

**MARKET CONDUCT EXAMINATION
OF**

**STEADFAST INSURANCE COMPANY
AS OF**

SEPTEMBER 30, 2005

Matthew Denn
Insurance Commissioner



Department of Insurance
841 Silver Lake Blvd.
Dover, DE 19904-2465
(302) 674-7300
(302) 739-5280 fax

I, Matthew Denn, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON MARKET CONDUCT EXAMINATION, made as of SEPTEMBER 30, 2005 of the

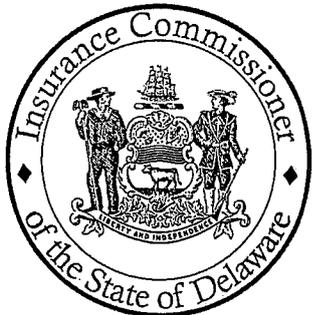
STEADFAST INSURANCE COMPANY

is a true and correct copy of the document filed with this Department.

ATTEST BY:

Antoinette Handy

DATE: 19 JUNE 2006



In Witness Whereof, I HAVE HEREUNTO SET MY HAND AND AFFIXED THE OFFICIAL SEAL OF THIS DEPARTMENT AT THE CITY OF DOVER, THIS 19TH DAY OF JUNE 2006.

Matthew Denn

Insurance Commissioner

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Insurance Commissioner



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REPORT ON MARKET CONDUCT EXAMINATION
OF THE
STEADFAST INSURANCE COMPANY
AS OF
SEPTEMBER 30, 2005

The above captioned Report was completed by examiners of the Delaware Insurance Department.

Consideration has duly been given to the comments, conclusions, and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted, and filed as an official record of this Department.

A handwritten signature in black ink, appearing to read "Matt Denn", is written over a horizontal line.

MATTHEW DENN
INSURANCE COMMISSIONER

DATED this 19TH day of JUNE, 2006.

Table of Contents

SALUTATION 1

SCOPE OF EXAMINATION..... 1

HISTORY AND PROFILE 2

METHODOLOGY 2

A. COMPANY OPERATIONS/MANAGEMENT..... 3

 Standard A 07 4

 Standard A 09 4

B. COMPLAINTS/GRIEVANCES..... 4

REVIEW OF PROCEDURES..... 5

 Procedure 01 – Audit Procedure (Internal and External)..... 5

 Procedure 02 – Assertion of Privilege Procedure 6

 Procedure 03 – Company records, central recovery and backup procedure 7

 Procedure 04 – Computer Security Procedure 8

 Procedure 05 – Anti Fraud Procedure 8

 Procedure 06 – Disaster Recovery Procedure 8

 Procedure 07 – MGA Oversight and Control Procedure 9

 Procedure 08 – Vendor Oversight and Control Procedure 9

 Procedure 09 – Customer and Consumer privacy protection Procedure 10

 Procedure 10 – Insurance Information Management Procedure..... 11

 Procedure 11 – Complaint Handling Procedure 11

 Procedure 13 – Advertising, sales and marketing Procedure 12

 Procedure 14 – Agent produced advertising Procedure 13

 Procedure 15 – Producer Training Procedure 13

 Procedure 20 – Producer Selection, Appointment and Termination Procedure 13

 Procedure 21 – Producer Defalcation Procedure 14

 Procedure 22 – Prevention of use of persons with felony conviction Procedure 15

 Procedure 23 – Policyholder Service Procedure..... 15

 Procedure 24 – Premium Billing Procedure 16

 Procedure 25 – Correspondence routing Procedure..... 17

 Procedure 26 – Policy Issuance Procedure 17

 Procedure 27 – Reinstatement Procedure 18

 Procedure 28 – Insured or Member Requested Claim History Procedure 18

 Procedure 30 – Premium Determination and Quotation Procedure..... 18

 Procedure 31 – Policyholder Disclosures Procedure 18

 Procedure 32 – Underwriting and Selection Procedure 19

 Procedure 33 – Rate and Form Filing Procedure 19

 Procedure 34 – Termination Procedure 19

 Procedure 35 – Underwriting File Documentation Procedure 20

 Procedure 36 – Underwriting Training Procedure 20

 Procedure 40 – Staff Training Procedure..... 21

 Procedure 42 – Adjuster Training Procedure..... 21

 Procedure 43 – Claim Handling Procedure 21

 Procedure 44 – Internal Claim Audit Procedure 24

 Procedure 45 – Claim File Documentation Procedure 24

Steadfast Insurance Company

Procedure 46 – Subrogation and Deductible Reimbursement Procedure 26
Procedure 47 – Reserve Establishment Procedure..... 27
SUMMARY 28
LIST OF RECOMMENDATIONS 28
CONCLUSION..... 29

SALUTATION

Honorable Matthew Denn
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Denn;

In compliance with the instructions contained in Certificate of Examination Authority Number 05.728, and pursuant to statutory provisions including 18 Del. C. §318-322, a market conduct examination has been conducted of the affairs and practices of:

Steadfast Insurance Company

hereinafter referred to as the "Company" or as "Steadfast." Steadfast Insurance Company is incorporated under the laws of the State of Delaware. This examination reviewed the operations of Steadfast. The on-site phase of the examination was conducted at the following location:

3910 Keswick Rd, Baltimore, MD 21211-2296

The examination is as of September 30, 2005.

Examination work was also conducted off site and at the offices of the Delaware Department of Insurance, hereinafter referred to as the "Department" or as "DDOI."

The report of examination thereon is respectfully submitted.

SCOPE OF EXAMINATION

The basic business areas that are subject to a Delaware Market Conduct Examination vary depending on the type of insurer. For all insurers, these areas include:

Company Operations/Management
Complaint Handling
Marketing and Sales
Producer Licensing
Policyholder Service
Underwriting and Rating
Claims

Steadfast Insurance Company

Additional areas may be included for an insurer writing Surplus Lines coverage. Each business area has standards that can be examined and measured, typically utilizing sampling methodologies.

This examination is a Delaware Baseline Market Conduct Examination. It is comprised of two components. The first is a review of the Company's countrywide complaint patterns. This is not a pass/fail test. Rather, this review is aimed at determining if there is a detectable pattern to the complaints the Company has received from all sources.

The second component is an analysis of the management of the various business areas subject to market conduct examination through a review of the written procedures of the Company. This review includes an analysis of how the Company communicates its instructions and intentions to its lower echelons, how it measures and monitors the results of those communications, and how it reacts to and modifies its communications based on the resulting findings of its measurement and monitoring activities. The examiners also determine whether this process is dynamic and results in enhanced compliance activities. Because of the predictive value of this form of analysis, focus is then directed on those areas where review indicators suggest that the process used by management does not appear to be achieving appropriate levels of statutory and regulatory compliance.

All business areas noted above are addressed to some extent by one or more of the procedures reviewed thus providing a comprehensive view of the Company and its component operations.

This examination report is a report by test rather than a report by exception. This means that all areas tested are described and results indicated. Substantial departure from the norm may result in a supplemental review focused on the area so noted.

