

WORKING P A P E R

Survey Instruments: Insurance Class Actions in the United States

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INSTITUTE FOR CIVIL JUSTICE

PREFACE

This working paper provides the survey instruments that were used in the report, *Insurance Class Actions in the United States* (RAND, MG-587-ICJ), by Nicholas M. Pace, Stephen J. Carroll, Ingo Vogelsang, and Laura Zakaras (2007), which describes the important characteristics of insurance class actions, including what types of classes are sought, where the cases are being filed, what allegations are made, how the cases are resolved, and how much time it takes to bring them to resolution.

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SURVEY INSTRUMENTS

INITIAL QUESTIONNAIRE

**RAND INSTITUTE FOR CIVIL JUSTICE
NATIONAL SURVEY OF INSURANCE CLASS ACTIONS**

XYZ Insurance Company
1234 Main Street
Anytown, USA 00000
Phone: 000-000-0000

- 1) Individual responding to survey and contact information:
 - a) NAME: _____ TITLE: _____
 - b) ADDRESS (if different from above):

 - c) PHONE (if different from above): _____
 - d) E-MAIL (optional): _____
- 2) XYZ Insurance Company will participate in the RAND Institute for Civil Justice data collection (check one):
 - a) _____ Yes
 - b) _____ No
 - c) _____ Please contact to discuss participation
- 3) Has your company ever been named as a defendant in any case open at any time during the period of 1993 through 2002 where class action status was sought, even if the case was not officially certified as a class action? This would include litigation where a motion for certification was filed but was either denied or never ruled upon by a judge. It would also include matters where the plaintiffs' pleadings characterized the issues involved as suitable for class treatment but no motion for certification was filed. (check one):
 - a) _____ **Yes**, we have been a named defendant in at least one case open during this period in which the plaintiffs sought class action treatment in some way.
 - b) _____ **No**, we do not believe that any case in which we were a named defendant at any time during this entire period also had plaintiffs seeking class action treatment in some way.
 - c) _____ **Unsure**. We have no records that clearly indicate we were a named defendant in a case open at any time during this period where plaintiffs were seeking class action treatment in some way. However, we cannot say with reasonable certainty that we were not involved in such a case because of the following reasons (check all that apply):
 - i) _____ We have never kept track of actual or attempted class actions against us, regardless of whether the class was officially certified or not.
 - ii) _____ While we are satisfied that we have never been the subject of a *certified* class action during this entire period, we generally do not keep track of cases where class action treatment was sought but never officially certified.
 - iii) _____ Our records for this period are incomplete. While we have no specific recollection of ever being a named defendant

in even one case during this period where the plaintiffs sought class action treatment, it is possible that we were involved in such cases because for some of those years, complete information was not collected or retained.

d) _____ Unable to answer this question for the following reasons:

Please use the enclosed envelope to return this survey by _____ .

SECONDARY SURVEYS

Instructions

RAND INSTITUTE FOR CIVIL JUSTICE NATIONAL SURVEY OF INSURANCE CLASS ACTIONS

Instructions

There are two types of questionnaires in this survey package: (1) a single "General Background Questionnaire" and (2) multiple "Case Specific Questionnaires". The shorter *General Background* survey seeks to learn the extent to which those responding have retained records about past class action litigation in which they have been a defendant while the longer *Case Specific* survey gathers detailed data on those cases that actually included class action claims.

Our primary goal is to collect information on any case where your company was a defendant, where the matter was open at any time during the period from 1993 through 2002, and where class action certification was formally or informally sought by the plaintiffs even if never granted. Cases where a class was certified by a judge are obviously included as are cases where a motion for certification was made but denied or where the motion was never ruled upon (perhaps because the matter was settled as an individual plaintiff case or dismissed). Also, those cases where plaintiffs' counsel indicated that a motion for class treatment was imminent or likely but in fact the motion was never actually made would also fall within the survey's scope.

But not all actual or putative class actions in which your company may have been involved should be included in your answers. This project's focus is on litigation that reflects the unique nature of the insurance industry and so the following types of cases are excluded:

- **Class actions initiated by the company's own employees, agents, brokers, or adjusters** (e.g., employment discrimination suits, overtime pay claims, breach of employment contract claims, etc.).
- **Class actions initiated by the company's own shareholders** (i.e., stockholder suits brought under the Securities Act of 1933 or the Securities Exchange Act of 1934).
- **Direct action suits naming or involving an insurer only for the purpose of deciding third party liability coverage issues** (e.g., common law or statutory direct action claims).

Respondents whose prior experience as a defendant in actual or putative class actions was limited solely to cases falling within one or more of the three excluded categories described above should nevertheless fill out Section A of the *General Background* survey. All other respondents (which will likely be most companies receiving this survey package) should fill out all sections of the *General Background* survey and if possible, a separate *Case Specific* survey for every putative or actual class action in which they have been a defendant during the period from 1993 through 2002.

Please note that the surveys concern only those cases in which your company was a specifically named defendant in a filed case. Litigation where related corporate entities, including parent companies and umbrella insurance groups, were named parties but where your company was never a formal defendant at any time should not be included in your responses (it is likely that the affiliated entity will receive a separate set of surveys as part of this project).

It is anticipated that many of the questions contained in the surveys, especially the *Case Specific* questionnaires, may not be possible to answer for a variety of reasons including an inability to review the original case file, confidentiality agreements executed between the parties, the fact that the matter is still in litigation, or the fact that those who were most closely involved with the case are no longer with the company. These reasons should not deter you from

answering as many of the questions as completely as possible and when necessary, simply choosing the option in each question which indicates that the information requested is not available.

Handwritten responses to the surveys are acceptable.

Do not hesitate to contact the project manager if you have any difficulties or questions when completing the survey package.

General Background Questionnaire

- The question involving "Class Action Litigation Record Keeping" is designed to determine the years for which a respondent can confidently answer whether or not they were the subject of an actual or putative class action. If it is not possible to know whether cases active in any particular year raised class certification issues, the last column for that year should be checked.
- "Number of Case-Specific Questionnaires". A *Case Specific* questionnaire should be filled out for every appropriate actual or putative class action in which your company was a defendant if at a minimum the case title (e.g., *Jones v. XYZ Insurance*) and court location (e.g., "Circuit Court for ABC County") are known. Even if no other information is available, the case name and filing court will allow us to obtain copies of pleadings if necessary.
- Every respondent should return at least the *General Background* questionnaire to RAND.

Case Specific Questionnaires

- Don't panic at the size of the survey! The actual time needed to answer the questions will be less than might appear given the number of pages.
- Five copies of this survey have been included for your use. If there are more than five class actions for which you will be filling out *Case Specific* questionnaires, feel free to make photocopies as needed or contact RAND for additional blank forms. It is very important, however, to make sure that any photocopied *Case Specific* questionnaires are used only for cases involving the specific company name found in the upper left corner of the form.
- Many questions are followed by extensive lists of possible answers for your use. Examples include the lines of insurance involved, the main allegations made by the plaintiffs, and the key statutes at the core of the case's issues. These are not exclusive lists and are provided solely for your convenience. You are strongly urged to write in more appropriate responses in greater detail in the "Other" section at the end of each multiple choice list should you feel it necessary to do so.
- You may find it more efficient to supplement your answers with copies of key pleadings in the case that touch on the plaintiffs' claims, the company's defenses, or the origin and/or conclusion of the case. Please feel free to send such materials as you see fit to RAND by mail or in electronic form.
- One area that may raise some concerns involves the request for you to indicate the plaintiffs' key allegations. It should be remembered that we are only asking what the plaintiff was essentially claiming about the defendant's actions, not whether your company agrees or disagrees with the allegations or assertions. The goal here is to be able to compare this particular litigation with similar cases brought elsewhere so you should circle all allegations or assertions brought at any time by the plaintiffs in the case, even if one or more of the specific claims circled were later dropped or dismissed. "Issue

spotting" isn't necessary; we are only looking for a shorthand way to categorize the case. Usually circling a few of the choices or writing in your own assessment should suffice.

- An efficient way to answer the "plaintiffs' key allegations" question would be to quickly review the choices available for "VARIOUS LINES" types of insurance and then review just those choices listed for the specific lines of insurance that are the subject of the case. If none of those choices are appropriate, feel free to describe the plaintiffs' claims more fully in the open-ended "Other" section.

Please use the enclosed envelopes to return the surveys to RAND at your earliest convenience.

General Questionnaire

RAND INSTITUTE FOR CIVIL JUSTICE
NATIONAL SURVEY OF INSURANCE CLASS ACTIONS
General Background Questionnaire

*NOTE: The questions below concern only those cases...
...open at any time from 1993 through 2002, and
...where Xxxxxx Xxxxxx Insurance Company was a named defendant, and
...where class action certification was sought by plaintiffs even if
never granted.*

SECTION A: General Information

RESPONDING DEFENDANT: XXXXXX XXXXXX INSURANCE COMPANY

Attn: Zzzzzz Y. Xxxxxx, General Counsel
The Xxxxxx Xxxxxx Insurance Group
1234 Xxxxxx Street, Yyyyyyy, ZZ 12345 Phone: 999-555-1212 xyz@xxxxxxx.com

1) - Individual responding to survey and contact information (**if different from above**):

a) NAME: _____ TITLE: _____

b) ADDRESS (if different from above):

c) PHONE (if different from above): _____

d) E-MAIL (optional): _____

2) - CLASS ACTION LITIGATION RECORD KEEPING

It is very important for us to understand the extent of information currently available to your company regarding past class action litigation. Please check off the appropriate description for each year listed below:

EACH YEAR-LINE SHOULD HAVE ONE AND ONLY ONE BOX CHECKED

Year Case Was Open	We are able to confidently identify ALL cases active during this year where class action status was EITHER certified or sought	We are able to confidently identify ONLY those cases active during this year where class action status was eventually certified (but NOT all of those where certification was sought but never granted)	We do not have reliable information about class action allegations for cases active during this year
2002			
2001			
2000			
1999			
1998			
1997			
1996			
1995			
1994			
1993			

3) - TYPES OF CLASS ACTIONS DEFENDED

Did all of the actual or putative class actions your company defended during the period of 1993 through 2002 fall into one of the following three categories?

