrogation was ***satisfactory, with room for improvement (2.22).*** More times than not salvage and subrogation were affirmatively considered and properly addressed.

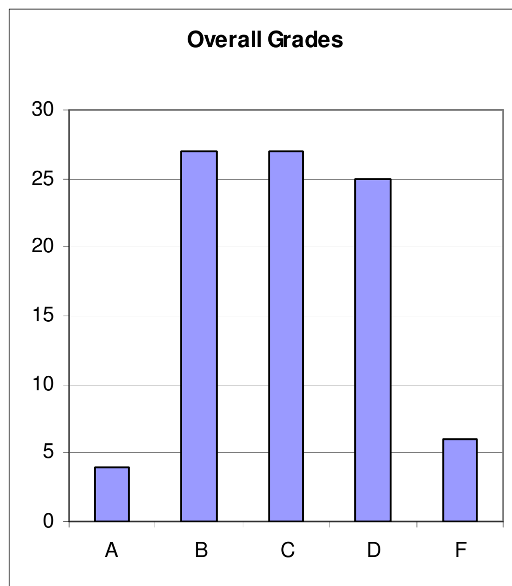
However, as mentioned in the third paragraph on our section titled “Investigation/Cause of Loss Determined” in a significant number (21) of cases either a poor origin and cause investigation was conducted by the retained expert, evidence was not properly retained, or the report was not understood or acted upon by the COVERAGE specialist and/or supervisor. Potential subrogation was not pursued on some very substantial losses. There were also a few cases where the file should have been referred to the subrogation unit, but was not.

We recognize salvage of damaged personal COVERAGE is a difficult issue to deal with as salvors are generally not interested in handling it. However, we saw 14 instances where it appeared that there was some value in the damaged COVERAGE and it was not pursued. There was one instance where damaged electronics were sold to branch employees under a supervised sealed bid process, and this may be an approach to use more widely (we also recognize the potential pitfalls of doing this). There were also a few instances where salvage was left with the insured or cleaning contractor for an allowance. This may be preferable to getting nothing at all, and in some instances having these people keep it anyway. It may be that a relationship with a national or regional salvor can be worked out where they assist with this COVERAGE as well as getting your good salvage. It also may be better to donate it to a charity than get nothing out of it.

Of course one does not want to incur more expense in disposing of salvage than one gets in return. However there is also the problem of not dealing with it and maybe paying for the COVERAGE twice. We would suggest you discuss this with your COVERAGE specialists and have them try to develop resources in their areas.

Overall:

The overall rating is ***satisfactory, with room for substantial improvement (1.96).*** Unfortunately, there are the same amount of "poor" and "failed" files as there are "Good" and "excellent" ones. WE recommend you look through the review sheets and our notes to get a better feeling for what we saw, in addition to my specific file comments contained in this report.



Severity Factors:

As the enclosed graph (Tab 2) shows service/timing, coverage analysis, scoping and recovery efforts had a more positive (reducing) impact on the amounts paid while file documentation, investigations, control, pricing, adjusters' performance and supervision had an overall negative (increasing) affect on how much was paid.

- **Service and Timing**. Prompt assignment, contact and inspections are the norm. However this factor did have a negative affect in 24% of the files generally due to delays in writing estimates, delays in reacting to loss of use and TYPE claims and the generally long time these files stay open.
- **File Documentation and Photographs.** This had a negative effect in 50% of the files. In addition to many photographs not being mounted, dated and labeled and diagrams poor or lacking, there was a general lack of supporting documentation in the form of invoices, receipts and estimates.
- **Coverage Analysis.** Some of the errors made actually caused claim payments to be less than they should have been, so in that sense they did not have a negative effect.
- **Investigation.** This mostly impacted subrogation potential, and, to a lesser extent, coverage evaluation.

- **Control.** This tied poor pricing for the second highest negative impact (after File Documentation). Often the specialists are not controlling the adjustment process; they seem to be reacting to the claim.
- **Scoping.** This was an overall positive area since the COVERAGE specialists scoped the building damages 72% of the time. However, it was also a negative impact over 30% of the time, indicating it can be done more frequently and with better quality.
- **Pricing.** Negative more than positive. More care needs to be given to estimates for pricing, duplications and the application of overhead and profit on top of materials sales tax.
- **Adjusters' Performance.** Consistent with the grading this was negative more than positive. In addition to doing a better job with scoping and building estimates the specialist need to do a better job documenting and evaluating the personal COVERAGE and loss of use losses, and in taking depreciation.
- **Supervision.** Too many adjuster errors went unrecognized and uncorrected.
- **Recovery.** Impact was both good and bad, as were the grades. The investigation/analysis for subrogation and salvage handing needs to improve.
- **Fraud.** Not a big impact, however in one case where both the branch and Home Office recommended an EUO of the insured, the COVERAGE claim specialist ignored it and paid the loss without one being conducted.

Conclusions and Recommendations:

While some of your COVERAGE Specialists do a good job and utilize their experience and expertise to provide good service to your insureds, it is clear that the performance of others is disappointing. They are not bringing a level of technical expertise to these losses that are required, they are not controlling the adjustment process, the files are taking too long to close, they are making errors in the adjustments, and it is having a negative impact on both claims service and claims severity.

These files do not seem to have any organization or direction; they drift forward with notes from which it is sometimes hard to tell what agreements have been reached, what remains to be done, when and by whom. As such, these claims are difficult to review and supervise.

The claim file is the company's best evidence of what has been done and remains to be done on an open claim, and what was paid on the claim, or was not, and why, for advance payments or on a closed claim. The INSURANCE COMPANY is not getting this product on a consistent basis.

Best Practices notes are not being properly used for this purpose. It may be that for large losses they do not suit that purpose in that it is too easy for the specialists to dismiss them. The specialist should be giving detailed accounts of what he/she did and when and what he/she intends to do, when and why so that one supervising the work can either see what is occurring is good, or if not, take corrective steps. Along with this, the supervisor needs to view the hard copy material going into the claim folder and be aware of its quality.

Included in Tab 6 are sections out of two COVERAGE loss adjusting texts dealing with captioned reports and statements of loss. The third item is extracted from an outline We did called "Requirements For Handling COVERAGE Losses" that We used to provide to independent adjusters to give them my reporting requirements. We recommend similar reporting requirements be made of

your specialists on large losses to make them think about all these aspects of adjusting and verbalize what they've done and intend to do so that anyone can pick up the claim and see what the status is, what has been paid, and why.

We also would suggest you consider a large loss reporting routine where the adjuster and/or supervisor completes a one or two page report on large losses (over $100,000?) which would go to senior claim, underwriting, loss control and field operations management to advise them of large losses, the nature of the risk, the cause of loss and reserves. We have found in the past that this exercise makes one tell senior management about the loss in an organized, disciplined fashion with no unanswered questions. This can be a healthy process for the adjuster and supervisor to make sure they have all the bases covered, and provide senior management with timely information about large loss activity.

WE want to thank NAME and NAME for their usual hard work, technical expertise and high standards they bring to the table. WE would also like to thank the CITY Branch for their hospitality the two weeks we were there. Please let me know if there are any questions regarding our findings and my recommendations, or if you would like to discuss them in further detail. Thank you for this opportunity to be of service.