Common Problems Identified by the Property and Casualty Market Conduct and Consumer Services Sections

The State Corporation Commission's Bureau of Insurance (Bureau) has developed the following information to assist insurers with compliance problems frequently found in the regulation of the market by the Market Conduct Section and the Consumer Services Section. The purpose of this document is to provide insurer personnel responsible for compliance with a checklist to review their operations in Virginia. Its purpose is not to provide specific guidance on how an insurer should conduct business in Virginia but to point out the areas in which the Bureau has found problems in the past. This list should not be considered all-inclusive, and the insurer should continue to review Title 38.2 of the Code of Virginia, the appropriate regulations, administrative letters, orders, and guidance documents on the Bureau's webpage to ensure compliance.

Any questions regarding the contents should be addressed either in writing or by calling:

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Common Problems Identified by the Property and Casualty Market Conduct and Consumer Services Sections

Private Passenger Automobile Terminations

Failure to include all named insureds on the termination notice. Section 38.2-2212 of the Code of Virginia requires that the cancellation and refusal to renew notices must be mailed to the named insureds shown on the policy. If there are multiple named insureds, all must be listed on the notice of cancellation and refusal to renew.

Failure to provide a specific reason for the cancellation or refusal to renew a policy. Section 38.2-2212 E 3 of the Code of Virginia requires that the insurer provide the insured with the specific reason for canceling or refusing to renew a policy. The Bureau does **not** consider the following examples to be specific reasons: "loss history," "driving record," "claims," "prohibited risk," "underwriting reason," etc. The insured is entitled to know why the insurer is cancelling or refusing to renew his policy and the insurer must provide the specific reason.

Cancellation of private passenger motor vehicle policies due to suspension or revocation of a license. Section 38.2-2212 D of the Code of Virginia sets forth the reasons that insurers may cancel such policies midterm. These reasons include cancelling when an insured's license is suspended or revoked during the policy period or (if a renewal) during the 90 days immediately preceding the last effective date of the policy. The effective date of the suspension or revocation must have started within the statutory time period. In some instances, insurers are misclassifying an expired license or no license as being revoked or suspended contrary to the statute.

Failure to retain a copy of the notice of cancellation or refusal to renew a policy. Section 38.2-2208 of the Code of Virginia provides the retention requirements for notices of cancellation and refusal to renew automobile policies. Insurers are often unable to provide the examiners with copies of notices either because the insurers fail to send the notice or because they do not have an adequate retention system. The inability to produce such a notice, while a violation of the statute, could also result in the insurer having to reinstate the policy and, perhaps, pay a claim. If the policy requires that the notice be sent to the lienholder, the insurer must also retain a copy of that notice.

Failure to provide the proper number of days' notice required when cancelling or refusing to renew a policy. Section 38.2-2212 of the Code of Virginia provides the various notice requirements for cancelling or refusing to renew a policy. Examiners frequently find that insurers fail to provide the proper number of days' notice required when terminating policies.

Notice of the right to review by the Commissioner improperly provided. Some insurers are including information in cancellation notices that insureds have a right to a review of the cancellation by the Commissioner of Insurance when such right does not exist. For example, no right to a review exists if the cancellation notice is sent before the 60th day after inception of a new private passenger automobile policy. Insurers should only send the right to review notice when required by statute and the policy.

Failure to obtain a proper proof of mailing for notices of cancellation and refusal to renew. Section 38.2-2208 of the Code of Virginia contains the procedures an insurer must follow when the notices of cancellation and refusal to renew private passenger automobile policies are mailed to the named insured. **NOTE:** § 38.2-2208 clarifies that insurers may use any first class tracking method including IMb Tracing™ to demonstrate that a notice of cancellation or refusal to renew has been mailed. This statute has been further amended to restore the option of using certificate of mailing to demonstrate proof of mailing. However, certificate of bulk mailing is not a permissible method. On March 3, 2016, the Bureau issued a memorandum to provide guidance to insurers that desire to use IMb Tracing™ to prove that these notices were mailed in accordance with the statute. The memorandum may be found on the SCC's website at: Guidance Using IMb Tracing

Insurers may provide notices of cancellation and refusal to renew electronically. Section 38.2-2212 of the Code of Virginia allows electronic transmittal of *all* notices of cancellation and refusal to renew to insureds, if such transmissions comply with § 38.2-2208 of the Code of Virginia and if both the insured and insurer agree to conduct business electronically. Refer also to § 38.2-325 of the Code of Virginia for additional requirements pertaining to the electronic delivery of all notices of cancellation and refusal to renew. Insurers must maintain a record of the ***electronic delivery*** of such notices to insureds for one year from the effective date of the termination.