HISTORY AND PROFILE

The Company was incorporated on August 31, 1973 under the laws of Delaware as a stock multiple lines insurance company having perpetual existence. Its original Delaware Certificate of Authority was issued on November 28, 1973. The Company's Registered and Home Offices are located at 32 Loockerman Square, Suite 202, Dover, DE 19901. The main administrative offices are located at 1400 American Lane, Schaumburg, IL, 60196. The Company owns American Zurich Insurance Company, which in turn owns Zurich American Insurance Company of Illinois. The Company is a member of the Zurich Insurance Group, a Swiss domiciled holding company system. The immediate parent is Zurich American Insurance Company, a New York domicile.

METHODOLOGY

This examination is based on the Standards and Tests for a Market Conduct Examination of a Property and Casualty Insurer found in Chapter VIII of the Delaware Market Conduct

Examiners' Handbook. This chapter is derived from applicable Delaware Statutes, Rules, and Regulations as referenced herein and the NAIC Market Conduct Examiners' Handbook.

The types of review used in this examination fall into three general categories: generic, sample, and electronic.

A "Generic" review is conducted through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review is conducted through direct review of a random sample of files using sampling methodology described in the Delaware Market Conduct Examiners' Handbook and the NAIC Market Conduct Examiners' Handbook. The sampling techniques used are based on a 95% confidence level. This means that there is a 95% confidence level that the error percentages shown in the various standards so tested are representative of the entire set of records from which it was drawn.

An "Electronic" review is conducted through use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically evaluates 100% of the records of a particular type.

The complaints pattern review is conducted using all three methodologies described above. The non-complaint procedures are reviewed using a "Generic" analysis methodology.

The Introduction to the Review of Procedures section of this report describes the basis for the analysis methodology. Each procedure reviewed is described and the result of the review is provided under the appropriate procedure. Each procedure is supported by 18 Del. C. §318(a) and 18 Del. C. §508(b). In some cases, there is additional specific statutory support; however, these have not been enumerated. The reference source for each procedure found in the NAIC Market Conduct Examiners' Handbook (*NAIC MCEH Reference*) is noted.

Each procedure is accompanied by the examiners' "Observations." In some cases a "Recommendation" for corrective action is made. Reference, Observations and Recommendations are reported with the appropriate Standard.

A. COMPANY OPERATIONS/MANAGEMENT

Comments: As stated above, this examination report is not designed to be a pass/fail report except for the following two criteria. Standards A7 and A9 read as follows:

- “The Company is licensed for the lines of business that are being written.”
- “The Company cooperates on a timely basis with examiners performing the examination.”

Standard A 07

NAIC Market Conduct Examiners' Handbook - Chapter VIII, §A, Standard 7.

The Company is licensed for the lines of business that are being written.

18 Del. C. §318(a), §505(b), §508(b).

Comments: The review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to ensure that the Company's operations are in conformance with the Company's certificate of authority.

Results: **Pass**

Observations: The Company is licensed for the lines of business being written.

Recommendations: None

Standard A 09

NAIC Market Conduct Examiners' Handbook - Chapter VIII, §A, Standard 9.

The Company cooperates on a timely basis with examiners performing the examinations.

18 Del. C. §318(a), §320(c), §508(b), §520(b)3.

Comment: The review for this standard is by "generic" methodology. This standard has a direct insurance statutory requirement. This standard is aimed at ensuring that the company is cooperating with the state in the completion of an open and cogent review of the company's operations. Cooperation with examiners in the conduct of an examination is not only required by statute, it is conducive to completing the examination in a timely fashion and minimizing cost.

Results: **Pass**

Observations: During the course of the examination the Company was provided with fifty-one (51) Information Requests (IR's) and all responses were returned on-time. The Company's communication with the examiners was very responsive. The examiners did not experience any delays during the course of the examination.

Recommendations: None

B. COMPLAINTS/GRIEVANCES

Comments: Evaluation of the Standards in this business area is based on the Company's response to various information requests (IR items) and complaint files at the Company. 18 Del. C. §2304(17) requires the Company to "...maintain a complete record of all complaints received." The statute also requires that "this record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint." Delaware's definition of a complaint is: "...any written communication primarily expressing a grievance."

Observations: The Company provided a database with fifty-seven (57) logged complaints for the period of examination. All complaints were reviewed for a pattern of problems relating to coverage. Eleven (11) complaints, or approximately nineteen percent (19%) of the total complaint files, were based on homeowner's environmental protection issues. A review of the correspondence indicated that in most cases, the complaint was a result of the insured demanding coverage not offered by the policy. Interviews with Company personnel indicate that the Company no longer writes this type of business. The review of the complaint process is noted in Procedure 11 below.

REVIEW OF PROCEDURES

The management of well-run companies generally has some processes that are similar in structure. These processes generally take the form of written procedures. While these procedures vary in effectiveness from company to company, the absence of them or the ineffective application of them is often reflected in the failure of the various Standards that follow this review. The processes at issue usually include:

- a planning function where direction, policy, objectives and goals are formulated;
- an execution or implementation of the planning function elements;
- a measurement function that considers the results of the planning and execution; and
- a reaction function that utilizes the results of measurement to take corrective action or to modify the process to develop more efficient and effective management of its operations.

The absence of written procedures that provide direction for company staff in its various operational areas tends to produce inconsistent application of the intended process. The same is generally true for the absence of a means to measure the results of the application of procedures and to determine that the process is performing as intended.

The reviews in this section of the report are not pass/fail measurements. Rather, they are intended to reflect those management strengths and weaknesses that have a bearing on regulatory compliance issues.

Procedure 01 – Audit Procedure (Internal and External)

Observations: The Company has a written audit procedure for internal audits. This procedure is dated February 23, 2005. The procedure is concise and readable, and is accessible to the persons it affects. The Company provides adequate training to those persons the procedure affects. The audit procedure does not appear to conflict with Delaware's statutes or regulations.

The Company stresses the following elements for all internal audit work:

- effective annual planning (involving risk assessment of auditable entities, including identification of risks that may have global impact)
- fact finding (to obtain a more effective understanding of the individual area to be audited, the risks present and the control environment)

Steadfast Insurance Company

- detailed risk analysis (assessment of risks within the area to confirm the need for the work and to enable prioritizing of internal audit work. If a problem is found, as a result of the fact finding and risk analysis, and the risks in the area are not of sufficient priority in relation to other work that could be performed by auditors, then the work should be discontinued.)

The Company defines “Audit” as follows:

The term ‘audit’ is used to represent a range of styles/activities. These can include:

- full audits (risk identification/assessment, testing, evaluation, reporting)
- audit checkpoints (periodic review of progress on a project or development)
- financial controls audits (review and substantive testing of financial controls)
- follow-up audits (reviews of management response to a reported vulnerability)
- involvement in ad-hoc projects or process reviews.

The Company stresses that internal audits interface with the Company at four levels:

- statutory boards
- Risk Management
- the affected business area
- Senior management

The Internal Audit Department’s primary focus is to provide the Audit Committee and Management of the Company with an independent assessment of the effectiveness and efficiency of internal controls within the Company’s business operations. Additionally, the internal audit department assists Management in fulfilling their responsibilities in managing business operations by performing both internal audits and special projects. Members of this department are also asked to consult within the Company regarding the design of internal controls and in defining business risks over new systems or processes.