- Class actions by insurance company employees, agents, brokers, or adjusters, **OR**
- Shareholder suits such as those brought under the Securities Act of 1933 or the Securities Exchange Act of 1934, **OR**
- Suits naming or involving an insurer only for the purpose of deciding third party liability coverage issues

Check one:

- a) _____ Yes, **every** actual or putative class action defended were one of the above three types (**STOP. Do not complete the remainder of this questionnaire or any of the Case Specific questionnaires. Please return this form to RAND.**)

- b) _____ No actual or putative class actions of any kind were defended by this company during the period of 1993 through 2002 (STOP. Do not complete the remainder of this questionnaire or any of the Case Specific questionnaires. Please return this form to RAND.)
- c) _____ No, this company defended other types of class actions during this period
- d) _____ Unable to answer (provide reasons below)

SECTION B: Class Action History

4) - NUMBER OF ACTUAL AND PUTATIVE CLASS ACTIONS

NOTE: The remaining questions do NOT apply to the following types of cases:

- *Class actions by insurance company employees, agents, brokers, or adjusters*
- *Shareholder suits such as those brought under the Securities Act of 1933 or the Securities Exchange Act of 1934*
- *Suits naming or involving an insurer only for the purpose of deciding third party liability coverage issues*

Please enter your best estimate of the number of cases filed in each of the following years where class certification was sought at some time during its life. NOTE: We understand that due to incomplete or unavailable records, the figures entered into the table below are at best minimum counts of known actual or putative class action filings.

Year of Filing	CASES WHERE A CLASS WAS ULTIMATELY CERTIFIED	CASES WHERE CLASS CERTIFICATION WAS SOUGHT BUT NEVER ACTUALLY GRANTED (include cases with certification issues still unresolved)
2002		
2001		
2000		
1999		
1998		
1997		
1996		
1995		
1994		
1993		
1992 or earlier		
Original filing date unknown but case was open during 1993 to 2002		
COLUMN TOTAL		

5) - NUMBER OF CASE-SPECIFIC QUESTIONNAIRES

Ideally, a "Case-Specific Questionnaire" should be filled out for each filing indicated in **Question 4** if at least the case title and court location are known. In the table below, please indicate the number of cases for which questionnaires have been completed and the number of cases without any specific information available (and so questionnaires were not completed):

Type of Actual or Putative Class Action Filing	Number of cases for which individual Case-Specific Questionnaires have been completed	Number of cases indicated in Question 4 for which not even case title and court location are known (and so no Case-Specific Questionnaires have been completed)
CASES WHERE A CLASS WAS ULTIMATELY CERTIFIED		
CASES WHERE CLASS CERTIFICATION WAS SOUGHT BUT NEVER ACTUALLY GRANTED (include cases with certification issues still unresolved)		

6) _____ CHECK HERE IF YOU WOULD LIKE TO BE CONTACTED BY RAND STAFF FOR ASSISTANCE IN COMPLETING THIS FORM

Please use the enclosed envelope to return all completed surveys for
XXXXXX XXXXXX Insurance Company by XX/YY/ZZ.

Case-Specific Questionnaire

**RAND INSTITUTE FOR CIVIL JUSTICE
NATIONAL SURVEY OF INSURANCE CLASS ACTIONS
Case Specific Questionnaire**

THIS FORM MAY BE REPRODUCED AS NEEDED FOR ADDITIONAL CASES INVOLVING THIS DEFENDANT

Complete a separate Case Specific Questionnaire for each case...

...open at any time from 1993 through 2002, and

...where Xxxxxx Xxxxxx Insurance Company was a named defendant, and

...where class action certification was sought by plaintiffs even if never granted.

NOTE: Do not fill out this form if the case was one of the following types:

- Class actions by insurance company employees, agents, brokers, or adjusters
- Shareholder suits such as those brought under the Securities Act of 1933 or the Securities Exchange Act of 1934
- "Direct action" suits naming an insurer only for the purpose of deciding third party liability coverage issues

RESPONDING DEFENDANT: XXXXXX XXXXXX INSURANCE COMPANY

Attn: Zzzzzz Y. Xxxxxx, General Counsel
The Xxxxxx Xxxxxx Insurance Group
1234 Xxxxxx Street, Yyyyyyy, ZZ 12345 Phone: 999-555-1212 xyz@xxxxxxx.com

1) Individual responding to survey and contact information (if different from above):

a) NAME: _____ TITLE: _____

b) ADDRESS:

c) PHONE: _____

d) E-MAIL (optional): _____

CASE SUMMARY INFORMATION

2) Case name at the trial court level (short title; use version at disposition or current if still active):

a) _____ Information not available (check if true) OR

b) Case (e.g., "Jones v. XYZ Insurance"):

3) Jurisdiction at the trial court level at time of **initial filing** (check one):

a) _____ Information not available b) _____ State court c) _____ Federal court

4) Jurisdiction at the trial court level at **disposition** (or **current** if still active) (check one):

- a) _____ Information not available b) _____ State court c) _____ Federal court

5) Name of trial court at disposition (or current if still active):

a) _____ Information not available (check if true) OR

b) Court (e.g., "3rd Judicial Circuit"):

c) State and County (if state court):

d) Federal District (if federal court):

6) Case number at the trial court level at disposition (or current if still active):

- a) _____ Information not available OR b) Case number: _____
(check if true)

7) Judge supervising case at the trial court level at disposition (or current if still active):

- a) _____ Information not available OR b) Judge : _____
(check if true)

8) Date of original filing at the trial court level:

- a) _____ Information not available OR b) Date (MM/DD/YY): _____
(check if true)

9) Approximate number of corporate entities named as defendants at disposition (or current if still active):

a) _____ Information not available (check if true) OR

b) Number of corporate defendants: _____

i) Names of other corporate defendants in this case (if applicable\known)

10) Was Xxxxxx Xxxxxx Insurance Company specifically named in this suit as a defendant or was it involved in the case only because a parent or related company was named? (check one)

a) _____ Information not available OR

b) _____ Individually named in suit

c) _____ Not specifically named in suit; only parent company or other related enterprise was named

i) Names of related defendants if not specifically named (if applicable)

11) Was this case ever subject to Federal Multi-District Litigation procedures? (check one):

- a) Information not available
- b) No, never an MDL case
- c) Yes, part of a consolidated MDL action for at least some part of its life
 - i) MDL number and Federal District (if known):

12) Was this case ever removed from state court to federal court or ever remanded from federal court to state court? (check one):

- a) Information not available
- b) No, remained in same court system for entire life
- c) Yes, removed or remanded at least once

13) Are you aware of similar class actions (actual or putative) filed against Xxxxxx Xxxxxx Insurance Company that allege essentially the same issues and have a similar (actual or proposed) class? (check one)

- a) Information not available **OR**
- b) No knowledge of similar class actions against this defendant.
- c) Yes, at least one similar class action was also filed
 - i) If known, case title, case number, and jurisdiction of filing for any similar actual or proposed class actions:

SCOPE

14) Lines involved in this case):

- a) Information not available
- OR - (check all that apply from list below)**
- b) Accident & Health - Credit
- c) Accident & Health - Group
- d) Accident & Health - Industrial
- e) Accident & Health - Other, multiple types, or not specified
- f) Aircraft
- g) Allied Lines
- h) Annuities - Group
- i) Annuities - Industrial
- j) Annuities - Other, multiple
- kk) Homeowners
- ll) Hospital Industrial
- mm) Inland Marine
- nn) Liability - Other, multiple types, or not specified
- oo) Life - Credit
- pp) Life - Group
- qq) Life - Industrial or Burial
- rr) Life - Ordinary
- ss) Life - Other, multiple types,

- types, or not specified
- k) _____ Annuities - Variable
- l) _____ Auto - Commercial
- m) _____ Auto - Industrial
- n) _____ Auto - Other, multiple types,
or not specified
- o) _____ Auto - Personal
- p) _____ Auto - Warranty
- q) _____ Boiler & Machinery
- r) _____ Burglary & Theft
- s) _____ Casualty
- t) _____ Collateral Protection
- u) _____ Credit
- v) _____ Crop & Hail
- w) _____ Dental
- x) _____ Directors & Officers Liability
- y) _____ Disability income
- z) _____ Earthquake
- aa) _____ Excess & Surplus
- bb) _____ Farm owners
- cc) _____ Fidelity
- dd) _____ Financial Guaranty
- ee) _____ Fire
- ff) _____ Flood
- gg) _____ General Liability
- hh) _____ Health, including Managed Care
Organizations
- ii) _____ Home Services
- jj) _____ Home Warranty

- or not specified
- tt) _____ Long Term Care
- uu) _____ Major Medical
- vv) _____ Medicare Supplement
- ww) _____ Mobile Home
- xx) _____ Mortgage Guaranty
- yy) _____ Multi-Peril - Commercial
- zz) _____ Multiple Lines - Commercial
- aaa) _____ Multiple Lines - Other,
multiple types, or not specified
- bbb) _____ Multiple Lines -
Personal
- ccc) _____ Ocean Marine
- ddd) _____ Products Liability
- eee) _____ Professional Liability -
Lawyer
- fff) _____ Professional Liability -
Medical Malpractice
- ggg) _____ Professional Liability -
Other, multiple types, or not
specified
- hhh) _____ Property - Commercial
- iii) _____ Reinsurance
- jjj) _____ Reinsurance - Casualty
- kkk) _____ Reinsurance - Other,
multiple types, or not specified
- lll) _____ Reinsurance - Property
- mmm) _____ Reinsurance - Surety
- nnn) _____ Residual Plans
- ooo) _____ Stop Loss
- ppp) _____ Surety
- qqq) _____ Warranties, Other
- rrr) _____ Workers' Compensation

sss) _____ **OTHER LINES INVOLVED IN THE CASE (describe below)**

15) **Plaintiffs'** key allegations during life of case (even if specific cause of action, claim, or allegation later dismissed or dropped):

a) _____ **Information not available**

- OR - (circle the numbers for all that apply from line-specific list below)

b) **VARIOUS LINES - Credit Report Issues**

- i) Declined to offer installment plan due to adverse credit report.
- ii) Declined to renew policy due to adverse credit report.
- iii) Denied coverage solely based on adverse credit report.
- iv) Discriminated against minorities due to systematic use of credit reports in underwriting.
- v) Failed to disclose adverse credit report that resulted in denial of insurance, rate increase, or coverage change.
- vi) Failed to disclose any use of or request for credit report.
- vii) Failed to notify of receipt of adverse credit report even if not used.
- viii) Improperly used credit histories when calculating premiums.
- ix) Increased rates based on adverse credit report.
- x) Ordered credit report without legally permissible purpose.

c) **VARIOUS LINES - Modal Issues**

- i) Failed to comply with Truth in Lending Act requirements for financed portion of the annual premiums paid on a periodic basis.
- ii) Failed to disclose annual percentage rate and finance charges incurred when paying premiums periodically rather than annually.
- iii) Imposed premium finance service charges in violation of state law.