Failure to handle correctly requests to cancel a policy by a premium finance company. A cancellation requested by a premium finance company is considered an insured-requested cancellation and should be handled accordingly.

Upon receiving a request from a premium finance company to cancel a policy, the insurer must verify that it has a copy of the premium finance agreement containing a power of attorney. If the insurer's contract provides for a short rate cancellation when the insured requests the policy to be cancelled, the earned premium should be calculated short rate when the policy is cancelled at the premium finance company's request. Section 14 VAC 5-390-40 A (the Rules Governing Insurance Premium Finance Companies) requires the insurer to notify the insured, the insurance agent, and the premium finance company that the policy has been cancelled and provide them with the information that is required by the regulation. The insurer must cancel the policy as soon as it legally may. For example, if there is a filing on the policy (such as an SR-22 or FR-44), the insurer must wait the requisite number of days and then cancel the policy as soon as permitted by the filing. Examiners frequently find that insurers are unaware of these requirements. Insurers should review 14 VAC 5-390-10 et seq. to determine their responsibilities under the regulation.

Insured-requested cancellations. Section 38.2-2212 F 2 of the Code of Virginia states that the provisions of the statute do not apply to the cancellation of a private passenger automobile policy if the insured, or his duly constituted attorney-in-fact, has notified the insurer or its agent orally, or in writing if the insurer requires such notification to be in writing, that he wishes the policy to be cancelled. The insurer demonstrates that it permits oral cancellations by amending the termination provisions of the insurer's automobile policy. This amendment must be filed with the Bureau of Insurance as a broadening to the standard private passenger automobile form. When accepting oral cancellations, insurers should maintain a record of the insured's request in the policy file to note the time of the call and the insured's requested cancellation effective date.

Failure to provide notice when the insurer does not wish to renew the insured's policy. If the insurer does not wish to renew a policy, a notice of refusal to renew must be sent to the insured. An exception to this exists in cases where an affiliated insurer has manifested its willingness to provide coverage to the insured at a premium that is lower than that which would have been charged for the same exposures on the expiring policy. The affiliated insurer's policy must have types and limits of coverage at least equal to those of the expiring policy unless the insured has requested a change in the coverage or limits. The insurer of the expiring policy is not required to send an offer of renewal, and the policy issued by the affiliated insurer will be deemed to be a renewal policy. (See § 38.2-2212 F 4 of the Code of Virginia.)

Failure to provide an adverse underwriting decision (AUD) notice. Section 38.2-610 of the Code of Virginia requires insurers to provide AUD notices when they decline to write coverage and when they terminate coverage. These notices are required when insurers initiate the cancellation of a policy mid-term (including cancellations in the first 59 days from the original inception date but excluding cancellations for nonpayment of the premium), refuse to renew a policy, or decline to write, in whole or in part, coverage requested by an applicant or policyholder. The definitions of "adverse underwriting decision," "declination of coverage," and "termination of insurance" are set forth in § 38.2-602 of the Code of Virginia. The Bureau of Insurance finds that insurers also fail to provide all of the information required in the AUD notice as set forth in § 38.2-610 of the Code of Virginia and Administrative Letter 2015-07 (revised).

Sending billing notice and cancellation notice together. Some insurers are sending a billing notice and a non-pay cancellation notice to the insured at the same time. This is not permissible as the insured is ***not in default*** under the terms of the policy at the time that such billing/cancellation notice is mailed. No cancellation notice for failure to pay premium may be sent by the insurer until the named insured is in default because he has failed to pay his premium when due. Additionally, § 38.2-2212 of the Code of Virginia requires the insurer to provide a notice giving the insured the right to request (within 15 days of the insured's receipt of the cancellation notice) the Commissioner of Insurance review the cancellation. If the cancellation notice is part of the billing notice, then the 15-day period could expire before the insured is in default.

Misclassifying policy fees when calculating earned premium. Insurers frequently charge policy fees when issuing a new or renewal policy. Such fees, including membership fees and other fees made for or in connection with a policy of insurance, are considered part of the rate for the policy and may **not** be fully earned. Examiners are finding instances where insurers are fully earning these fees in violation of Virginia insurance law. In contrast, service fees for installments, bad check fees, SR-22/FR-44 fees, and other fees not charged for the procurement of insurance may be fully earned. (See §§ 38.2-100 and 38.2-310 of the Code of Virginia.)