The Internal Audit Department has an obligation to ensure issues reported are rectified. Follow up is be risk-based, however, if key issues are not corrected Internal Audit should follow up immediately. In order to gain further assurance that actions have been completed successfully, Internal Audit will check independently on the completion of some actions, particularly those designed to address significant issues. In this context, while business assurances may be received, “High Impact” findings (or audits in which a series of important findings have been located) should be formally followed-up by Internal Audit within a month of the agreed upon implementation date, (depending on the issue and the agreed target dates for the action). Follow-up of this nature may involve the formal examination and re-testing of the area concerned.

Recommendations: None

Procedure 02 – Assertion of Privilege Procedure

Observations: The Company does not have a written assertion of privilege procedure.

Recommendations: It is recommended that the Company establish a formal written procedure for assertion of privilege.

Procedure 03 – Company Records, Central Recovery and Backup Procedure

Observations: Full weekly backups of the Company's mainframe are performed on Sundays and are initiated by automated batch jobs. Daily full pack backups and daily selected dataset backups are also performed. Hierarchical Storage Management (HSM) utilities are also run which back up any files that have changed.

On a nightly basis, a batch job is run that flags tapes that should be taken off-site and ejects these tapes from one of the ten tape silos. This job also produces a report listing the tapes that will be moved off-site. An operator packs the tapes and reconciles the tapes with the list generated by the batch job.

An off-site retention schedule is maintained by the data center staff. When a shipment of tapes is received, the tapes in the shipment are matched against the schedule to ensure that all of the tapes that should be returning were brought back and that no additional tapes were included in the shipment. Once checked in, the tapes are ready to be reused.

UNIX and Network

Backups are initiated by automated batch jobs and occur every night from 6 p.m. to 8 a.m. Each server is backed up daily. Some backups are full backups, such as claims, while others are incremental, such as UNIX and Windows servers.

Backup tapes are stored in locked, approved containers until they are picked up by a vendor each afternoon. Each tape is retained by the vendor for at least thirty (30) days before the tapes are shipped back on-site and reused.

Prior to June 2004, three users from the Distributed Tape Management Group would review the printed backup logs in order to verify that the servers were successfully backed up. In June 2004, the Operational Reporting Tool was implemented, which e-mails the three users in the Distributed Tape Management Group a summary of the servers that were backed up. The Operational Reporting Tool has specific thresholds built into it. Each day, it reports certain attributes compared to the predefined thresholds. If the backups were completed successfully, the user does not look at the detailed log. If any server was not backed up successfully, one of the three users will review the detailed log to determine the issue and then complete a problem ticket for the server in question. This problem ticket goes to the Backup and Restore group that investigates and remediates the problem.

Recommendations: None

Procedure 04 – Computer Security Procedure

Observations: The Company has a detailed written computer security procedure. The procedure is clear but was not dated. No conflicts with Delaware statutes or regulations were noted.

Because of the sensitive nature of the information related to this Procedure the details of this review are not provided in this report. The procedures that were reviewed are contained in the examination workpapers, and as such are considered confidential and not subject to public disclosure. A copy of these procedures has been provided to the “Department” for their review.

Recommendations: None.

Procedure 05 – Anti Fraud Procedure

Observations: The Company does not have a formal written anti-fraud procedure.

The anti-fraud requirements of the state of Delaware consist of:

1. Requiring a fraud warning on documents and benefit checks; and
2. Mandatory reporting to the bureau when a reasonable belief exists that insurance fraud is being, or has been, committed

The mandatory reporting is a function of the Special Investigation Unit (“SIU”) at the claim investigator level, generally at the conclusion of the SIU investigation. Delaware has a referral form that is required to be used, as do most states with this requirement.

The Company indicated that a fraud manual will be developed and placed on the Company intranet by the end of September 2005.

Recommendations: It is recommended that the Company develop a formal written anti-fraud procedure.

Procedure 06 – Disaster Recovery Procedure

Observations: The Company has an extensive Business Continuity Program (“BCP”) that is directed out of the Business Continuity Office (“BCO”). All identified critical business processes are required to have a business continuity plan implemented and stored as described in the Business Impact Analysis (“BIA”), which is in turn stored within the BCO repository system. The repository system utilized is Strohl’s Living Disaster Recovery System, and is administered by the BCO.

Each business unit within the Company is responsible for developing the response and recovery strategy that is documented in their continuity plan. Each plan has a plan owner who executes the plan based on the recovery strategy. The plan development process also includes exercising,

testing, and maintenance of the documented plan. Current continuity plans and data are backed up daily. Online backups are sent to a server in New York. A physical copy of the information is stored off-site at a third-party vendor.

There is a proactive disaster recovery preparedness program in place that is designed to support any event where systems availability or operations is impacted to a significant degree. The plan provides for service interruptions, e.g., computer and personnel problems, as well as physical events, such as natural and man made disasters.

This plan covers the four major computer platforms in use at Zurich. In addition, there are Universal Power Source capabilities to provide immediate power capabilities for short-term interruptions. The disaster recovery plan is reviewed and maintained on a regular basis to adjust for changes in the environment. The integrity of the plans is tested at least twice a year for mainframe and distributed platforms recovery and network transfers.

Recommendations: None

Procedure 07 – MGA Oversight and Control Procedure

Observations: The contract that Zurich or Steadfast enters into with a Managing General Agent (MGA) outlines the controls that the insurer maintains over that MGA. The Company provided a sample of the general agency contract for review. The contract details the authority of the program administrator (MGA), the limitation of authority, binder issuance and processing, claims cooperation, notice, authority, and bankruptcy of the insured, administrative services of the program administrator, premiums, company instructions, underwriting guides, rules, manuals, books, accounts and records, licensing, compensation, errors and omissions, liability insurance and fidelity bond, advertising and marketing materials, expenses, non-renewal and cancellation, indemnification, representations and warranties, financed premiums, confidentiality, service of process, complaints, and termination. The Company performs audits and reviews monthly except in January, July and December. The results are used to provide information to both the field and home office management.

Recommendations: None.

Procedure 08 – Vendor Oversight and Control Procedure

Observations: The Company has a written vendor oversight and control procedure. The procedure is clear and readable. No conflict with Delaware statutes or regulations was noted.

Vendor oversight is broken down into the following areas:

”Vendor Maintenance: all vendor's must be registered with the Company, with correct Federal tax ID, only Company authorized signatories are allowed to enter into contract with the specific vendors, a date and time stamp for all vendor requests, back up of the service/goods requested in the form of a copy of the invoice or payable instructions on the vendor's letterhead;”

“Vendor Verification: these procedures have been established in order to minimize the creation of fraudulent vendors. A form for employee vendors was created in order to scrutinize this normally conflict-ridden area. Texas workers’ compensation claims adjustment is performed through a separate system of vendor verification. All other vendor requests must be accompanied by approved audit documentation (i.e., invoices, change noted, payable instructions, etc.). Vendor verification also includes documentation leading to verification that the vendor is a legitimate company. Foreign vendors cannot be verified over the telephone. The Company provides a list of internet sites that are useful in determining whether a particular company exists (e.g., state incorporation websites, federal tax ID verifications, yellow pages, etc.)”

“Vendor 1099 Reporting: The Company provides clear guidelines for 1099 reporting. Create Vendor: after the vendor maintenance form is approved, signed by authorized signatory, and the vendor has been verified, the vendor will then be assigned to a specific account group in order to facilitate payment.”