d) **VARIOUS LINES - Other Issues**

- i) Denied claims based on policy exclusions that are legally unenforceable because they are not tied to specific premium discounts.
 - ii) Failed to pay claims stemming from the Jewish or Armenian Holocausts.
 - iii) Failed to pay interest on delays in paying liability settlements.
 - iv) Received the benefit of broker fees improperly charged by independent agents.
- e) ANNUITIES**
- i) Failed to disclose payments made to annuity provider by mutual fund companies.
 - ii) Failed to fully inform prospective and current policyholders about withdrawal penalty for transferring or switching policies.
 - iii) Failed to inform when variable contracts purchased in tax-deferred plans provided no additional benefit to the customer.
 - iv) Failed to register annuities as securities.
 - v) Failure to disclose possibility of lower return in different market conditions.
 - vi) Falsely represented that assets could be transferred among funds offered in the contracts without charge.
 - vii) Made changes to interest rate used for payments that did not reflect market conditions as promised.
 - viii) Misrepresented annuity contract interest rate adjustments conditions.
 - ix) Misrepresented the risk of annuities as an investment.
 - x) Misrepresenting that tax benefits in tax-deferred plans are only available if they are funded with an annuity contract.
 - xi) Replaced original mutual funds included in annuities with inferior funds.
 - xii) Represented annuities as a type of insurance product.
 - xiii) Sold 403(b) retirement plans improperly as debt-consolidation plans.
 - xiv) Sold 403(b) retirement plans that were defective in tax consequences.
 - xv) Unauthorized replacement of existing annuities with new contract.
 - xvi) Unnecessary placement of tax-deferred annuities into tax-deferred retirement plans.
- f) AUTO (VARIOUS)**
- i) Calculated premiums in manner not consistent with state law.
 - ii) Continued to charge higher premiums for drivers with prior accidents even though law required removal of the surcharge.
 - iii) Improperly surcharged or denied discounts to drivers whose prior coverage was a non-standard insurance policy.
 - iv) Included "owned but not insured" exclusion in policies without a corresponding premium adjustment.
 - v) Marketed multiple types of policies at different premium levels but with no difference in coverage or benefits.
 - vi) Over billed regular policyholders by setting improperly high profit margin in order to subsidize high risk customer pool.
- g) AUTO (1st PARTY) - Diminished Value Issues**
- i) Failed to reimburse policyholders for the diminished value of repaired vehicles.
- h) AUTO (1st PARTY) - Increased Value Issues**
- i) Deducted portion of payments for vehicle repair based on alleged betterment in value of vehicle from upgraded parts or repairs.
- i) AUTO (1st PARTY) - OEM Issues**
- i) Conspired with other insurers to manipulate the price of auto physical damage coverage with the use of aftermarket parts.
 - ii) Created Certified Automotive Parts Association (CAPA) to conceal flaws in aftermarket parts.
 - iii) Failed to disclose the use of aftermarket parts for repairs rather than using original equipment manufacturer parts.
 - iv) Failed to pass along savings realized by the use of aftermarket parts for repairs rather than using OEM parts to policyholders.
 - v) Specified aftermarket parts for repairs rather than using OEM parts, resulting in diminished value and safety issues.
- j) AUTO (1st PARTY) - Other Issues**
- i) Failed to obtain salvage title after totaling vehicles.
 - ii) Failed to reimburse deductibles paid on claims where other driver was at fault.
 - iii) Systematically omitted payment for certain necessary types of safety-related repairs.

- iv) Systematically referred policyholders to auto repair shops that use substandard replacement parts and repair methods.
- v) Used valuation software package designed to produce offers for automobile total loss at less than fair market value.
- k) AUTO (LIABILITY) - 3rd Party Claimants**
 - i) Discouraged claimants from seeking counsel.
 - ii) Unfairly \ deceptively handled claims.
 - iii) Unnecessarily delay in payment of concluded settlements without including interest payments.
- l) AUTO (PIP\MEDPAY) - Health Care Providers**
 - i) Made inappropriate fee reductions on claims submitted under PIP coverage.
 - ii) Provided cash incentives to claims reviewers who would deny or limit tests and treatments.
 - iii) Used cost-based criteria to review claims.
- m) AUTO (PIP\MEDPAY) - Policyholders**
 - i) Failed to disclose practice of paying only bills at a fixed percentile of local "usual and customary" charges.
 - ii) Systematic denial of claims for MRI payments.
 - iii) Systematic reduction of PIP benefits through bill review computer program.
 - iv) Systematically refused to reimburse on "reasonable and customary" grounds without investigating particular merits of the claim.
 - v) Used medical file review firms with unqualified, non-medical reviewers making claims decisions.
 - vi) Used valuation software package designed to produce offers for personal injury claims at less than full and fair value.
- n) AUTO (UM\UIM) - 3rd Party Claimants**
 - i) Threatened uninsured motorists with loss of license in order to obtain reimbursement.
- o) AUTO (UM\UIM) - Policyholders**
 - i) Charged for multi-car "stack" coverage when actually only one car.
 - ii) Failed to pay uninsured/underinsured motorist claims on vehicles based on an unenforceable "other-owned auto exclusion".
 - iii) Sought reimbursement from uninsured motorists in a way that prevented insureds from pursuing own claims.
- p) COLLATERAL PROTECTION**
 - i) Charged premiums in excess of those allowed by law.
- q) COMMERCIAL GENERAL LIABILITY - 3rd Party Claimants**
 - i) Inappropriate inducement to accept low settlement amounts while handling asbestos claims.
- r) COMMERCIAL GENERAL LIABILITY - Policyholders**
 - i) Conspired to fix the terms of CGL policies in violation of antitrust laws.
- s) CREDIT LIFE**
 - i) Calculated premiums on total amount financed plus all future interest rather than on unpaid principal only.
 - ii) Induced borrowers to purchase optional credit insurance products unknowingly.
 - iii) Sold policies not approved by state regulators.
 - iv) Sold policies without required federal Truth in Lending disclosures.
- t) CROP**
 - i) Refused to write supplemental crop insurance.
- u) DISABILITY**
 - i) Created inappropriate financial incentives to employees to routinely deny claims.
 - ii) Systematically cancelled long-term disability policies for patients with cancer, heart disease, and other high value claims.
- v) HEALTH - Members**
 - i) Calculated premiums based on higher "usual and prevailing" provider fees though actually paid Medicare maximums.
 - ii) Cancellation of "guaranteed renewable" policies when substantial claims filed.
 - iii) Charged improper premiums for replacement coverage.
 - iv) Claimed to be non-profit association health service providers when in fact for-profit insurance companies.
 - v) Collected deductible and co-payments calculated on original billing rather than on negotiated, discounted rate.
 - vi) Discriminated against women by limiting or excluding coverage of prescription contraceptives.

- vii) Enforcing illegal arbitration clauses.
 - viii) Failed to comply with small group pooling laws.
 - ix) Failed to disclose full impact of arbitration clauses.
 - x) Failed to disclose to members how benefit and coverage decisions are made.
 - xi) Failed to disclose to members how providers are compensated.
 - xii) Failed to notify former policyholders of conversion rights after termination.
 - xiii) Failed to provide members with proper appeals process.
 - xiv) Failed to provide notice of adverse health care decisions.
 - xv) Failed to refund or rebate to members tobacco settlement money obtained for costs expended for their health care.
 - xvi) Failed to reimburse members for out-of-pocket expenses for alternative care despite legal requirement to do so.
 - xvii) Failed to warn customers of financial compensation incentive program for providers to limit treatment or tests.
 - xviii) Falsely represented that providers, and not administrators, would direct medical care.
 - xix) Forced enrollment into Medicare in violation of Secondary Payer Act.
 - xx) Issued cancer supplement replacement policies that were more expensive and contained reduced benefits.
 - xxi) Offered only inferior policies at higher rates after canceling "guaranteed renewable" policies when substantial claims filed.
 - xxii) Pressured providers and patients to accept generic versions of drug that are not as safe and effective as brand name versions.
 - xxiii) Pursued subrogation recovery efforts so as to interfere with members rights to settle personal injury claims.
 - xxiv) Pursued subrogation recovery efforts without legal basis for doing so.
 - xxv) Systematically denied members lead poison testing.
 - xxvi) Systematically reduced payments for necessary anesthesia services.
 - xxvii) Terminated depositor medical insurance without adequate warning.
 - xxviii) Used "tier rating" with premium price hikes greater for ill policyholders than healthy ones.
 - xxix) Used renewal rating methodology in violation of law.
 - xxx) Used utilization-management guidelines as a substitute for decision-making by doctors.
 - xxxi) Violated fiduciary obligations with interchange programs and negotiation of formulary rebates \ discounts from drug manufacturers.
 - xxxii) Violated non-profit status by failure to keep premiums in line.
 - xxxiii) Violated non-profit status by failure to provide coverage to high risk or low income population.
 - xxxiv) Violated non-profit status by large surplus growth.
- w) **HEALTH - Providers**
- i) Arbitrarily changed provider reimbursement rates.
 - ii) Attempted to fix prices paid to providers for services in violation of antitrust laws.
 - iii) Delayed payments unnecessarily without paying interest on valid claims.
 - iv) Disregarded medically necessary criteria in making coverage and treatment decisions.
 - v) Divided up market in conspiracy with other plans to dictate prices and terms in violation of antitrust laws.
 - vi) Entered into illegal capitation arrangements.
 - vii) Failed to adequately explain to providers how the reimbursement fee schedule was designed and how it operates.
 - viii) Failed to maintain accurate books and records resulting in improper payments to providers.
 - ix) Failed to maintain consistent medical utilization/quality management and administration of covered services.
 - x) Failed to make increased reimbursement payments when the treatment required extra time and resources.
 - xi) Inappropriately used cost-based criteria to review claims.
 - xii) Interfered with providers' relationships with patients by arbitrarily denying or delaying authorizations and/or payments.
 - xiii) Made treatment and payment decisions based in part on prior history of provider's actions and charges.
 - xiv) Paid financial incentives and performance bonuses to review staff to limit patient care costs.