Failing to provide SR-22/FR-44 financial responsibility filing when requested by the insured. When requested by a named insured, insurers are required to provide to the DMV ***without unreasonable delay*** proof of future financial

responsibility as required by Title 46.2. See § 38.2-228 of the Code of Virginia. Some insurers, either directly or through their agents, are telling an insured that the insurer "does not write SR22/FR44 policies" or that their "systems do not permit them to add an SR22/FR44 filing," and that the policy must be cancelled mid-term. In some instances, insurers are cancelling policies and rewriting the policies as **new** business, which then allows the insurers to cancel the policies in the first 60 days for any reason, including requesting a financial responsibility filing. This practice may result in the use of a higher rate on the new policy or the application of surcharges for intervening accidents and convictions. These practices are in direct contravention of the law. Insurers are required to issue the financial responsibility filing on the existing policy (or its equivalent) when requested. Insurers are only permitted to make changes to policies with financial responsibility filings on renewal and in accordance with the provisions of § 38.2-2212 of the Code of Virginia.

Homeowners' Terminations

Failure to include all named insureds on the termination notice. Section 38.2-2114 of the Code of Virginia requires notices of cancellation and refusal to renew to be mailed to the named insureds shown on the policy. If there are multiple named insureds, all must be listed on the notice of cancellation or refusal to renew.

Failure to provide a specific reason for the cancellation or refusal to renew a policy. Section 38.2-2114 of the Code of Virginia requires that the insurer provide the insured with the specific reason for canceling or refusing to renew a policy. The Bureau does **not** consider the following examples of reasons used by insurers to be specific: "loss history," "condition of property," "underwriting reasons," "prohibited risk," "no longer insurable," etc. The insured is entitled to know why the insurer is cancelling or refusing to renew his policy and the insurer must provide the specific reason.

Failure to provide the proper number of days' notice required when terminating a policy. Section 38.2-2114 of the Code of Virginia provides the various notice requirements for cancelling or refusing to renew a policy insuring an owner-occupied dwelling. Examiners frequently find that insurers fail to provide the proper number of days' notice when terminating policies.

Failure to retain a copy of a notice of cancellation or refusal to renew a policy. Section 38.2-2113 of the Code of Virginia provides the retention requirements for notices of cancellation and refusal to renew homeowners' policies. Insurers are often unable to provide the examiners with copies of notices either because they fail to send the notice or because they do not have an adequate retention system. The inability to provide such a notice, while a violation of the statute, could also result in the insurer having to reinstate the policy and, perhaps, pay a claim. If the policy requires that the notice be sent to the lienholder, the insurer must also maintain a copy of that notice.

Failure to properly obtain proof of mailing notices of cancellation and refusal to renew. Section 38.2-2113 of the Code of Virginia contains the procedures an insurer must follow when the notices of cancellation and refusal to renew owner-occupied policies are mailed to the named insured. **NOTE:** The 2016 General Assembly amended § 38.2-2113 by clarifying that insurers may use any first class tracking method including IMb Tracing™ to demonstrate that a termination notice has been mailed. This statute has been further amended to restore the option of using certificate of mailing to demonstrate proof of mailing. However, certificate of bulk mailing is **not** a permissible method. On March 3, 2016, the Bureau issued a memorandum to provide guidance to insurers that desire to use IMb Tracing™ to prove that these notices were mailed in accordance with the statute. The memorandum may be found on the SCC's website at: Guidance Using IMb Tracing.

Insurers may provide all notices of cancellation and refusal to renew electronically. Section 38.2-2113 of the Code of Virginia allows electronic transmittal of *all* notices of cancellation and refusal to renew to insureds, if both the insurer and insured agree to conduct business electronically. Refer also to § 38.2-325 of the Code of Virginia for additional requirements pertaining to the electronic delivery of all notices of cancellation or refusal to renew. Insurers must maintain a record of the ***electronic delivery*** of notices of cancellation and refusal to renew for one year from the effective date of the termination.

Canceling policies mid-term for reasons not permitted by statute. After a new homeowners' policy has been in effect for 90 days (or a shorter period if specified in the policy), homeowners' policies can only be cancelled for one of the six reasons listed in § 38.2-2114 A of the Code of Virginia. For an insurer to use a physical change in the property as a reason to cancel mid-term, the insurer must show that there has been a physical change since the policy was renewed. In most cases, this would require two inspection reports to support the insurer's position that there has been a physical change. Examiners often find insurers cancelling policies for reasons not allowed, such as vacancy or the home is no longer owner-occupied. However, the policy provides some modified coverage in some circumstances if the dwelling becomes vacant. *An insurer may cancel the policy when foreclosure efforts by the secured party against the property covered by the policy have resulted in the sale of the property by a trustee under a deed of trust as duly recorded in the land title records of the jurisdiction in which the property is located.* Some insurers are cancelling homeowners' policies at the request of the mortgagee prior to the completion of the foreclosure process. **No insurer may cancel a homeowners' policy mid-term due to a foreclosure until the foreclosure efforts *have resulted in***

the sale of the property by a trustee under a deed of trust as duly recorded in the land title records of the jurisdiction in which the property is located. The mortgage company is not the policyholder and does not have the right to request cancellation of the homeowner policy or receive the unearned premium.