Recommendations: None

Procedure 09 – Customer and Consumer Privacy Protection Procedure

Observations: The Company has a written customer and consumer privacy protection procedure. The procedure is clear and is dated January 24, 2002. No conflict with Delaware statutes or regulations was noted.

The Company's Best Practices Manual for Customer and Consumer Privacy Protection is comprehensive and clear as to employee direction. The Manual describes in detail the following Company procedures and practices:

- Nonpublic Personal Information – Confidentiality Best Practices;
- Customer or Policyholder Confidential Information – Confidentiality Agreed to by Contract;
- Confidentiality of Zurich Trade Secrets
- Security Measures for Information Classified by Zurich as Confidential.

Zurich American Insurance Company and its affiliated companies (collectively referred to as “Zurich”), have a privacy policy concerning the treatment of nonpublic personal information of its customers including, but not limited to, claimants and policyholders. Federal and State laws prohibit Zurich from disclosing nonpublic personal information to non affiliated third parties unless otherwise permitted or required by law. Nonpublic personal information is generally information that personally identifies an individual and which is not otherwise available to the public. Nonpublic personal information includes both financial and health information of such individuals.

To enforce compliance with NAIC and other State privacy regulations or laws, where a contract is required to protect the confidentiality of nonpublic personal financial (“NPI”) or health information, the form used by the Company requires the third party to keep such information confidential and to hold Zurich harmless if there is a breach of conditions.

Assignments to service providers must be made in writing. The confidentiality agreement document is added as an addendum and is explicitly tied to the assignment. If the provider performs a service for Zurich, they also agree to the terms of confidentiality. If they do not agree to the confidentiality terms, they are expected to reject the assignment.

Key elements of the document include: defining the need to keep personal information confidential, the proper use of the NPI data for its intended purpose, and the assumption of responsibility for improper use as well as the maintenance of data security received. All of the above provisions are ongoing with rights to audit the vendors' procedures.

Zurich may seek injunctive relief for any breach of its confidentiality requirements, in addition to any other legal and equitable remedies which may be available, and the company consents to the obtaining of such injunctive relief.

These confidentiality and non-disclosure obligations shall survive any termination of this Agreement or other relationship with Zurich.

Recommendations: None

Procedure 10 – Insurance Information Management Procedure

Observations: The Company policy provides guidance to employees on which records to keep, for how long, and under what circumstances they may or may not be discarded or destroyed, as well as the proper method for destroying such documents. All records are maintained and discarded or destroyed in accordance with corporate procedures. Business units and service units have established Best Practices to implement the corporate policy. The Best Practices are established by the record Manager. The Record Manager position resides in Zurich's Enterprise Risk Management Department. Enterprise Risk Management is the area responsible for the implementation of these procedures. These procedures are housed on the employee intranet site for all employees to view and as changes are made, all employees are notified via intranet announcements. Audits of odd-site storage facility are performed by the Records Manager.

The Company's corporate policy is detailed and extensive.

Recommendations: None

Procedure 11 – Complaint Handling Procedure

Observations: The Company has written procedures regarding complaints. The procedure is dated June 23, 2004. The procedure is clear and readable, and accessible to all persons it affects. The Company provides adequate training to those persons the procedure affects.

The Company's Law Department has the responsibility for monitoring complaints and ensuring proper compliance with the various states' requirements. In order to meet that responsibility, the following procedures are followed:

Steadfast Insurance Company

The Company defines a “complaint” as any written communication primarily expressing a grievance. A complaint may be filed with an insurance commissioner/department or sent directly to the company by the insured or the insured's representative.

All written complaints must be documented in writing, regardless of whether the complaint was previously resolved verbally. The corporate standard is ten (10) days after the complaint is received.

The Company states the following process is used when dealing with complains.

“Upon receipt of a complaint the person receiving the correspondence shall immediately contact the Law Department and supply a copy of the complaint.”

“A determination will be made as to who will respond to the complaint and the nature of the response. Generally, the head of the department from where the complaint originated will be responsible for investigating the complaint, evaluating the action taken, and drafting a response.”

“A draft response will be reviewed and approved by the Law Department before the response is released. A copy of the final response and all backup information will be sent to the Law Department.”

“All complaints should be answered within five (5) working days or within the days required by the insurance departments.”

“The department where the complaint originated is responsible for gathering and supplying any information required.”

“The Law Department shall maintain the required complaint file and maintain copies of all information necessary to document the complaint handling. A log has been developed for this purpose. Each Division should also maintain a complaint log in order to assure that all complaints have been handled properly.”

The Company also provides for complaint contingencies such as mass-media notification of complaints, and the privacy requirements contained in the Gramm-Leach-Bliley Act.

The complaint handling procedure does not appear to conflict with Delaware statutes or regulations.

Recommendations: None

Procedure 13 – Advertising, Sales and Marketing Procedure

Observations: The Company does not have a formal written advertising, sales and marketing procedure. Since the Company is a Surplus Lines insurance company they are prohibited from

Steadfast Insurance Company

conducting direct solicitation or advertising. However, Surplus Lines agents can advertise their own company in insurance related periodicals. The Company is not required to approve the surplus lines agent advertising since they are not advertising on the Company's behalf. Surplus lines agents are also prohibited by state law to use the Company's name in agency advertisements.

Recommendations: None

Procedure 14 – Agent Produced Advertising Procedure

Observations: The Company is a surplus lines non-admitted insurer for all states in which it issues policies. Advertising for a non-admitted company in most states is forbidden, regardless of whether the advertisement is directly issued by the company or issued by agents, producers, brokers or any other non-related entity. In order to ensure compliance by independent agents regarding advertising, the Company has included in its agency contract the following language:

“Producer shall ensure that its distribution of any advertisements, promotional materials and other business communications referring to Company, or to Company’s coverages or services, are distributed in accordance with applicable federal and state law, including those laws that regulate commercial electronic messages and facsimile transmissions. You shall not broadcast, transmit, publish or distribute any advertisements, promotional materials and other business communication referring to Company or to Company’s coverages or services without first securing Company’s approval in writing.”

Recommendations: None

Procedure 15 – Producer Training Procedure

Observations: The Company has a written producer training procedure outlined on the Company website, which is accessible and link-able to producer websites. The underwriting manual includes ISO-based portfolio packages, as well as sample policy-writing guidelines for health, surety, errors and omissions, and disability coverage. Claim and loss reporting is governed by forms available online, which include automobile, general liability, property, workers’ compensation, as well as Zurich/Industry forms. Policies, applications for insurance and marketing materials are also available on this site.

There are no formal procedures containing management review, measurement, oversight and control. No producer requirements demanding and/or measuring producer knowledge of the information on the website was noted.

Recommendations: None.

Procedure 20 – Producer Selection, Appointment and Termination Procedure

Observations: The Company provided formal procedures for the following areas of producer selection, appointment and termination:

”New Distributor Appointments: this requirement is for determining the financial condition of a prospective distributor to ensure that Zurich North America appoints distributors who can meet their fiduciary responsibility. The Company requires financial statements covering a two year period, preferably prepared by a CPA. The data is then entered into the Company's Financial Model Worksheet which provides an analysis indicating whether or not the required financial position is present. The analysis scores applicants on a 1-100 scale, indicating the amount of trust needed to handle particular amounts and kinds of business.

Financial Due Diligence: this requirement determines the financial condition of a prospective distributor to ensure that the Company appoints distributors who can meet their fiduciary responsibility and for monitoring and appropriately reacting to delinquent distributors.”