- xv) Paid out-of-network providers less than billed charges.
 - xvi) Performed industry wide boycott of certain medical services.
 - xvii) Reimbursed fees to providers at levels lower than true prevailing rates.
 - xviii) Reimbursed providers based on the frequency of which they order a particular test or treatment.
 - xix) Sent Explanation of Benefit notices to members that appeared to suggest providers' charges exceeded usual and customary rates.
 - xx) Systematically refused to pay for treatments by falsely claiming no referral from primary care physician.
 - xxi) Used claim review software to "bundle", drop, and "downcode" claim codes submitted by providers without justification.
 - xxii) Violated state prompt-payments laws.
- x) INVESTMENTS**
- i) Claimed to be offering individual financial planning services when purpose was to sell high-risk partnerships.
 - ii) Made misleading statements about the return rates of limited partnerships.
 - iii) Made misleading statements about the risk of limited partnerships.
- y) LIFE**
- i) Attempted to recoup funds based on changing economic conditions unrelated to expected mortality experience.
 - ii) Began a deceptive voluntary exchange program designed to terminate policies with prohibited cost of insurance increases.
 - iii) Claimed premiums would "vanish" over time.
 - iv) Collected premiums for the period prior to the delivery of the policy and/or prior to coverage start.
 - v) Continued to collect additional premiums for "child rider" after cut-off age for coverage.
 - vi) Discriminated against disabled by excluding applicants with health problems without evidence of negative effect on life expectancy.
 - vii) Discriminated based on race by targeting small-face-value policies with benefits less than total premium payments to minorities.
 - viii) Discriminated based on race by targeting policies with higher prices, no cash accumulation, or fewer benefits to minorities.
 - ix) Discriminated by setting premium levels based on race.
 - x) Failed to accurately disclose impact of demutualization on existing policyholders.
 - xi) Failed to disclose early withdrawal penalties.
 - xii) Failed to disclose that money paid would be used to pay charges and fees and would not earn any interest or investment income.
 - xiii) Failed to inform term life policyholders of right to convert during last year of conversion period.
 - xiv) Failed to notify policyholder's employer and end automatic payroll deductions for premiums when policy canceled.
 - xv) Failed to observe the guaranteed features of term life policies.
 - xvi) Failed to pay persistency bonus for continuing to keep the policy in force as promised.
 - xvii) Failed to register as an investment company when investing its assets primarily in other securities.
 - xviii) Failed to register as an investment company when issuing securities in the form of variable insurance products.
 - xix) Failed to register variable life policies as securities under state Blue Sky laws.
 - xx) Improperly characterized variable life policies as mutual fund investments.
 - xxi) Improperly charged excess costs of insurance, expenses and admin. fees in violation of contract and marketing materials.
 - xxii) Improperly charged policies with costs and other fees including deferred acquisitions cost tax.
 - xxiii) Increased cost of insurance charges on whole life in order to induce policyholders to surrender policies or allow to lapse.
 - xxiv) Increased premiums, reduced benefits, or terminated coverage after group life policyholders retired.
 - xxv) Made dividend payments at less than the contractually required amount.
 - xxvi) Mislead prospective buyer about the company's shaky financial condition.
 - xxvii) Misrepresented policy performance projections.

- xxviii) Misrepresented the benefits from and suitability of "rolling over" some or all of an existing life insurance policy's cash value.
 - xxix) Misrepresented the cash value and/or benefits a policyholder would realize under a policy.
 - xxx) Provided misleading advice to "churn" existing policies with new ones and obtain transaction fees.
 - xxxi) Provided misleading advice to "churn" existing policies with new ones with higher premiums and/or reduced benefits.
 - xxxii) Provided misleading advice that implied policy was a "high interest retirement savings vehicles" and not insurance.
 - xxxiii) Set monthly premiums which were not, and could never be, sufficient to pay current policy cost or to meet forecasts.
 - xxxiv) Sold higher priced policies, rather than less expensive ones with the same coverage, because commissions were higher.
 - xxxv) Sold life policies to existing Medigap customers without consent or knowledge and/or as "health" coverage.
 - xxxvi) Sold life policies to non-US residents that were actually "securities" in violation of state Blue Sky laws.
 - xxxvii) Unfairly allocated portfolio yields to universal life policies.
- z) LONG TERM CARE**
- i) Failed to disclose that premiums could increase.
- aa) MEDICAL MALPRACTICE**
- i) Collected premiums to cover cost of supposedly free future tail coverage on occurrence policies.
 - ii) Refused to provide tail coverage on occurrence policies as had been promised.
 - iii) Withdrew from market in breach of contract and in bad faith to policyholders.
- bb) MORTGAGE**
- i) Provided pool insurance and other products to lenders at reduced prices in exchange for the referral of insurance business.
- cc) PROPERTY**
- i) Charged a "management fee" in order to illegally increase premiums.
 - ii) Discriminated based on race by refusing to insure or only offering policies with fewer benefits in particular geographic areas.
 - iii) Discriminated based on race by refusing to insure older homes or only offering policies with fewer benefits to minorities.
 - iv) Failed to provide allowance for general contractor's overhead and profit when paying for repairs with multiple trade specialists.
 - v) Paid reduced benefits when homeowners do own repairs.
 - vi) Provided poor customer service, delayed responding to inquiries, and generally mishandling claims.
 - vii) Systematically denied supplemental claims on the basis of a time bar even though additional damage recently discovered.
 - viii) Systematically estimated damage at lower than actual cost of repair.
 - ix) Used "survey" sent to policyholders following disaster to later deny claims and/or as a waiver of rights.
 - x) Used unqualified estimators, adjusters, contractors, or engineers for damage evaluation.
 - xi) Wrongly limited coverage for water or mold damage.
- dd) STRUCTURED SETTLEMENTS**
- i) Failed to disclose rebate of portion of the commission paid to annuity broker.
 - ii) Represented structured settlements as partial assignments when in fact full assignments.
- ee) TITLE**
- i) Charged escrow customers fees for services never performed or were worth less than amount charged.
 - ii) Discussed and set prices for title insurance with other insurers in violation of antitrust laws.
 - iii) Failed to disclose referral based bonuses paid to agents.
 - iv) Failed to give unclaimed property to the state on a timely basis.
 - v) Improperly charged for the filing for the release of mortgages even though actual filing is done by others.
 - vi) Received secret interest payments from banks on escrow account without remitting to customers.
 - vii) Retained fees for reconveyance and recording services company did not perform.

viii) Used "earnings credits" schemes to get around no-interest on escrow account rules.

ff) VEHICLE SERVICE CONTRACTS

i) Failed to disclose rebates from insurers to sellers.

gg) VIATICAL SETTLEMENTS

i) Sold interests in settlements purchased from policyholders before contestability period ended.

ii) Sold interests in settlements purchased from policyholders who had fraudulently obtained policies.

hh) WORKERS' COMPENSATION

i) Administered experience readjustments unfairly.

ii) Conspired to charge unduly high fees on businesses placed in assigned risk pool.

iii) Conspired to fix prices in violation of antitrust laws.

iv) Conspired to overload assigned risk pool.

v) Conspired with the National Council on Compensation Insurance to charge more than approved by state Board of Insurance.

vi) Failed to pay applicable insurance taxes.

vii) Failed to warn or protect insured entities' employees of asbestos danger at covered facility.

viii) Inflated in-house counsel bills to insureds w/ negative impact on loss histories for reimbursement dividends and future rates.

ix) Inflated in-house counsel bills to self-insureds for services in order to generate increased income.

x) Misreported medical-legal expenses to Rating Bureau as claim costs rather than general expenses to inflate experience modifiers.

xi) Overcharged customers in order to inflate surplus and reserves to later engage in predatory price wars and reduce competition.

xii) Passed on excessive servicing carrier fees to policyholders in the form of higher rates.

ii) **OTHER (describe below) Please include specific type of insurance product, type of putative or actual class members, and key allegations of plaintiffs regarding defendants' conduct.**

16) Key statutes involved in the claims and defenses asserted in this case:

- a) Information not available
- OR - (check all that apply from list below)
- b) State securities acts ("Blue Sky" laws)
- c) State anti-trust laws
- d) State unfair or deceptive trade practices acts
- e) State unfair claims, settlement, or other insurance practices acts
- f) ERISA (federal Employee Retirement Income Security Act)
- g) RICO (federal Racketeer Influenced and Corrupt Organizations Act)
- h) Federal Securities Act of 1933 or Securities Exchange Act of 1934
- i) Federal Sherman Anti-trust Act
- j) Federal Clayton Anti-trust Act

- k) _____ Federal Medicare Secondary Payer Act
- l) _____ Federal McCarran-Ferguson Act
- m) _____ Federal Truth In Lending Act
- n) _____ Federal Fair Debt Collection Practices Act
- o) _____ Federal Fair Credit Reporting Act
- p) _____ Other (describe below)

17) Was the exclusive or primary jurisdiction of state or federal regulators to decide some or all of the issues in the case asserted by any defendant?

- a) _____ Information not available
- OR - (check all that apply from list below)
- b) _____ Regulators were claimed to have exclusive jurisdiction over some or all case issues
- c) _____ Regulators were claimed to have primary jurisdiction over some or all case issues
- d) _____ Authority of regulators not an issue in this case
- e) _____ Other (describe below)

18) Were any government agencies or entities (including state insurance commissioners or attorneys general) involved in this case?

- a) _____ Information not available (go to Question 20)
- OR - (check all that apply from list below)
- b) _____ No direct or indirect involvement by any government agency or entity (go to Question 20)
- c) _____ Government agencies or entities were named parties in this case or intervened during its life
- d) _____ Government agencies or entities filed amicus briefs
- e) _____ Government agencies or entities attempted to broker dispute between actual or putative class and defendants
- f) _____ Other type of involvement with case (describe below)

19) Did the government agencies or entities referred to in the preceding question generally support the claims of the actual or putative class or the defendants in this case?

a) Information not available

- OR - (check all that apply from list below)

b) Government agencies or entities were generally supportive of the actual or putative class

c) Government agencies or entities were generally supportive of the defendants

d) Government agencies or entities did not appear to support the claims or allegations of either side

e) Other type of involvement with case (describe below)

CERTIFIED OR PUTATIVE CLASS

20) Brief description of certified or putative plaintiff class (e.g., "Homeowners who purchased life policies during the years 1992 to ..."):

Information not available (check if true) OR

21) States of residency for member of certified or putative class at disposition (or current if still active):

a) Information not available OR

b) All 50 states and District of Columbia OR

c) _____ All 50 states and District of Columbia EXCEPT THOSE CHECKED OFF BELOW OR

d) _____ ONLY THOSE JURISDICTIONS CHECKED OFF BELOW

STATE LIST for responses C) or D) (if applicable)

AL _____ (Alabama)	KY _____ (Kentucky)	ND _____ (North Dakota)
AK _____ (Alaska)	LA _____ (Louisiana)	OH _____ (Ohio)
AZ _____ (Arizona)	ME _____ (Maine)	OK _____ (Oklahoma)
AR _____ (Arkansas)	MD _____ (Maryland)	OR _____ (Oregon)
CA _____ (California)	MA _____ (Massachusetts)	PA _____ (Pennsylvania)
CO _____ (Colorado)	MI _____ (Michigan)	RI _____ (Rhode Island)
CT _____ (Connecticut)	MN _____ (Minnesota)	SC _____ (South Carolina)
DE _____ (Delaware)	MS _____ (Mississippi)	SD _____ (South Dakota)
DC _____ (Dist. of Col.)	MO _____ (Missouri)	TN _____ (Tennessee)
FL _____ (Florida)	MT _____ (Montana)	TX _____ (Texas)
GA _____ (Georgia)	NE _____ (Nebraska)	UT _____ (Utah)
HI _____ (Hawaii)	NV _____ (Nevada)	VT _____ (Vermont)
ID _____ (Idaho)	NH _____ (New Hampshire)	VA _____ (Virginia)
IL _____ (Illinois)	NJ _____ (New Jersey)	WA _____ (Washington)
IN _____ (Indiana)	NM _____ (New Mexico)	WV _____ (West Virginia)
IA _____ (Iowa)	NY _____ (New York)	WI _____ (Wisconsin)
KS _____ (Kansas)	NC _____ (North Carolina)	WY _____ (Wyoming)