Insured-requested cancellations. Section 38.2-2114 E 3 of the Code of Virginia states that the provisions of the statute do not apply to the cancellation of a homeowners' policy if the insured, or his duly constituted attorney-in-fact, has notified the insurer or its agent orally, or in writing, if the insurer requires such notification to be in writing, that he wishes the policy to be cancelled. When accepting oral cancellations, insurers should maintain a record of the insured's request in the policy file to note the time of the call and the insured's requested cancellation effective date.

Failure to provide notice when the insurer refuses renew the insured's policy. If the insurer does not wish to renew a policy, a notice of refusal to renew must be sent to the insured. An exception to this exists in cases where an affiliated insurer has manifested its willingness to provide coverage to the insured at a premium that is lower than that which would have been charged for the same exposures on the expiring policy. The affiliated insurer's policy must have types and limits of coverage at least equal to those of the expiring policy unless the insured has requested a change in the coverage or limits. The insurer of the expiring policy is not required to send an offer of renewal, and the policy issued by the affiliated insurer will be deemed to be a renewal policy. (See § 38.2-2114 of the Code of Virginia.)

Failure to provide an adverse underwriting decision (AUD) notice. Section 38.2-610 of the Code of Virginia requires insurers to provide AUD notices when they decline to write coverage and when they terminate coverage. These notices are required when insurers initiate the cancellation of a policy mid-term (including cancellations in the first 89 days from the original inception date but excluding cancellations for nonpayment of the premium), refuse to renew a policy, or decline to write, in whole or in part, coverage requested by an applicant or policyholder. The definitions of "adverse underwriting decision," "declination of coverage," and "termination of insurance" are set forth in § 38.2-602 of the Code of Virginia. The Bureau of Insurance finds that insurers also fail to provide all of the information required in the AUD notice as set forth in § 38.2-610 of the Code of Virginia and Administrative Letter 2015-07 (revised).

Misclassifying policy fees when calculating earned premium. Insurers frequently charge policy fees when issuing a new or renewal policy. Such fees, including membership fees and other fees made for or in connection with a policy of insurance, are considered part of the rate for the policy and may **not** be fully earned. Examiners are finding instances where insurers are fully earning these fees in violation of Virginia insurance law. In contrast, service fees for installments, bad check fees, and other fees not charged for the procurement of insurance may be fully earned. (See §§ 38.2-100 and 38.2-310 of the Code of Virginia.)

Commercial Automobile/Property and Liability Notices (Cancellation, Refusal to Renew, and Premium Increase, and Reduction in Coverage)

Failure to provide a specific reason when providing a notice required by Section 38.2-231. Section 38.2-231 of the Code of Virginia requires that the insurer provide the insured with the specific reason for canceling or refusing to renew a policy as well as for increasing the premium more than 25% and reducing the coverage. The Bureau does **not** consider the following examples to be specific reasons: "loss history," "driving record," "claims," "prohibited risk," "underwriting reason," etc. The insured is entitled to know why the insurer is taking one of these actions, and the insurer must provide the specific reason.

Failure to provide the proper number of days' notice required when providing a notice required by Section 38.2-231. Section 38.2-231 of the Code of Virginia provides the various notice requirements on an insurer cancelling or refusing to renew a policy, as well as increasing the premium more than 25% or reducing the coverage on the policy. Additionally, medical malpractice insurers must provide at least 90 days' notice when cancelling the policy (other than for failure to pay the premium, which requires at least 15 days' notice of cancellation), or refusing to renew the policy. Examiners frequently find that insurers fail to provide the proper number of days' notice when terminating policies.

Failure to retain a copy of a termination notice. Section 38.2-231 F of the Code of Virginia provides the retention requirements for notices of cancellation and refusal to renew certain commercial policies. Insurers are often unable to provide the examiners with copies of notices either because they fail to send the notice or because they do not have an adequate retention system. The inability to provide such a notice, while a violation of the statute, could also result in the insurer having to reinstate the policy and, perhaps, pay a claim. If the policy requires that the notice be sent to the lienholder, the insurer must also maintain a copy of that notice.