“Delinquent Distributors: the Company relies on the manual *Agency Accounting Policy and Procedures Manual*, which provides detailed steps to assist supervisors and managers in the recognition and reaction to various financial and operational warning signs. In addition, once distributors fall below certain scores, the manual provides a list of remedial actions to be taken, including termination.”

In addition to the above, the Company also provided checklists for delinquent payments, the required financial reporting form, and cash review procedures on agency accounts. The Company also produced printed guidelines indicating that all agency accounts are reviewed on a monthly basis.

Recommendations: None

Procedure 21 – Producer Defalcation Procedure

Observations: The Company does not have a formal written producer defalcation procedure but they do have a summary of the processes used for delinquent agency payables. A delinquent agency payable in which the agency has been paid by the insured or client, due to insufficient funds, is defalcation. Such funds are held in a fiduciary capacity by the agency until due to the Company. Misappropriation or misuse of such funds is generally a criminal act. An insurer will generally take steps to avoid that potential or eliminate it.

The Company's Accounts Receivable sends notice of delinquency to the appropriate business unit. If payment is not made on first delinquency notice, the billing office (accounts receivable) will make telephone contact with the agent. In addition, the appropriate business unit will also make contact in order to enforce terms of the agency agreement, which may include imposition of direct billing, reduced commissions, suspension of new business, and ultimately severance of the contractual relationship. Upon a third occurrence within the billing cycle, the parent company will contact the agent, and inform them as to whether the impositions stated prior will be applied.

After the incoming information is documented and validated an investigation is initiated. Notice is then made to the appropriate parties, (i.e., HR/Corp Law/law enforcement) where necessary.

Steadfast Insurance Company

Upon completion, the appropriate disposition is selected. Those possible dispositions are as follows:

- Recommend and pursue criminal, civil, terminations and/or administrative actions, as deemed appropriate.
 1. Federal/state law enforcement and government agencies.
 2. Department of Insurance
 3. Fraud Bureaus
 4. Human Resources/Corporate Law/Staff Legal
- Pursue monetary recoveries.
- Identify internal control deficiencies with referral to appropriate management.
- Provide fraud activity information required for the state compliance reports.
- Provide fraud activity information to senior management.

It is the responsibility of the assigned investigator to create and maintain an open dialogue with the above listed individuals throughout the investigation.

The assigned investigator must ensure that any control failures or vulnerabilities are identified and that action is taken to prevent a reoccurrence. Any control issues must be referred to Internal Audit and or other appropriate departments at the management level, for follow-up action/review, or other company management, as appropriate. The assigned investigator will document their conversation/actions and include any required follow-up action with IA (or other departments) on the Investigations and Security Risks incident report form and in the case activity notes.

Recommendations: It is recommended that the Company develop a formal written producer defalcation procedure.

Procedure 22 – Prevention of Use of Persons with Felony Conviction Procedure

Observations: When a request is made to process a state appointment for a specified producer, a background check letter is prepared and forwarded to the agency employing the producer requesting verification that the agency has performed all the necessary background checks and that they vouch for that the individual.

Recommendations: It is recommended that the Company establish a formal written procedure concerning use of persons with felony convictions.

Procedure 23 – Policyholder Service Procedure

Observations: The Company has a written procedure manual for policyholder services that is clear and readable. The procedure is accessible to all persons subject to its provisions, and it appears that adequate training is provided to persons affected by the procedure. No conflict with Delaware statutes or regulations was noted.

Steadfast uses agents and brokers to sell its policies. The Agency Accounting section of the Agency Accounting & Collections department at Steadfast is responsible for collecting premium

Steadfast Insurance Company

from these producers. The Agency Accounting section uses the accounts receivable module of Primis, Agent Open Items (AOI), to assist them in dealing with the producers, as well as with analyzing and maintaining these accounts. AOI does not interface with the general ledger system and acts only as a detailed sub-ledger of each producer's sales.

Each night the AOI system is updated with all of the current day's premium/commission activity, which is transferred, by batch processing, from the Policy module to the AOI module. AOI shows gross premium, commission, net premium, policy number, effective date, type of transaction, insured's name, commission percentage, and other relevant information for each transaction. Each producer's account is assigned to a particular Account Analyst who handles all processing, analysis, correspondence, telephone calls, billing, and other functions relating to that account.

Recommendations: None

Procedure 24 – Premium Billing Procedure

Observations: The Company has a written procedure manual for premium billing that is clear and readable. The procedure is accessible to all persons subject to its provisions, and it appears that adequate training is provided to persons affected by the procedure. No conflict with Delaware statutes or regulations was noted.

The Company categorizes billings into three categories, according to the following guidelines:

Agency Billing:

- Account Current: A monthly itemized statement is generated by the agency and submitted. Account Current statements are due no later than the 10th of the following month;
- Billing Statement: A month billing invoice is generated by the Company for all premium recorded or effective (whichever is the later of the two) during a given accounting month. Any agency adjustments to the billing statement are communicated back to the Company by the end of the month in which it was received.

Direct Bill Method:

- Statement of Account: A monthly itemized invoice mailed directly to the insured for all direct-bill premiums;
- Electronic Statement of Account: A secure, state-of-the-art electronic bill available to insureds with internet access. Bill presentation and payment options are available through the internet.

Special Bill Method:

- Individually Invoiced Accounts: billing to individual accounts
- Third Party Deductible: Generated by the Company collection department.

Recommendations: None

Procedure 25 – Correspondence Routing Procedure

Observations: The Company provided a flow chart showing typical mail routing. All mail sent to the Company's Post Office addresses is Air Expresed to Chicago for a 5:30 a.m. pickup by the Company Document Distribution Center. The mail is then processed by dedicated mail processors assigned to various offices. The mail is opened and processed according to a priority hierarchy established by the Company.

The Document Distribution Center does monthly quality reviews on all mail processors. They do a review to ensure proper folder type identification: each folder contains one claimant; the quality of the document is good; the mail is assigned to the correct claim number; and that the right person in the right office.

The Company keeps a complete record of complaints received. The Customer Inquiry Center (CIC) maintains the Corporate Complaint Register and keeps a file of written complaints received by the Company for tracking purposes.

Recommendations: None

Procedure 26 – Policy Issuance Procedure

Observations: The Company has a policy issuance procedure that is dated April 28, 2004. The following is the Company's procedure.

One or both of the following must apply before a policy may be issued:

- The kind or class of insurance must appear on the export list of the state in which the insured is domiciled; or
- If there is no export list or if the risk or coverage does not appear on an export list, coverage may be issued if there is no other admitted insurer. The diligence of the search for other providers is governed by the standards of the state in which the insured is domiciled.

Once the above test is met, the broker issuing coverage is responsible for doing the following:

- advising the prospect about the differences between an admitted insurer and a non-admitted insurer and providing a disclosure statement and having it signed;
- completing the application and related information and sending it to the insured;
- reporting to the DOI of each state any required information about the non-admitted transaction;
- collecting and remitting the premium;
- calculating premium taxes;
- reviewing the policy for completeness;
- providing the insured with the policy and the appropriate disclosure statements for the states in which the insured has a presence that is covered under the policy.