22) Was a motion for certification actually made by any plaintiff? (include motions made in conjunction with a simultaneous request for settlement approval) (check one):

a) _____ Information not available (go to CASE STATUS section below)

b) _____ Yes (go to Question 23)

c) _____ No

i) If no motion for certification was ever made, what factors indicated that class treatment was a possibility?: (check all that apply):

(1) _____ Information not available (go to CASE STATUS section below)

(2) _____ Complaint or other pleading indicated that case involved potential class (go to CASE STATUS section below)

(3) _____ Communications from plaintiffs indicated that case involved potential class (go to CASE STATUS section below)

(4) _____ Other (please describe) (go to CASE STATUS section below)

23) Date of most recent motion for certification (including motions made simultaneously with requests for settlement approval):

a) _____ Information not available OR b) Date (MM/DD/YY): _____
(check if true)

24) Status of most recent motion for certification (including motions made simultaneously with requests for settlement approval): (check one):

a) _____ Information not available OR

b) _____ Approved

i) Date of approval:

(1) _____ Information not available OR (2) Date (MM/DD/YY): _____
(check if true)

c) _____ Denied

i) Date of denial:

(1) _____ Information not available OR (2) Date (MM/DD/YY): _____
(check if true)

d) _____ Case was resolved prior to decision

e) _____ Still under consideration

f) _____ Motion withdrawn by plaintiffs

g) _____ Other outcome (please describe)

CASE STATUS

25) Most recent status of case at the trial court level: (check one)

a) _____ Information not available OR

b) _____ Trial completed

i) Outcome: (check one)

(1) _____ Information not available (check if true)

(2) _____ Verdict for plaintiffs

(3) _____ Verdict for defendants

ii) End date of trial (MM/DD/YY): _____

c) _____ Summary judgment or other dispositive ruling in favor of **plaintiffs**

i) _____ Information not available OR ii) Date of ruling (MM/DD/YY): _____
(check if true)

d) _____ Summary judgment or other dispositive ruling in favor of **defendants**

i) _____ Information not available OR ii) Date of ruling (MM/DD/YY): _____
(check if true)

e) _____ Voluntary dismissal without settlement

i) _____ Information not available OR ii) Date of dismissal (MM/DD/YY): _____
(check if true)

f) _____ Certified class settlement approved

i) _____ Information not available OR ii) Date of approval (MM/DD/YY): _____
(check if true)

g) _____ Certified class settlement submitted for review, final decision pending

- h) Certified class settlement rejected by judge, matter still being litigated
- i) Matter still being litigated, no settlement ever submitted for review
- j) Case resolved through non-class settlement with limited number of individual plaintiffs
 - i) Information not available OR ii) Date of resolution (MM/DD/YY): _____
(check if true)
- k) Other outcome (please describe)

26) Was any aspect of this case ever appealed? (check one)

- a) Information not available OR
- b) No
- c) Yes, currently on appeal (enter name of highest appellate court below)
- d) Yes, appeal resolved or refused to be heard (enter name of highest appellate court below)
- e) Other (please describe)

OUTCOME

NOTE: COMPLETE REST OF SURVEY ONLY IF CASE RESULTED IN A SETTLEMENT OR A TRIAL VERDICT FOR PLAINTIFFS

27) Scope of outcome: (check one)

- a) Information not available (**STOP. End coding.**) OR
- b) Resolution of case affects approved\certified class of plaintiffs (**Please answer Q. 28 and remainder of form.**)
- c) Resolution of case only affects limited number of individual non-class plaintiffs (**STOP. End coding.**)

28) Please describe the following features of the case resolution:

- a) Approximate size of award to class counsel for fees and expenses

i) _____ Information not available (check if true) OR

ii) Description: _____

b) Approximate final size of qualifying plaintiff class

i) _____ Information not available (check if true) OR

ii) Description: _____

c) Approximate size of aggregate pool of funds available to plaintiff class

i) _____ Information not available (check if true) OR

ii) Description: _____

d) Short description of claiming or distribution mechanism (e.g., automatic refunds of accounts, claim form sent in by mail, etc.)

i) _____ Information not available (check if true) OR

ii) Description: _____

e) Short description of notification mechanism of claiming or distribution process (e.g., TV ads, etc.)

i) _____ Information not available (check if true) OR

ii) Description: _____

f) Approximate final number of plaintiffs with compensated claims

i) _____ Information not available (check if true) OR

ii) Description: _____

g) Approximate final sum of all dollars paid out to plaintiff class

i) _____ Information not available (check if true) OR

ii) Description: _____

h) Description of other case resolution information (e.g., cy pres payments, coupons, etc.)

i) _____ Information not available (check if true) OR

ii) Description: _____

29) _____ CHECK HERE IF YOU WOULD LIKE TO BE CONTACTED BY RAND STAFF FOR ASSISTANCE IN COMPLETING THIS FORM

IF YOU BELIEVE IT WOULD HELP BETTER EXPLAIN THE ISSUES AND\OR THE LITIGATION PROCESS, PLEASE FEEL FREE TO FORWARD COPIES OF ANY RELEVANT PLEADINGS SUCH AS COMPLAINTS, BRIEFS FOR OR AGAINST CERTIFICATION, BRIEFS FOR SETTLEMENT APPROVAL, ETC.

Please use the enclosed envelopes to return this survey by XX/YY/ZZ

STATE DEPARTMENTS OF INSURANCE SURVEY

Greetings:

The RAND Corporation's Institute for Civil Justice (ICJ), widely regarded as the nation's leading research institution focusing on our civil justice system, is requesting your participation in an important study of class action litigation involving the insurance industry.

As part of this project, we have contacted a sample of the property & casualty, life, and health insurers operating within the U.S. and asked each company about their recent experiences as defendants in cases that have sought class action status. We received detailed information on approximately 1000 certified or attempted class actions, learning of their locations, dates of filing and resolution, parties in the case, lines of insurance involved, key allegations made by the plaintiffs, key statutes involved, actual or proposed classes including geographical coverage, details about the process for seeking certification, and outcomes.

One area that we are interested in investigating involves the relationship between these cases and our state-based system of administrative regulation of the insurance industry. We would like to be able to report on the frequency in which class actions involve issues that are also the routine subject of administrative rulemaking, enforcement, or adjudication activities. Obviously, not every allegation or defense in an insurance class action has a significant relationship to the authority of a regulator to, for example, require standardized forms, review and approve proposed rates, license agents and brokers, liquidate insolvent insurers, or perform some other traditional task. But clearly there are at least some instances where regulators themselves believe the issues in certain types of cases, especially ones in which involve large numbers of policyholders, assignees of benefits, or others, should be first subject to the agency's own review or at least turn on decisions and rules previously generated by that same agency.

In order to achieve this goal, we need to be able to rank the issues in the cases the insurers told us about by their potential for touching on the traditional activities of insurance regulators. Such a ranking would, of course, be very subjective as reasonable people can differ as to what the proper role of a state department of insurance might be. Not every state employs the same regulatory approach and an issue that might be repeatedly subject to agency enforcement or other action in one state may be totally outside the traditional scope of an agency in another. Moreover, the facts of every civil case, class actions included, are unique and often quite complex, and it can be difficult to know whether an issue briefly summarized in a single sentence truly involves an agency's authority without knowing considerably more about the particular litigation. Nevertheless, we hope that you will help us by taking a look at the list of issues below that we encountered as part of our study and give us your impression as to the degree to which they are likely to overlap upon the activities of the insurance department in your own state.

Please rate each issue in terms of its relationship to the authority and activities of your insurance regulator, using a 1-to-5 scale on which 1 equals "Little or no relationship", 3 equals "Moderate relationship", and 5 equals "Significant relationship". You need not have had this particular issue raised directly by any certified or attempted class action previously litigated in your state as we are asking only about the theoretical relationship as you perceive it to be; as such, whether or not your state's regulator affirmatively asserted its authority in a previous case or took some other action is not important. Please try to rate these issues in a way that reflects the

regulator's position regarding the allegations of an entire class of policyholders or other individuals or businesses; while departments of insurance often investigate and attempt to resolve the majority of individual complaints received by the agency regardless of subject matter, they do not always believe it to be appropriate or within their scope of authority to become involved in a case where that same issue is being litigated en masse. If you are unable to answer the question at all, please use the "N\A" option though we hope that you'll attempt to provide us with your initial impression for each and every one of the issues below. You need only place a check alongside the desired rating value (if answering an electronic version of this survey, simply insert an "X" in the proper location).

In order to encourage candid responses, you should be assured that your name, your employer, and your state will not be identified in our report. While this survey is being conducted for RAND as a courtesy by the Class Action Insurance Litigation Working Group of the National Association of Insurance Commissioners, the data collected will be retained and used only by RAND. RAND and the Institute for Civil Justice has had a multi-decade long history of safeguarding sensitive information. If you would prefer to return your answers directly to RAND (in which case you can be assured that no outsider, including members or employees of the NAIC, would read or have access to your questionnaire), you can email the responses to nickpace@rand.org or mail them to:

Nicholas M. Pace
Institute for Civil Justice
RAND Corporation
1776 Main Street
Santa Monica, California 90401

Thank you for your help in shedding light on this very important issue. In order that the survey results may be of the greatest relevance to the current policy debate over class action litigation, we respectfully request that you return the enclosed questionnaires to RAND at your earliest convenience and if possible, no later than ____.

INSURANCE REGULATION AND CLASS ACTIONS SURVEY

Name: _____
 Title: _____
 Agency: _____
 State: _____
 Phone: _____

- 1 equals "Little or no relationship between this class action issue and the traditional authority and regular activities of your state's insurance regulator"
- 3 equals "Moderate relationship between this class action issue and the traditional authority and regular activities of your state's insurance regulator"
- 5 equals "Significant relationship between this class action issue and the traditional authority and regular activities of your state's insurance regulator "

#	Least				Most	Unk.	ISSUE
(b) VARIOUS LINES - Credit Report Issues							
B03	1__	2__	3__	4__	5__	N\A__	Denied coverage solely based on adverse credit report.
B05	1__	2__	3__	4__	5__	N\A__	Failed to disclose adverse credit report that resulted in denial of insurance, rate increase, or coverage change.