Failure to properly obtain proof of mailing notices required by Section 38.2-231. Section 38.2-231 of the Code of Virginia contains the procedures an insurer must follow when mailing to the first named insured a notice of cancellation or refusal to renew, as well as a notice of premium increase greater than 25% or a reduction in coverage for commercial liability policies. **NOTE:** The 2016 General Assembly amended § 38.2-231 by clarifying that insurers may use any first class tracking method including IMb Tracing™ to demonstrate that such notices have been mailed. This statute has been further amended to restore the option of using certificate of mailing to demonstrate proof of mailing. However, certificate of bulk mailing is **not** a permissible method. On March 3, 2016, the Bureau issued a memorandum to provide guidance to insurers that desire to use IMb Tracing™ to prove that these notices were mailed in accordance with the statute. The memorandum may be found on the SCC's website at: Guidance Using IMb Tracing.

Insurers may provide all notices referenced in Section 38.2-231 electronically. Section 38.2-231 F of the Code of Virginia allows electronic transmittal of cancellation, refusal to renew, increase in premium greater than 25%, and reduction in coverage notices to insureds, if both the insurer and insured agree to conduct business electronically. Refer also to § 38.2-325 of the Code of Virginia for additional requirements pertaining to the electronic delivery of such notices. Insurers must maintain records of the ***electronic delivery*** to insureds of such notices for one year from the effective date of the notice.

Failure to correctly handle requests by a premium finance company to cancel a policy. A cancellation at the request of a premium finance company is an insured-requested cancellation and should be handled accordingly. If the insurer's contract provides for a short rate cancellation when the insured requests the policy be cancelled, the unearned premium should be calculated short rate when the policy is cancelled at the premium finance company's request. Section 14 VAC 5-390-40 A (Rules Governing Insurance Premium Finance Companies) requires the insurer to notify the insured, the insurance agent, and the premium finance company that the policy has been cancelled and provide them with a list of information that is required by the regulation. Examiners frequently find that insurers are unaware of these requirements. Insurers should review 14 VAC 5-390-10 et seq. to determine their responsibilities under the regulation.

Failure to provide notice when the insurer increases the insured's premium by more than 25%. Section 38.2-231 of the Code of Virginia requires the insurers of commercial liability insurance (including medical malpractice insurance), commercial automobile insurance, and certain types of miscellaneous casualty insurance to provide an advance notice to the named insured when there will be a premium increase greater than 25%, if the increase is

initiated by the insurer. Some examples of an insurer-initiated increase would be an increase in the filed rates; changes in experience or schedule rating resulting in an increase in premium; and for claims-made policies, annual premium increases until the risk reaches a mature claims-made status. See also Administrative Letter 2016-08.

Failure to provide notice of refusal to renew an insured's policy. Section 38.2-231 of the Code of Virginia requires an insurer to provide a notice to the insured, if his policy will not be renewed. An exception to this provision is where an affiliated insurer has manifested its willingness to provide coverage to the insured at a premium that is *lower* than that which would have been charged for the same exposures on the expiring policy and the affiliated insurer's policy has types and limits of coverage at least equal to those of the expiring policy unless the insured has requested a change in the coverage or limits. Under these circumstances, the insurer of the expiring policy is not required to send an offer of renewal, and the policy issued by the affiliated insurer will be deemed to be a renewal policy.

Reduction in coverage notice. Insurers should not provide a right to review by the Commissioner of Insurance under § 38.2-231 of the Code of Virginia when sending a notice of reduction in coverage unless the line of insurance under which the liability policy was written is subject to § 38.2-1912 of the Code of Virginia.

When notice of reduction in coverage or increase in premium is not required. Section 38.2-231 E of the Code of Virginia states that the notice is *not* required if: (a) the insurer delivers or mails to the named insured a renewal policy or a renewal offer not less than 45 days prior to the effective date or, in the case of medical malpractice insurance, not less than 90 days prior to the effective date of the policy; (b) the policy is issued to a large commercial risk as defined in § 38.2-1903.1 C of the Code of Virginia (except that policies of medical malpractice insurance are not exempt from the notice requirement); or (c) the policy is retrospectively rated, where the premium is adjusted at the end of the policy period to reflect the insured's actual loss experience.

Misclassifying policy fees when calculating earned premium. Insurers frequently charge policy fees when issuing a new or renewal policy. Such fees, including membership fees and other fees made for or in connection with a policy of insurance, are considered part of the rate for the policy and are, therefore, *premium* and may **not** be fully earned. Examiners are finding instances where insurers are fully earning these fees in violation of Virginia insurance law. In contrast, service fees for installments, bad check fees, and other fees not charged for the procurement of insurance may be fully earned because they are not premium. (See §§ 38.2-100 and 38.2-310 of the Code of Virginia.)