Recommendations: None

Procedure 27 – Reinstatement Procedure

Observations: The Company's reinstatement procedure states that no agents or representatives may reinstate policies that have lapsed or cancelled. Per Company information, sole authority to reinstate a policy is vested in the Company underwriting department assigned to the agent/representative when the policy was initially issued. The Company provided the forms to be submitted but no controls or management overview was provided.

Recommendations: None

Procedure 28 – Insured or Member Requested Claim History Procedure

Observations: The Company's procedure for providing claim history requires the insured's or insured's agent of record to request, in writing, claim history information. A review of a sample Customer Report by Policy Effective Date was performed by the examiner.

Recommendations: None

Procedure 30 – Premium Determination and Quotation Procedure

Observations: The Company uses brokers and independent agents for issuance of policies. Prior written authority may be delegated to the surplus lines broker to apply an appropriate rate and quote based on rating or underwriting guidelines established by the Company.

Recommendations: None

Procedure 31 – Policyholder Disclosures Procedure

Observations: Disclosure statement notices are given to and signed by the insured or prospective insured advising that insurance is being placed or sought with a non-admitted insurer that is not protected by the state guaranty fund and that the non-admitted carrier is not regulated by the DOI as is an admitted carrier. These notices vary by state. Almost all states require the policy to carry such a disclosure.

The Company issues the policy and includes the appropriate state disclosure on/or with the policy prior to sending the policy to the broker. They rely on the internal controls, underwriting audits, and internal audits to monitor state requirements. The Company also relies on the surplus lines broker to include the appropriate disclosure on/or with the policy prior to sending the policy to the insured. Because the policies are in many instances filed with the state insurance department or a surplus stamping office, who in turn audits the policy to ensure the proper notice, is included, the Company does not consider it necessary to monitor the surplus lines broker. The Company does have an outline that describes the responsibility of the surplus lines broker and provides it to all parts affected.

Recommendation: None

Procedure 32 – Underwriting and Selection Procedure

Observations: The Company has a written underwriting and selection procedure. The procedure is clear and readable and is accessible to the persons it affects. The Company provides adequate training to those persons the procedure affects.

Upon completion of training, Company employees are authorized in the following procedures:

- Communicate with brokers and agents
- Gather information needed to evaluate a prospect
- Utilize claim and risk engineering services
- Complete an underwriting narrative
- Rate various lines of business (manual rating, experience rating, loss rating)
- Analyze financial statements
- Create a proposal

Company employees are trained in and practice the five-step underwriting process. [This five-step process is further explained in Procedure 35 of this report.] The classroom sessions provide insight on how to obtain information needed to analyze and evaluate a prospective account. With instruction from some of Zurich's most experienced underwriters, the employees are given in-depth training pertaining to workers' compensation, general liability, commercial automobile, marine, property, and business interruption. The classroom sessions provide an awareness of the various on-line tools (both internal and external to Zurich) that can benefit an underwriter when evaluating an account.

Recommendations: None

Procedure 33 – Rate and Form Filing Procedure

Observations: The Company provided extensive literature on rate and form filing procedures. A checklist is provided by the Company's Actuarial and Risk Management Services Department to business units. Projects (i.e., policies) are reviewed by the business unit for completeness before being submitted to the regulatory services department. A filing analyst will enter the project into the Company's *i-trac*© system, which will produce a form letter to be used for each applicable state affected by the filing. Where states accept electronic filing, the NAIC's SERFF system is used to communicate the filing (with the exception of Florida, which requires rates and forms submissions through its own Florida I-File system). The Company's *i-trac*© system is used to track the submissions. If there is a state objection to any filing the Company's regulatory services department will intervene. Upon approval or disapproval, the final status of the submission will be entered into *i-trac*©. Any rates or rules affected by an approved filing will be noted in the Zurich Reference Library.

Recommendations: None

Procedure 34 – Termination Procedure

Steadfast Insurance Company

Observations: The Company does not have a formal written procedure but the process guidance is in the form of the information from CCH Insurance Services, which provides state-specific compliance guidelines and forms for termination and/or denial of coverage. No other information was provided by the Company.

Recommendations: It is recommended that the Company establish a formal written procedure governing terminations.

Procedure 35 – Underwriting File Documentation Procedure

Observations: The Company does not have a formal written underwriting file documentation procedure. The Company provided the training program used to familiarize employees with the underwriting procedures. Employees are required to complete the following training in underwriting:

- Policy construction/coverage analysis,
- Information gathering and analysis,
- Determine coverage
- Hazard and loss identification and analysis,
- Financial Analysis

This training develops skills in evaluating files with emphasis on identifying loss exposures, analyzing Risk Engineering and financial reports. After training, the employee is expected to independently select forms for issuance and provide quotations.

Recommendations: None

Procedure 36 – Underwriting Training Procedure

Observations: The Company provided its program used to familiarize employees with the underwriting procedures. Employees are required to complete the following training areas in underwriting:

- Introduction to the Underwriting Business Unit (“UBU”)
- UBU Workflow
- Introduction to Underwriting
- Policy Issues and Support Underwriting
- Underwriting Worksheet
- Underwriting Financial Analysis
- General Liability Underwriting
- Workers’ Compensation Underwriting
- Premium Audit
- Commercial Automobile Underwriting
- Commercial Property Underwriting
- Accounting and Collections

Steadfast Insurance Company

The training program was comprehensive and detailed, and provided for management control and evaluation.

Recommendations: None.

Procedure 40 – Staff Training Procedure

Observations: The Company does not have generic written staff training procedure. Each of the Company's departments trains employees assigned to that department. Each department trains employees through "Best Practices" manuals, which were noted in other procedures as being extensive and well organized.

Recommendations: None.

Procedure 42 – Adjuster Training Procedure

Observations: All new employees are trained and oriented based on a New Employee Checklist. These activities are monitored by local offices and Corporate Organizational Development. These activities are completed in the first ninety (90) days of employment. Claims staff attend in-house seminars and complete basic training modules related to claims based on position and experience. All employees are required to review the Corporate Conflict of Interest Policy as well as attend privacy and Office of Foreign Asset Control (OFAC) training.

Field Technology Champions (FTCs) within the claim offices are used to convey, communicate, and train claims staff on system changes. All new employees are trained on eZACCESS within the first few days of being hired. New employees are provided with the most recent version of the "Introduction to eZACCESS Participant Guide," which was initially developed when eZACCESS was created. The training class takes approximately eight hours and provides an overview of registering claims, handling new loss, z-Notes, diaries, payments, and closing claims. This guide is updated each quarter as new iterations of eZACCESS are released. The FTCs monitor the system training needed for an office and maintain a record of employees attending training sessions.

Recommendations: None

Procedure 43 – Claim Handling Procedure

Observations: The Company distinguishes four claims handling procedures by line of business. The four types of procedures are further divided into the following categories: product liability, specialties (surplus lines), medical, and property. A review of each policy and procedure indicates that reporting dates, notice requirements, documentation, etc., are essentially the same, and are outlined below.

Coverage

The case manager confirms that the submitted claim falls within the coverage terms of the policy within 1 day of receipt of claim. The type of policy, policy limits and other policy parameters are documented in the file where appropriate, excess and aggregate carriers are notified of estimated exposure. Investigation of relevant facts is initiated within two (2) days of recognition of coverage issues. Within thirty (30) days of recognition of coverage issues, the insured is notified with either a reservation of rights or declination letter. Reservation of rights letters explains the basis for reservations, and clearly state information needed to resolve coverage issues. All case managers are expected to be familiar with states regulations concerning content and timing of coverage letters.