NOTE: THE FOLLOWING CONTAINS THE COMPLETE LISTING OF ALL ISSUES INCLUDED IN THIS QUESTIONNAIRE..

Annuities

- Claimed minimum floor for variable interest rate.
- Death claim benefit figured at time of election rather than at time of death which is what contract says (changed market conditions, Mortality & Expense fees charged over time, etc.)
- Failed to disclose payments made to annuity provider by mutual fund companies.
- Failed to disclose that annuity offered was a type of insurance product
- Failed to fully inform prospective and current policyholders about withdrawal penalty for transferring or switching policies.
- Failed to inform when variable contracts purchased in tax-deferred plans provided no additional benefit to the customer.
- Falsely represented that assets could be transferred among funds offered in the contracts without charge.
- Misrepresenting that tax benefits in tax-deferred plans are only available if they are funded with an annuity contract.
- Unnecessary placement of tax-deferred annuities into tax-deferred retirement plans.

Automobile 1st party coverage - Diminished value issues

- Failed to reimburse policyholders for the diminished value of repaired vehicles.

Automobile 1st party coverage - Increased value issues

- Deducted portion of payments for vehicle repair based on alleged betterment in value of vehicle from upgraded parts or repairs.

Automobile 1st party coverage - OEM issues

- Conspired with other insurers to manipulate the price of auto physical damage coverage with the use of aftermarket parts.
- Created Certified Automotive Parts Association (CAPA) to conceal flaws in aftermarket parts.
- Failed to disclose the use of aftermarket parts for repairs rather than using original equipment manufacturer parts.
- Failed to pass along savings realized by the use of aftermarket parts for repairs rather than using OEM parts to policyholders.
- Specified aftermarket parts for repairs rather than using OEM parts, resulting in diminished value, safety issues, or any loss (other than policy cost).

Automobile 1st party coverage - Other issues

- Added inappropriate or unfair surcharge on 1st party policies for auto theft prevention authority or other separate or voluntary program.
- Calculated cost of repair using artificially low competitive bids and/or prevailing competitive prices.
- Did not include payment for identify and measure procedure.
- Double-with: Multiple parties in accident with the same ins a) paid deduct when no one at fault, b) both paid full deductible, c) not have deductible prorated at relative deg of fault, or d) unable to recover from own or other policies.
- Failed to initiate investigation, acknowledge claim, provide est., communicate with insured, and/or take other required action (other than make payment or deny claim) within required time limits.
- Failed to obtain salvage title after totaling vehicles.
- Failed to reimburse insureds for salvage value of vehicle when given to insurer following total loss.
- Repairs limited to visual inspection alone
- Sales tax on losses issues
- Systematically denied or undervalued claims arising from single event (e.g., hail storm or hurricane)
- Systematically omitted payment for necessary repairs, including safety related issues (e.g. seat belt check or four wheel alignment).
- Systematically referred policyholders to auto repair shops that use substandard replacement parts and repair methods.
- Unspecified problem involving insufficient valuation of total loss claims.
- Unspecified problem with premium charges for comprehensive or collision coverage.
- Used collection methods or entity that sought reimburse from 3rd party tortfeasors for amounts paid to insureds in an unlawful or deceptive manner
- Used N.A.D.A Official Used Car Guide as sole basis for calculating total loss of insureds vehicle.
- Used remanufactured or used or substandard or incorrect parts rather than new and appropriate in vehicle repair (but NOT non-OEM)
- Used valuation software package designed to produce offers for automobile total loss at less than fair market value, actual retail price, fair retail value, or other required measure.

Automobile 3rd party liability coverage

- 3rd party OEM - Breached 3rd party beneficiary contract or other duty\understanding\etc by specifying\using\ etc aftermarket parts for repair
- Discouraged claimants from seeking counsel.
- Failed to pay attorneys fees to 3rd party claimants when sued as real party in interest as subrogee of damages arising from personal injuries.
- Failed to pay necessary taxes, fees, and other ancillary exp required to fully reimburse total loss suffered by 3rd party claimants.
- Failed to pay pro rata cost of 3rd party claimants collision damage waiver (e.g., such as might be incurred from car rental)
- Failed to reimburse 3rd party claimants for diminished value and\or failed to notify of right to make claim for diminished value
- Failed to reimburse 3rd party claimants for loss of use of their autos.
- Procured liability settlement with 3rd party in a manner that violated statutes and\or rules
- Unfairly \ deceptively handled claims.
- Unnecessarily delay in payment of concluded settlements without including interest payments.
- Wrongfully used mandatory insurance statute to deny liability to uninsured parked cars damaged by own insureds.

Automobile no-fault, personal injury protection, or medical payments coverage -

Health care provider issues

- Denied medical claims or failed to pay claims within time limits without first obtaining report from appropriate health care provider.
- Denied payments to health care providers for failure to attend examination under oath and\or provide a sworn statement.
- Failed to pay MRI exam benefits at the highest possible rate as per medical regulations.
- Failed to pay or reduced bills in manner not in accordance with annual state medical consumer price index or other mandated inflation index.
- Failed to pay providers when obtaining medical records of insureds.
- Failed to pay required interest or interest on delayed payments to health care provider on claims
- Made inappropriate fee reductions on claims submitted under PIP coverage.
- Other or unexplained delay in making payments to health care providers
- Reduced or denied payments to health care providers based on outside entity database or software
- Systematic and\or arbitrary denial of health care provider claims for MRI or thermograph services
- Wrongfully paid charges according to MRI fee schedule, Medicare\Medicaid schedule., workers' compensation fee schedule. or a participating or non-participating provider fee schedule instead of schedule.\criteria\rate required by law or contract.
- Wrongfully paid insureds health care providers at negotiated rates which is not possible as insurer is not legitimate Preferred Provider Organization.
- Wrongfully reduced benefits to providers using new statute without possessing state approved plan as required by statute.
- Wrongfully refused to pay bills for medical services rendered more than 30 days before submission.

Automobile no-fault, personal injury protection, or medical payments coverage -

Policyholder

- Allowed invasion of privacy and disclosed confidential medical records by use of outside medical file review firms.
- Asserted subrogation claim for PIP or MedPay benefits paid against insureds recovery from 3rd party tortfeasor or UM\UIM proceedings but failed to pay pro rata share of litigation fees and exp..
- Denied (in whole or in part) claims or delayed payment based upon generalized criteria not specific to claimants injuries.
- Denied chiropractic care and\or other types of treatments after claiming not curative or that insureds reached maximum medical improvement stage despite right to palliative or maintenance care under state PIP or MedPay law.
- Denied insureds claims for TV, phone, and other reasonable ancillary charges while hospitalized.
- Denied medical claims or failed to pay claims within time limits without first obtaining report from appropriate health care provider.
- Denied or reduced PIP payments to insureds when all or part of exp already paid by collateral source
- Denied PIP or MedPay claim because incident was work-related accident that was eligible for workers' compensation benefits.
- Denied the right to stack additional PIP or MedPay policies existing in the same household.
- Failed to automatically include PIP or MedPay coverage as part of standard auto policy.
- Failed to disclose at time of purchase that policies would not cover exp paid by collateral sources.
- Failed to disclose existence and\or details of medical cost containment program or that claims might be subjected to retrospective UR or that treatment would require pre-authorization as reasonable and necessary.
- Failed to disclose practice of paying only bills at a fixed percentile of local usual and customary charges.
- Failed to initiate investigation, acknowledge claim, provide est., communicate with insured, and\or take other required action (other than make payment or deny claim) within required time limits.
- Failed to inquire at purchase or renewal whether not expecting to require wage loss reimburse benefits b\c of age or other reason; including unnecessary charges for lost wage coverage or failing to offer or provide notice of option.
- Failed to pay benefits by claiming that insureds HMO was other insurance and as such PIP or MedPay coverage was secondary.
- Failed to pay benefits by claiming that Medicare or Medicaid was primary coverage.
- Failed to pay interest on delayed claim payments
- Failed to pay lost wages for illegal immigrants when wage claims are unsupported by tax returns.
- Failed to provide additional statutory benefits available to those who exceeded PIP or MedPay policy limits.
- Failed to provide PIP or MedPay benefits to pedestrians by providing only minimum limits rather than extended limits.
- Failure to make timely payments of medical and other bills under PIP

- Improperly required reimburse or denied of all or part of PIP or MedPay benefits when asserting subrogation rights to 3rd party settlement.
- Improperly used accident reconstruction experts or other external entities or individuals to review causation issues and deny claims.
- Incorporated medical cost containment program that because of pre-determined criteria for cost and type of treatment, results in managed care coverage rather than indemnity coverage.
- Limited payment to usual and customary charges in the claimants area which state law actually requires payment for reasonable and necessary charge.
- Offset policy limits payoff by previous payments under PIP or MedPay coverage.
- Other or undefined failure to pay proper or full PIP or MedPay benefits.
- Paid claims based upon unconstitutional PIP or MedPay threshold statute.
- Paid fees to broker (such as those for MRI services) rather than making payments directly to health care providers which ultimately reduced insureds policy benefits.
- Paid interest on delayed claim only starting at end of time limit and not from the first day claim was payable.
- PIP or MedPay election\rejection\waiver at time of initial policy purchase issues (basic and\or extended\enhanced upgrade; includes misleading representations, invalid forms, failure to offer as required)
- Reduced benefits available to insureds by paying out subrogation claims to health care recovery companies.
- Reduced medical payments for pre-existing conditions or prior impairment though state law and\or policy requires full payment.
- Refused to pre-authorize or pre-certify requested medical treatment when good faith and fair dealing would give such authorization.
- Required Independent Medical Examinations either when unnecessary or in violation of law or policy or used examiners who were unqualified, biased, or given improper incentives.
- Required insureds to first seek payment against other PIP or MedPay carriers and exhaust those policies before paying on own.
- Required screening, examination, report, or other process at the time of policy purchase or at time of making claims that inherently discriminated against those with disabilities.
- Sought reimburse of PIP or MedPay benefits before the insureds had been made whole for all economic and noneconomic losses (includes failing to investigate to ensure insureds made whole).
- Sought subrogation or reimburse from 3rd party tortfeasors in a way that interfered with PIP or MedPay policy insureds own pursuit of claims with 3rd party (including attempts prior to completion of insureds own negotiations).
- Systematic and\or arbitrary denial of policyholders claims for cost reimburse for MRI or thermograph or other testing.
- Systematic denial of claims in whole or in part solely to meet quotas or other internal cost cutting needs.
- Systematic denial or reduction for chiropractor services as excessive or not reasonably necessary.
- Systematic reduction of PIP benefits through bill review computer program.
- Systematic reduction of PIP or MedPay benefits through the use of medical file review firms or other retrospective UR process.
- Systematically refused to reimburse on reasonable and customary or medically necessary or other appropriate basis without investigating

particular merits of the claim or without reasonable grounds for making decision.