Insurers writing lines of insurance subject to rule/rate/form filing exemption orders. Any insurer writing lines of insurance for which the Bureau has issued administrative orders exempting such lines from the rule/rate/form filing requirements in the Code must still provide the notices required by § 38.2-231 of the Code of Virginia.

Automobile and Homeowners' Rating

Charging points or increasing premium because of accidents. Section 38.2-1905 of the Code of Virginia provides the guidelines for charging points or increasing premiums for accidents in which the insured was wholly or partially at fault. Administrative Letter 1992-25 and Administrative Letter 1980-12 provide further clarification and require that the insurer has proof of fault prior to the assignment of points. Examiners often find that an insurer has increased the insured's premium without first obtaining evidence of fault. Furthermore, the Consumer Services Section finds insurers using "failure to maintain control of the vehicle" as justification for charging points. This is not evidence of fault without more information. Please be aware that a Virginia Motor Vehicle report does not indicate fault; rather, it indicates that the driver was involved in an accident. Fault must be determined through additional research. Finally, when insurers send the right to appeal notice to an insured because the insurer has applied points to the insured's policy or increased his premium as a result of a motor vehicle accident, the notice should provide the date of the accident so that the insured knows why the points are being applied. Insurers are required to inform insureds to whom notices are sent pursuant to Section 38.2-1905 of the Code of Virginia that the insured has 60 days from receipt of the notice to request a review by the Commissioner of Insurance of the application of points to his policy as a result of an motor vehicle accident. Insurers are only required to send an accident surcharge notice once when the surcharge is initially applied to the policy rather than with every renewal until the expiration date of the surcharge.

Please note: Some insurers' rules (delineating those accidents that are not considered "chargeable") state that if the operator involved in the accident was hit by a "hit and run driver, the accident is not chargeable if the accident is reported to the proper authorities within 24 hours." Subsection 38.2-2206 D of the Code of Virginia provides that if the owner or operator of a motor vehicle that causes bodily injury or property damage is unknown ***and*** there has been *no contact* between the motor vehicle and the insured's person/motor vehicle, the accident must be reported *promptly* to either (i) the insurer ***or*** (ii) to a law enforcement officer in order for the insured to receive uninsured motorist benefits. Furthermore, if there *is* contact between the insured and a motor vehicle operated by an unknown owner or operator, then ***no such notice*** is required for the insured to receive uninsured motorist benefits. Therefore, no "hit and run" accident can be characterized as "at-fault" with respect to the insured. All rating rules to the contrary should be immediately amended.

Application of surcharges for convictions and at-fault accidents. Some insurers fail to ask the insured which vehicle each driver customarily operates. Although insurers may assign drivers to vehicles based upon who drives each vehicle the most, Safe Driver Insurance Plan (SDIP) point surcharges may only be applied to the vehicle that driver customarily operates. This may result in more than one driver customarily operating the same vehicle. The insurer must ensure that the SDIP points are assigned to the vehicle customarily driven by the operator responsible for the accident as required by § 38.2-1905 C of the Code of Virginia and explained by Administrative Letter 1990-9.

Rounding of Uninsured Motorist (UM) Rates. Insurers are permitted to round uninsured motorist rates provided that the insurer has filed the appropriate rounding rule. If an insurer has a separate rounding rule for UM, then the insurer should follow that rounding rule. Due to a requirement that has been withdrawn, some insurers still have filed rules that all UM rates will be rounded down unlike other rounding rules that apply to other rates.

Using rates that have not been filed or that have been superseded. Insurers must use the rates have been filed with the Bureau. All rates, rules and other supplementary rate information that is necessary to calculate the charged premium should be filed with the Bureau. Examiners frequently find that insurers use rates that have not been filed or that have been superseded by a new filing. *Insurers that use advisory loss costs provided by rate service organizations and file their own loss cost multipliers* should carefully review Administrative Letter 2006-16 and the PC-IRF forms filed with the Bureau to ensure that the proper rates are being used. Please also refer to the Property and Casualty Filing Guidelines Handbook for more specific guidance.

Failure to use the correct/filed symbol classification. Errors occur most frequently with independently filed symbols because the policy file does not adequately indicate which filed symbol defines the insured vehicle. For example, the filed symbol(s) may not have enough characteristics to distinguish between similar models of a vehicle. If the insurer files its own symbols, the symbol classifications must correspond to the vehicle documentation maintained in the file.