Customer Service

The insured and claimant must be contacted within 1 day from receipt of claim. The case manager must make personal contact with one or the other. Third party contact (i.e., independent adjusters) and voice mail are not considered to be contact. On transferred claim files, the new case manager must send a letter to all interested parties introducing himself/herself within five (5) business days of the transfer. The claim manager must communicate with the insured on a regular basis (at least every ninety (90) days) throughout the life of the claim.

Investigation

The case manager is responsible for investigation into all aspects of the claim (liability, injury, damages, contribution/subrogation, etc.). The case manager's evaluation of losses is fully documented in the file. An evaluation is completed and documented in the file within thirty (30) days of receipt of the information. Case managers are trained to recognize fraud indicators, and must refer any indication of fraud to the Zurich SIU department within thirty (30) days of recognition.

Reserving

Initial reserves are set within 1 business day of receipt of the claim. Case reserves are set within a thirty (30) day period. Expense reserves (sums expected to be incurred in the defense, investigation, and adjustment) must be supported by a litigation plan and a budget. Reserve adequacy is re-evaluated at least every 180 days. The claim file must contain a clear explanation for all reserves, with support. If the reserve level exceeds the case manager's authority, extension of authority from senior management will be included in the file.

Litigation Management

A new suit must be referred to qualified counsel within 1 business day of receipt of service of process. The case manager negotiates billing rates. Litigation strategy must be completed and documented in the file within forty-five (45) days of referral to counsel.

Resolution

A customized strategy for resolution of the claim must be developed within forty-five (45) days of receipt of the claim. For claims in litigation, the litigation plan shall serve as the claim disposition plan. The claim file must contain any decision to settle and a reasonable settlement amount. Subrogation and contribution opportunities should be identified.

File Management

A diary system clearly identifying the policy and underwriting company name is kept.

The Claim Manager determines if the loss date is within the policy period, if there are any unusual circumstances and/or any potentially large losses involved, reviews the loss notice and indicates the claim examiner's name, claim number, and the claim reserve amount. The claim is returned to the Claim Associate (CA) who sets up a physical claim file, using Primis, which automatically assigns a new claim number. The CA then enters some of the basic information in Primis, including date received, insured name, policy number, claimant name, and date of loss. Although other employees can browse the claim module, members of the claim department staff are the only ones who have authority to enter claims into Primis. When a claims processor sets up a claim in PRIMIS, a screen appears listing all claims set up under that policy so the claims processor (CP) can review for potential duplicate claims.

New claims are typically entered into the system within twenty-four (24) hours. The CP copies the coverage information from the policy file. This includes the declarations and coverage pages and any applicable endorsements. A copy of the claim notice is sent to the underwriting unit with a reserve amount noted.

Two types of payments are made using the Primis system's claims processing function: loss payments and expense payments. Claims processors are responsible for any expense payments up to their designated authority limits and the claims examiners make the loss/indemnity payments up to their designated authority limit. Processors have access only to the expense fields. For casualty claims where a lawsuit is involved, the claim check is not released until a waiver of liability has been obtained.

If the payment request exceeds the reserve amount in a partial payment, the reserve is increased through the reserve change process. If it is a final payment, the system automatically generates the increased reserve entries needed to balance the payment and the reserve amount. When any payment is generated, the system verifies that the total incurred loss on the claim including this payment is within the claims examiner's authority before issuing the payment. When the checks are issued, a copy of the check, as well as the authorization, is maintained in the file.

If the settlement or payment amount exceeds the claims examiners authority limit, they must consult with, and receive approval from, the claims manager who will then change the system authority to allow the payment. The Vice Presidents and the Claim Managers have the ability to change an examiner's authority limit on a claim by claim basis to any amount (within the managers' authority limit) necessary to work the claim. The user's authority limits are used to place constraints on the amount of reserves or check authority each person is granted. If a claim reserve is over the Vice President's user authority, he will send a notice to the Chief Operating Officer or Senior Vice President of Finance who will authorize information technology (IT) to change the maximum authority for that particular claim. IT personnel will then increase the authority limit for the particular claim, allow the claim Vice Presidents to set the reserve amount, then immediately change the limit back to the original level.

Steadfast Insurance Company

Claim check numbers are automatically assigned by the system, then reviewed and verified by the Accounting Department. The Vice President of claims reviews a daily check register listing all payments for a given day exceeding \$5,000 and they also review the daily transaction reports. Copies of the check and supporting documents are routed back to the claim department to be matched back with the related claim and filed.

The check writer application (Paybase) resides on one personal desktop computer located in a room in the corporate accounting department. Paybase is password protected and only a limited number of employees in the accounting department have log-in ID's and passwords. A system control exists in Paybase preventing any of the claim payment information from being altered after it has been downloaded from PRIMIS.

To ensure the accuracy of the recording of claim payments, bank reconciliations are performed on a monthly basis for all claims affiliated bank accounts. Undeliverable claim checks returned by the post office are routed directly to Financial Accounting who then sends a copy of the returned check to Claims to research the correct address. When the correct address is obtained, the check is re-mailed by the Financial Accounting Department. The live check never returns to the possession of the claims department. Although on occasion this did occur for purposes of researching bad addresses, as of September 1, 2004 the company has instructed the mail room to never send a live check to the claims department, and a copy of the check will always be sent back to the Financial Accounting Department.

Recommendations: None

Procedure 44 – Internal Claim Audit Procedure

Observations: The Company employs a Claims Quality Assurance Unit to assist the claims organization compliance with the “Best Practices Processes” outlined in Procedure 43. The Best Practices for each line of business are used as guidelines for audits.

Recommendation: None

Procedure 45 – Claim File Documentation Procedure

Observations: Once the case manager receives notice of a claim, applicable limits and other key parameters are confirmed within one business day. A claim file is completely registered in ACCESS within 1 business day of receipt of the claim by the Company. All applicable coverage issues are recognized immediately upon receipt of information (first notice, pleading, letter, investigation report, etc.) evidencing the potential coverage issues.

All claimed injuries and damages are evaluated and verified by the case manager through credible evidence and/or the use of appropriate experts/vendors. File documentation must support the degree of injuries and damages outlined in the case exposure evaluation.

An effective coverage analysis and determination will be made as soon as practicable, but no later than thirty (30) days from the company's receipt of all necessary coverage-related

information. All coverage letters are to be written in a clear, concise and understandable manner, with all-pertinent facts and relevant policy provisions effectively explained. Reservation of rights letters must clearly explain the bases for the reservations (pertinent facts and relevant policy provisions) and the information needed to allow resolution of the coverage issue(s). Declination letters must clearly explain the bases for denial of coverage (pertinent facts and relevant policy provisions), and must also advise the insured that the Company will re-evaluate a declined coverage position upon presentation of additional, material information relative to the relevant coverage issue(s).

The claim file must contain a clear explanation for all reserves, as well as all information needed to properly support said reserves (i.e. case summary, counsel's evaluation letter, jury verdict research, etc.).