- Used ambiguous or misleading language in policy in order to be able to construe coverage issues in favor of insurer when needed.
- Used medical file review firms with reviewers who are unqualified, non-medical, biased, given improper incentives, or who have colluded\conspired with insureds to deny claims.
- Used valuation software package designed to produce offers for personal injury claims at less than full and fair value.
- Violated PIP or MedPay statute by binding coverage prior to providing written explanation of coverage.
- Wrongfully enforced statute of limitations on coverage.
- Wrongfully paid insureds' health care providers at negotiated rates which is not possible as insurer is not legitimate Preferred Provider Organization.
- Wrongfully required policyholders to give recorded statements under oath, attend examination under oath, and\or provide a sworn statement.
- Wrongfully required pre-approval of non-emergency medical care under patient selected provider or similar option.
- Wrongfully set premiums based on payment of reasonable and necessary medical exp even though in practice paid claims at a discounted rate for preferred providers.

Automobile uninsured\underinsured motorist coverage - Policyholder issues

- Charged for multi-car stack coverage when actually only one car.
- Chose biased arbitrator and \ or failed to disclose prior relationship with arbitrator for UM\UIM arbitration.
- Deducted 3rd party recovery from UM\UIM limits paid to policyholders in breach of contract (includes claims that UM limits were the same as mandatory BI limits which makes coverage illusory).
- Denied right to stack UM\UIM and BI coverages in same household.
- Denied the right to stack additional UM\UIM policies existing in the same household.
- Denied UM\UIM claim because incident was work-related accident that was eligible for workers' compensation benefits.
- Failed to initiate investigation, acknowledge claim, provide est., and\or take other required action (other than make payment or deny claim) within required time limits.
- Failed to learn of amounts insureds were legally entitled to recover from tortfeasors and\or failed to use this amount as the basis to settle claims.
- Failed to pay claims of insureds for injuries incurred by relatives caused by uninsured\underinsured motorist.
- Failed to pay fair share of attorney contingency fees in 1st party proceedings under common fund doctrine due to offset of prior payments.
- Failed to pay for reasonable loss of use.
- Failed to pay last offer made at arbitration or pay all undisputed amounts.
- Failed to pay uninsured/underinsured motorist claims on vehicles based on an unenforceable other-owned auto exclusion.
- Failed to reduce rates or lower premiums when anti-stacking clause introduced into coverage.
- Failure to make timely payments of claims.
- Illegally required insureds to share in cost of arbitrators fees and exp..

- Inappropriate offset of UM\UIM payments by multiple sources of benefits (such as workers' compensation or 3rd party recovery) previously received when only one offset is actually allowed.
- Inappropriate offset of UM\UIM payments by PIP or MedPay benefits or 3rd party tortfeasor payments previously received.
- Made unreasonable offers to settle UM\UIM claims forcing insureds to arbitrate and incur unnecessary exp..
- Non-specified discrimination on basis of race, national origin, language spoken, or other reason.
- Offered less in UM\UIM benefits than what was paid for PIP or MedPay payments.
- Offset 3rd party tortfeasors limits of liability rather than the actual amount of settlement.
- Offset recovery from 3rd parties from UM\UIM benefits without adjusting (either 100% or pro rata share) for insureds attorneys fees and costs to obtain such recovery.
- Paid tortfeasor-caused damage under collision or comprehensive rather than UM\UIM coverage resulting in failure to pay diminished value, higher deductibles, and/or higher premiums.
- Reduced payment of BI claim under UM\UIM due to bad faith use of Independent Medical Exams.
- Sold multiple UM\UIM policies to insureds with more than one car when only one is needed.
- Sold multiple UM\UIM policies to policyholders with more than one car even though doing so would not increase coverage.
- Sought reimburse or subrogation from 3rd party tortfeasor in a way that prevented or interfered with UM policy insureds own pursuit of claims with 3rd party (includes attempts prior to completion of insureds own negotiations).
- Systematically excluded motorcycles from the definition of uninsured auto in order to deny claims.
- UM\UIM election\rejection at time of initial policy purchase issues (basic and/or extended/enhanced upgrade; includes misleading representations, invalid forms, failure to offer as required, failure to obtain written rejection).
- UM\UIM limits raised without permission to match liability coverage OR limits exceeded minimum financial responsibility limits without permission or similar issues.
- Wrongfully advised insured that UM\UIM coverage was not available.
- Wrongfully offset UM\UIM benefits by any extra-policy collateral sources such as workers' compensation or disability insurance or any other sources.

Automobile coverage - Other issues

- Offered inadequate amounts for personal mileage reimbursement.
- Auto insurer failed to reimburse any part of personal transportation exp (such as for medical treatment)
- Calculated premiums in manner not consistent with state law.
- Conspired with other insurers to fix prices for reimburse of health care providers under all types of auto policies.
- Discriminated based on race by charging excessive premiums in certain geographic areas.
- Failed to fully reimburse insureds for amounts (including deduct.) insurer recovered from 3rd party tortfeasors; including failure to pay interest on recovered amounts and instances where insurer failed to obtain recovery from 3rd parties.

- Failed to give rate discounts for passive restraint devices and/or anti-theft devices.
- Failed to pay interest accruing from date of settlements with insureds or third parties arising from any and all types of claims.
- Failed to properly account for fines in its reporting to the state for the purposes of rate making
- Handled double-with claims where multiple parties in same incident insured by same insurer without seeking consent of insureds.
- Improperly allowed adjuster on 3rd party liability claim access to file and information related to 1st party claim made by insured against own insurer (who insured all vehicles in incident).
- Included owned but not insured exclusion in policies without a corresponding premium adjustment.
- Made misleading reps., used invalid or defective forms, failed to offer as required, or failed to fully disclose differences regarding Full Tort\Limited Tort choice election\rejection at time of initial policy purchase.
- Other or undefined auto policy rating problem.
- Retroactively applied premiums to date of acquisition when car purchased if no accident and prospectively if accident occurs.
- Surcharged for accidents without first determining fault.
- Surcharged or denied insurance or other adverse action due to minor traffic infractions, non-moving violations, or other unrelated or irrelevant criminal or civil situation.
- Unexplained issues regarding auto policies and anti-trust and\or restraint of trade issues.
- Unspecified issues related to the applicability of no-fault vs. limited tort thresholds.
- Used unverifiable accident record surcharge in violation of prohibition of underwriting and rating based on lack of prior insurance.
- Wrongfully denied business policy as including coverage for UM\UIM and\or PIP or MedPay even though policy had auto liability provisions and by law must include such coverage.

Commercial general liability - 3rd party claimants

- Knew of dangers of asbestos or other toxic substances but conspired with insureds to avoid liability and\or deny obviously legitimate claims.

Credit life coverage

- Conspired to fix the price of credit life insurance.
- Failed to disclose details about credit life premiums.
- Induced borrowers to purchase optional credit insurance products unknowingly.
- Sold policies without required federal Truth in Lending disclosures.

Disability coverage

- Agents issued incorrect policies compared to policyholders needs and wants and contractual arrangements.
- Denied claims solely on the basis of unverifiable income.
- Failed to file disability policies with and\or obtain approval on those policies from state insurance commissioner or agency before offering for sale.
- Refused to grant an increase in benefits on the grounds that allowing such an increase would exceed the policies issues and participation limits.

Health insurance coverage - Health care provider issues

- Arbitrarily changed provider reimburse rates.
- Delayed payments unnecessarily without paying interest on valid claims.
- Disregarded medically necessary criteria in making coverage and treatment decisions.
- Entered into illegal capitation arrangements.
- Failed to adequately explain to providers how the reimburse fee schedule was designed and how it operates.
- Failed to maintain consistent medical utilization/quality management and administration of covered services.
- Failed to make increased reimburse payments when the treatment required extra time and resources.
- Failed to update average wholesale price of drugs on a timely basis
- Interfered with providers relationships with patients by arbitrarily denying or delaying authorizations and/or payments.
- Paid out-of-network providers less than billed charges.
- Provided services to, had relationship with, or failed to determine status of non-admitted or sham insurer in violation of law.
- reimbursed fees to providers at levels lower than true prevailing rates.
- Used claim review software to bundle, drop, and downcode claim codes submitted by providers without justification.
- Violated state prompt-payments laws.
- Wrongfully excluded certain medical specialties (such as chiropractors) from provider network.

Health insurance coverage - Policyholder issues

- Claimed type of treatment classified as experimental or investigational should have been covered
- Collected deductible and co-payments calculated on original billing rather than on negotiated, discounted rate.
- Failed to disclose to members how benefit and coverage decisions are made.
- Failed to disclose to members how providers are compensated.
- Failed to provide \ denied claim for emergency treatment counter to policy or legal requirements
- Failed to provide members with proper appeals process.
- Failed to provide notice of adverse health care decisions.
- Failed to reimburse members for out-of-pocket exp for alternative care despite legal requirement to do so.
- Improperly denied benefits for particular treatment in unauthorized setting though approved by health care provider
- Made marketing misrepresentation regarding membership fees in health coverage.
- Terminated depositor medical insurance without adequate warning.
- Used renewal rating methodology in violation of law.
- Violated non-profit status by failure to keep premiums in line.

Life coverage

- Agents issued incorrect policies compared to policyholders needs and wants and contractual arrangements.
- Began a deceptive voluntary exchange program designed to terminate policies with prohibited cost of insurance increases.
- Burial policy actually worth less than respectable funeral.
- Claimed premiums would vanish over time.

- Collected premiums for the period prior to the delivery of the policy and/or prior to coverage start.
- Discriminated based on race by targeting small-face-value policies with benefits less than total premium payments to minorities.
- Discriminated by setting premium levels based on race.
- Failed to comply with laws and regulations pertaining to replacement of policies
- Failed to credit back unused portion of interest on loans taken out on policy value following lapse.
- Failed to disclose early withdrawal penalties.
- Failed to disclose that money paid would be used to pay charges and fees and would not earn any interest or investment income.
- Improperly characterized variable life policies as mutual fund investments.
- Improperly charged excess costs of insurance, exp and admin fees in violation of contract and marketing materials.
- Improperly charged rates on juvenile policies based on smoker mortality tables.
- Improperly sold/converted life policies into 403(b) plans.
- Made loans against life policies that exceeded cash surrender value, causing lapse.
- Made loans against life policies that included unauthorized or excessive interest charges.
- Misrepresented the benefits from and suitability of rolling over some or all of an existing life insurance policy's cash value.
- Misrepresented the cash value and/or benefits a policyholder would realize under a policy.
- Premiums exceeded face value of policy through lifetime of payments (discrimination not an issue)
- Provided misleading advice to churn existing policies with new ones and obtain transaction fees.
- Provided misleading advice to churn existing policies with new ones with higher premiums and/or reduced benefits.