If the symbol is VIN specific, the pertinent VIN characteristics should be filed and documented in the policy file. If the symbol is cost specific, the cost of the vehicle must be documented in the policy file to support how the insurer arrived at the symbol classification. The examiners should be able to view the information from the policy file and determine the specific symbol that defines the vehicle.

Miscellaneous rating problems. Other rating problems include the use of incorrect tiers, territories and classifications. While all random errors cannot be prevented, the insurer is encouraged to review its internal auditing program in order to prevent as many mistakes as possible. Insurers should also audit automated rating systems to ensure that they are programmed to rate in accordance with filed rating plans. (While this might seem obvious, examiners frequently encounter situations where there has been a programming error that causes many policies to be rated incorrectly because no one audited the newly programmed rates or rules.)

For information regarding rate standards for use in Virginia, see Administrative Letter 2016-03 Compliance with Rate Standards in File and Use Lines of Insurance. For information about rate capping in Virginia, see Chapter 345 Rules Governing Rate Stabilization in Property and Casualty Insurance.

Failure to provide an adverse underwriting decision (AUD) notice. Section 38.2-610 of the Code of Virginia requires insurers to provide AUD notices when they make an "adverse underwriting decision." AUD's include the failure of an agent to place the insured in the specific insurance institution requested by the insured, the placement of the insured by the agent or the insurance institution with a residual market mechanism or an unlicensed insurer, the declination of requested coverage (in whole or in part), and the charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished. (See § 38.2-602 of the Code of Virginia and Administrative Letter 2015-07 (revised).)

Commercial Automobile, General Liability, and Commercial Property Rating

Failure to document individual risk premium modifications (IRPM). Section 38.2-1904 C of the Code of Virginia allows an insurer to modify class rates for individual risks in accordance with rating plans that establish standards for measuring variations in risk. Administrative Letter 2006-16 provides guidance for filing these rating plans and states that justification for the variations must be kept on an individual risk basis. Administrative Letter 2006-16 reiterates that all premium debits and credits which are applied pursuant to any schedule rating plan/individual risk premium modification plan must be supported by evidence documented in the underwriting file of every new business and renewal policy. Examiners frequently find no evidence to support the IRPM credits or debits in the underwriting file. This documentation should be specific, available for review, and kept current.

Using rates that have not been filed or that have been superseded. Insurers must use the rates that are filed with the Bureau. Examiners frequently find that insurers use rates that have not been filed or that have been superseded by a new filing. *Insurers that use advisory loss costs provided by rate service organizations and file their own expense multipliers* should carefully review Administrative Letter 2006-16 and the PC-IRF forms filed with the Bureau to ensure that the proper rates are being used. This advice also applies to insurers filing their own independent loss costs and loss cost multipliers. Please also refer to the Property and Casualty Filing Guidelines Handbook for more specific guidance.

Failing to notify the Bureau when rates and rules filed by a rate service organization (RSO) on behalf of the insurer will not be used. Insurers are required to use rules and rates that they file or that are filed on their behalf by an RSO. Failure to use the filed rules or rates or to timely delay adoption of them is a violation of § 38.2-1906 D of the Code of Virginia,. A timely filing to delay adoption of rules or rates filed on behalf of the insurer is on or before the RSO filing effective date.

Failure to file rates for certain commercial inland marine coverages. Administrative Order 9079, dated January 7, 1986, suspends the filing requirement for certain commercial inland marine rules and rates. The administrative order also sets forth the inland marine classes for which rules and rates must be filed with the Bureau prior to use. Rates for the following commercial inland marine coverages must be filed: accounts receivable, cameras, camera and musical instrument dealers, equipment dealers, film, floor plan, installment sales or conditional sales floater, mail, mobile agricultural equipment and livestock, musical instruments, physicians' and surgeons' equipment, signs and street clocks, theatrical property, and valuable papers and records.

Rounding of Uninsured Motorist (UM) Rates. Insurers are permitted to round uninsured motorist rates provided the insurer has filed the appropriate rounding rule. If an insurer has a separate rounding rule for UM, then that rounding rule applies. Due to a requirement that has been withdrawn, some insurers still have filed rules that all UM rates will be rounded down unlike rounding rules that apply to other rates.

All Claims

Failure to document adequately claims file. The Rules Governing Unfair Claim Settlement Practices (14 VAC 5-400-10 et seq.) require that a claim file contain all notes and work papers pertaining to the claim, and that the documentation is detailed so that pertinent events and the dates of those events can be reconstructed. (See 14 VAC 5-400-30.) The claims adage *"If it isn't in the file, it never happened"* is the rule that governs proper documentation. If the file does not contain a denial letter, a copy of the estimate, a note indicating that coverage has been discussed, a response to an inquiry, etc., the examiner cannot assume the file was handled correctly. Claim handlers should be instructed that their actions must be documented and that written insurer procedures do not take the place of supporting documentation.