Regarding MCU level files, the case manager prepares an effective case summary report clearly explaining the bases for the recommended reserve. That report contains all material facts and information effecting claim exposure, a thorough evaluation of the estimated realistic claim exposure (using, as may be appropriate, decision tree analysis, jury verdict research, defense counsel's assessment, etc.), and a customized resolution strategy and action plan.

The reserve is posted within the case manager's authority. If the necessary authority is extended by the case manager's supervisor, claim manager or senior management, the extension of that authority must be properly documented in the file.

The case manager must refer a new suit to qualified defense counsel within 3 business days of receipt of the suit by the case manager. Unless prohibited by applicable law or the Special Handling Instructions, suits are referred to the Legal Staff, when appropriate, or counsel, where available. If the suit is referred to a firm other than the Legal Staff or ZAAP counsel, the rationale for that assignment must be clearly documented in the file and approved by the Team Manager and either the Claim Manager/AVP or the Regional Litigation Manager. If the suit is referred to counsel other than Staff Legal or ZAAP counsel, the case manager must secure and confirm in writing counsel's agreement to comply with Zurich's Litigation Management Guidelines for Defense Counsel (Guidelines) and billing expectations (consistent with applicable law).

The case manager must confer with defense counsel to develop a focused, cost-effective litigation strategy, regardless of the complexity of the case. The initial strategy conference is to be held within fifteen (15) days of assignment. The file notes must reflect documentation of this conference. Said litigation strategy should be further documented in the form of a Case Management Plan completed by counsel and sent to case manager within forty-five (45) days of assignment to counsel.

The case manager is responsible for the review and payment of all legal bills. The claim file shall reflect that the case manager and/or Litigation Management have reviewed all legal bills prior to payment.

Where necessary, the case manager will select and retain qualified vendors to assist in the investigation, evaluation and/or adjustment of the claim. The rationale supporting the necessity and selection of a vendor must be clearly documented in the file. The retention of any vendor must be memorialized in a vendor assignment/retention letter, which specifies the scope of the assignment, the time frame for performance and the agreed budget.

Circumstances of a claim must support the decision to settle and the reasonable settlement amount. Settlement value must be supported by appropriate file documentation.

The claim file must clearly document all subrogation, contribution and salvage activities.

Recommendations: None

Procedure 46 – Subrogation and Deductible Reimbursement Procedure

Observations: The Company does not have a formal written subrogation and deductible reimbursement procedure but they have a detailed process explaining their current process.

The Claims Quality Assurance Unit provides assistance to claims areas by providing compliance tests based on the Best Practices reviewed in P44. Audits of closed files, chosen on a random basis, are reviewed every ninety (90) days.

The Recovery Unit receives referrals from the Case Managers and Team Managers through monthly reviews of claims, and from a data-mining program within ACCESS. Referrals are based on the nature of the claim, as particular claim types are more likely to have subrogation potential. The automated data-mining program uses a historical weighted average of a particular type of claim code in order to determine whether a recovery is statistically likely. Claims where recovery potential is likely to be greater than \$100,000, and Workers' Compensation claims, are automatically 'tagged' for recovery/subrogation review.

Once the Recovery Unit receives a referral it is assigned to one of seven regional recovery hubs based on the claim office responsible for that claim. The claim is then investigated to determine the level of the recovery. The type of claim determines which business unit handles the investigation:

- Workers' Compensation: Recovery Unit handles entire investigation
- Automobile Physical Damage: First party Case Manager makes initial observation and refers to Recovery Unit (all property recoveries greater than \$100,000 must be referred within twenty-four (24) hours)
- Property: First party Case Manager makes initial observation and refers to Recovery Unit (all property recoveries greater than \$100,000 must be referred within twenty-four (24) hours)

After a recovery is approved for pursuit, the Recovery Unit determines if the adverse party is insured. Self-audits are performed quarterly by the Team Managers. Team Managers are required to review three claims per Case Manager by the 15th of the month following the end of a quarter. The Team Manager verifies that the claim information is accurate and that the following best practices are complied with:

- coverage analysis and issues: employer's liability claims;
- customer services
- investigation
- reserves
- medical management
- litigation management
- plan of action
- file management

The Case Manager receives a score and feedback from the Team Manager. The Quality Assurance Team verifies that the Team Managers complete these reviews.

Customer protocol audits are performed annually for most claim offices. These audits measure compliance with certain key customer expectations, mostly pertaining to financial related communications.

Recommendations: None

Procedure 47 – Reserve Establishment Procedure

Observations: Initial reserves are set within 1 business day of receipt of the claim by the case manager. The initial reserve will be based on the limited information received from the notice of loss.

Estimated realistic case exposure is recognized as soon as practicable, but no more than thirty (30) days from receipt of information evidencing that exposure (or change in exposure). Appropriate case reserves are set within said thirty (30) day period. Case reserves reflect estimated realistic exposure given the degree of liability, severity of loss and measure of damages. Reserves are established in accordance with policy limits, terms and conditions.

Expense reserves reflect all sums expected to be incurred in the defense, investigation and adjustment of the claim. For litigated cases, expense reserves must be supported by a litigation plan and budget (with the exception of Level One cases).

Reserve adequacy is routinely re-evaluated at least every 180 days.

The reserve is posted within the case manager's authority. If the necessary authority is extended by the case manager's supervisor, claim manager or senior management, the extension of that authority must be properly documented in the file.

Recommendations: None

SUMMARY

Steadfast Insurance Company (Steadfast) is a Delaware domiciled company. The Company is a diversified multiple lines insurance company. The Company is a member of the Zurich Insurance Group, a Swiss domiciled holding company system. The immediate parent is Zurich American Insurance Company, a New York domicile.

The examination was a Delaware Baseline Market Conduct Examination of the following business areas: Company Operations/Management, Complaint Handling, Marketing and Sales, Producer Licensing, Policyholder Service, Underwriting and Rating, and Claims.

Significant issues arising during the course of the examination include:

- Lack of written procedures for Assertion of Privilege. (P-02)
- Lack of written procedures for Anti Fraud. (P-05)
- Lack of written procedures for Producer Defalcation. (P-21)
- Lack of written procedures for Prevention of use of Persons with Felony Conviction. (P-22)
- Lack of written procedures for Termination. (P-34)

Recommendations have been made to address the areas of concern noted during the examination. These are summarized below.

LIST OF RECOMMENDATIONS

Recommendation P-2, Assertion of Privilege

It is recommended that the Company establish a formal written procedure for assertion of privilege.

Recommendation P-5, Anti Fraud Procedure

It is recommended that the Company develop a formal written anti-fraud procedure.

Recommendation P-21, Producer Defalcation Procedure

It is recommended that the Company develop a formal written producer defalcation procedure.

Recommendation P-22, Prevention of use of persons with felony conviction Procedure

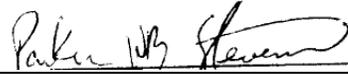
It is recommended that the Company establish a formal written procedure concerning use of persons with felony convictions.

Recommendation P-34, Termination Procedure

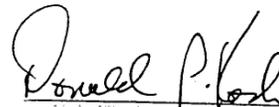
It is recommended that the Company establish a formal written procedure governing terminations.

CONCLUSION

The examination was conducted by Donald P. Koch, Parker W.B. Stevens, and Peter Schaeffer and is respectfully submitted,



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Market Conduct Examiner-in-Charge
Insurance Department
State of Delaware



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