Long term care coverage

- Premiums continued to be billed after contract cutoff date

Property coverage

- Conspired with state insurance department/commissioner to approve higher deductibles for certain types of properties.
- Continued to charge same or increased premiums or used an inflation coverage endorsement on property that depreciated (such as mobile homes) while only paying actual cash value rather than replacement cost.
- Denied claims after expiration of policies one-year limitation provision.
- Depreciated the amount of building materials or parts or repair/labor costs or withheld an amount for depreciation to the premises or item on partial losses to real or personal prop.
- Discriminated against low income and minorities by applying surcharge for age of utilities which results in a de facto surcharge for age of the home.
- Discriminated based on race by refusing to insure older homes or only offering policies with fewer benefits to minorities.
- Discriminated based on race by refusing to insure or only offering policies with fewer benefits in particular geographic areas.

- Failed to adequately explain \ provide a factual basis for \ put in writing reasons for full or partial denial of claims.
- Failed to adequately explain terms of property policy coverage at time of purchase.
- Failed to advise insureds of appraisal process or failed to make appraisal process available or failed to hire independent appraiser or refused to grant appraisal request.
- Failed to advise insureds of their right to property repaired or receive cash settlement following partial losses.
- Failed to determine that property was in special zone, or failed to advise insureds, which prevented insureds from participating in federal, state, and\or pooled risk flood and\or fire programs.
- Failed to fully reimburse insureds for any amounts (including deductibles) insurer recovered from 3rd party tortfeasors; includes failure to pay interest on recovered amounts.
- Failed to make commensurate reduction in premiums when coverage was decreased as a result of property appraisal\inspection.
- Failed to notify policyholders of a material change in the policy that removed automatic coverage for certain types of losses.
- Failed to pay full replacement cost of personal property lost in theft.
- Failed to provide allowance for general contractors overhead and profit when paying for repairs.
- Failed to provide notice and\or opportunity to object to changes in terms\benefits\premiums triggered by inflation coverage.
- Improperly calculated premiums, resulting in overcharges.
- Improperly denied foundation\slab or other below-ground claims on the basis of earth movement, water causes, and\or other concurrent causations.
- Made replacement cost coverage illusionary by paying depreciation or ACV on partial property losses until repair\replacement completed.
- Miscellaneous or unspecific adjusting improprieties.
- Misled policyholders about the nature and extent of damage to their properties.
- Provided misleading and\or fraudulent coverage for collapse losses.
- Provided poor customer service, delayed responding to inquiries, and generally mishandling claims.
- Reduced benefits by omitting sales taxes or other mandatory fees and charges (such as on the calculation of personal property losses or for building materials for partial real property losses)
- required void and unenforceable contractual appraisal provision requiring each side to bear own costs in every instance.
- Sold illusory homeowner coverage for libel, slander, invasion of privacy, and false arrest because of practice of denying coverage for intentional conduct.
- Systematically denied (or failed to adjust, settle, and pay) hail and\or wind damage claims as either preexisting or as due to other causes.
- Systematically denied total replacement of completely damaged properties (including those sustaining damage in excess of 50% of value) by granting only partial replacements or requiring repairs.
- Systematically estimated damage at lower than actual cost of repair.
- Systematically failed to properly adjust soft metal items such as gutters and siding.

- Systematically over-insured\appraised property (or used excessive replacement cost estimator, unnecessary mortgage requirements, bundling coverage, included land value, or used defective valuation process) to generate additional premiums.
- Systematically performed unfair or other wrongful adjustment of claims arising from a single event (e.g. hail storm or earthquake)
- Systematically refused to pay for repairs to property that required creating access to fixtures and\or appliances even when repairs were needed to prevent further damage.
- Systematically undervalued\underappraised\failed to exercise reasonable care when estimating repair\replacement value or appraising property resulting in underinsured prop..
- Used biased and\or wrongly incentivized and\or unqualified estimators, adjusters, contractors, or engineers for damage evaluation.
- Violated contract with policyholders by increasing deductible on certain types of properties.
- Wrongfully denied claims for hail damage to concrete driveways, patios, and other concrete aggregate structures
- Wrongfully withheld amounts for debris removal on partial real property losses.
- Wrongly limited coverage for lead testing and\or lead abatement.
- Wrongly limited coverage for water or mold damage or failed to test for same.
- Wrongly shifted hurricane deductibles from a flat dollar amount to percentage basis or increased percentage.

Structured settlements

- Coerced use of annuities at above market rates
- Coerced use of annuities by particular seller
- Failed to disclose rebate of portion of the commission paid to annuity broker.

Workers' compensation coverage

- Administered experience readjustments unfairly.
- Conspired to charge unduly high fees on businesses placed in assigned risk pool.
- Conspired to fix prices in violation of antitrust laws.
- Conspired to overload assigned risk pool.
- Conspired with the National Council on Compensation Insurance to charge more than approved by state Board of Insurance.
- Employees: Conspired with state workers' compensation agency\commission to deny full delivery of all legally entitled benefits.
- Employees: Failed to pay employees of workers' compensation insureds interest on funds withheld for payment of attorneys fees.
- Employees: Failed to segregate and safe keep monies that employees of workers' compensation insureds requested be set aside from award for future services.
- Employees: Miscellaneous denial or delay in paying workers' compensation benefits to employees (includes conspiracy to deny or delay)
- Employees: Systematic under-compensation of employee\beneficiaries receiving workers' compensation disability benefits.
- Failed to properly allocate med.-legal exp.

- Health care providers - Failed to pay interest or fines to Health Care Providers on delayed or denied claims
- Health care providers - Failed to periodically adjust rates for medical procedures
- Illegally passed through residual market assessments to customers in the voluntary market.
- Improperly sold retrospectively-rated policies.
- Paid broker fees out of monies owed to or belonging to insureds without insureds knowledge or consent.
- Sold occupational health insurance as workers' compensation insurance.
- Sold useless contingent workers' compensation policy rather than one required by law.
- Used forms and/or rates other than those approved by Insurance Commissioner, the Department of Insurance, statute, regulation, or other authority.

Multiple types of coverages - Credit issues

- Denied coverage solely based on adverse credit report.
- Failed to disclose adverse credit report that resulted in denial of insurance, rate increase, or coverage change.
- Failed to disclose any use of or request for credit report.
- Failed to notify of receipt of adverse credit report even if not used.
- Improperly used credit histories when calculating premiums.
- Increased rates based on adverse credit report.
- Ordered credit report without legally permissible purpose.

Multiple types of coverages - Modal premium issues

- Failed to comply with Truth in Lending Act requirements for financed portion of the annual premiums paid on a periodic basis.
- Failed to disclose annual percentage rate and finance charges incurred when paying premiums periodically rather than annually.
- Imposed premium finance service charges (or any separate finance, service, and/or installment charge or fee related to periodic payments) in violation of law or in excess of legal maximums.

Multiple types of coverages - Other issues

- Accumulated excessive surplus and/or overcapitalized without declaring adequate dividends or retained in other manner that would be to the detriment of the policyholders..
- Agents forged signature of insureds on applications.
- Aided or assisted or authorized the sale of inappropriate or illegal insurance and would therefore be liable for all unpaid claims.
- Allowed unlicensed persons to solicit, negotiate, contract for, sell, or administer contracts of insurance.
- Allowed unlicensed telemarketers or others not formally connected to insurers to misrepresent on whose behalf policies were being sold.
- Changed terms of policy to require binding arbitration of disputes which effectively resulted in a reduction in coverage.
- Charged more for premiums than quoted in application, including undisclosed fees, charges, or other considerations (does not include issues related to taxes or modal payments).
- Collected money from insureds under questionable subrogation clause
- Conspired to obtain money from the investing public in violation of the registration & anti-fraud provisions of federal securities laws.

- Failed to file policies with and/or obtain approval on those policies from state insurance commissioner or agency before offering for sale.
- Failed to have settlements with minors approved by courts.
- Failed to pay interest on delays in paying liability settlements.
- Failed to pay premium taxes on behalf of insureds though insurers were unauthorized or non-admitted or otherwise failed to comply with legal requirements for doing business.
- Failed to pay proper amount of contingency fees in subrogation matters under common fund doctrine
- Failed to provide legally mandated disclosures at the time of sales presentation.
- Failed to refund portions of unused premiums for uncovered gap period when fully paid policies were cancelled and then reinstated.
- Failed to reimburse insureds or failed to disclose right for reimbursement) for lost earnings and/or other expenses related to liability defense provided by own insurer or other insurer-required legal proceeding.
- Failed to use returned or unused premiums for paying off existing balance or applied to next installment (e.g., using as collateral instead).
- Fraudulent inducement to settle through false inspections, inaccurate adjustments, etc.
- Improper apportionment to policyholders of surplus or other funds from catastrophic, pooled risk, or other special fund.
- Influenced/steered/failed to inform/induced purchases of own policies rather than less expensive government preferred risk, subsidized pool, or other more appropriate program.
- Miscellaneous issues related to claims against directors and officers of associations and corporations.
- Misrepresented policy as replacement coverage when in fact it was for actual cash value.
- Other problem regarding settlement with minor (other than failure to obtain court approval or improper use of biased counsel); includes inadequate offers, fraud, bad faith, and misrepresentations.
- Pattern and practice of denial of claims made
- Provided inadequate, improper, or misleading notices to policyholders concerning changes in coverage.
- Received excess profits in violation of state insurance laws.
- Received non-disclosed kickbacks, commissions, or other consideration from agents or brokers.
- Required membership in organization (such as non-profit association) as eligibility criterion in violation of contract and/or law
- Sold, solicited, underwrote, or other action taken in regards to surplus lines without making good faith effort to find proper insurer in admitted market.
- Unconscionable/improper/unauthorized/illegal use of excess surplus or premiums collected or dividends (e.g., for political advertising)
- Underreported amounts of bad faith or class action settlements and judgments when submitting rate bases.
- Unspecified breach of contract, bad faith, or prohibited practice .
- Unspecified misrepresentation of scope and level of coverage.
- Used in-house or selected counsel to assist in getting settlements with unrepresented 3rd party minors approved by the court or failed to disclose prior relationship with said counsel.

- Used non-admitted in-house counsel in defense of claims against insured in violation of rules against unauthorized practice of law.
- Used policy forms other than approved or required by law or regulation or order
- Used prohibited class (e.g., age, sex, length of driving experience, or physical handicaps) in underwriting or rating.
- Wrongfully collected premium taxes that were higher than state average.