Failure to advise the insured of benefits or coverages of the policy. Insurers must advise first party claimants of the benefits, coverages, or other provisions of the policy when those benefits, coverages, or other provisions are pertinent to a claim. Additionally, insurers must promptly provide necessary claim forms and reasonable assistance so that first party claimants can comply with policy conditions and the insurer's reasonable requirements. Examiners frequently see files where the claim handler failed to mention the first party coverages applicable to the claim, even though the claims report clearly indicates that the coverage is pertinent to the claim. The areas where this happens most often are medical expense/loss of income coverage, rental reimbursement or transportation expenses coverage, and uninsured/underinsured motorist coverage (including bodily injury, and reimbursement of collision deductible, and rental benefits).

Additionally, examiners are finding that some insurers are not advising guest passengers in private passenger motor vehicles of medical expense benefits and/income loss benefits when such benefits are pertinent to, the guest passenger's claim under the policy. A guest passenger is an insured under the medical expense benefits/income loss coverage under the policy and must be advised of all benefits and coverages that are pertinent to any claim covered by policy. Issues that arise in this area are frequently caused by the failure to *document* properly the file regarding the discussions held with the claimant. See The Rules Governing Unfair Claim Settlement Practices (14 VAC 5-400-10 et seq.)

Failure to deny a claim in writing. Subsection 14 VAC 5-400-70 A (Rules Governing Unfair Claim Settlement Practices) requires *any* denial to be given to the claimant in writing. A claim is defined as a demand for payment. If the insurer is presented with a bill or a receipt from the claimant, a demand has been made. If the insurer denies payment, in whole or in part, a written denial must be given to the claimant and a copy maintained in the claim file. Note: a partial denial of a claim requires an insurer to send the claimant a written denial letter in compliance with the regulation referenced above. Oral denials of claims do not meet the requirements of the regulation.

Failure to provide an explanation for denial of a claim. Subsection B of 14 VAC 5-400-70 (Rules Governing Unfair Claim Settlement Practices) requires that any written denial contain a reasonable explanation of the basis for the denial and that specific reference to a policy provision, condition, or exclusion be made if the denial is based on the provision, condition, or exclusion. Examiners often find that the denial letter only states that the loss is "not covered" with no reference to the policy exclusion. Or, examiners will find that the denial letter states that the insurer's investigation determined that the insured is not legally liable for the loss. This is not an adequate reason for denying the claim. To make the explanation for the denial adequate, the insurer would need to comment on what it found in its investigation that it relied upon to make this determination. It is not enough to tell a claimant that the reason for denying his claim is that the insurer's insured is not "legally liable." A statement explaining why the insurer's insured is not liable should also be included. For example, the insurer might give as additional support a statement that the evidence indicates that the claimant contributed to the loss due to his excessive speed.

Failure to state the coverage under which a claim is paid. Section 38.2-510 A of the Code of Virginia requires that any payment of a claim be accompanied by a statement indicating the coverage under which the payment is being made. This can be accomplished by providing this information on the check or draft or in a document provided with the payment. Examiners frequently find that the insurer uses the peril instead of the coverage, uses an incorrect coverage, or does not provide any information. While the insurer can include the peril or other information that more clearly describes the loss, the coverage must be included.

Notification of Insured or Claimant When Settlement Check Issued to Attorney/Other Representative. Section 38.2-236 of the Code of Virginia requires insurers in Virginia to provide notice to a first or third-party claimant when an insurer issues to an attorney (licensed in the Commonwealth) or other representative of the claimant a payment on a claim of $ 5000 or more in a single check. The notice must be sent *within five business days of the date that the check was sent to that attorney or representative*. A copy of the notice shall be sent simultaneously to the attorney or representative and the claimant. This section provides the language for the notice, which must be stated as set forth in the statute. ***Insurers should not send the notice required by this section until the payment has been sent to the claimant's attorney.*** A "representative" may be a guardian, an executor, public adjuster, power of attorney, etc. This section applies to all lines of insurance except those set forth in Chapters 42 and 43 of Title 38.2. Please see the Administrative Letter 2013-06 for additional information. **NOTE: It has come to the attention of the Bureau that, in certain cases, some insurers are sending settlement checks to defense attorneys and requiring that such attorneys be responsible for sending the settlements to the *claimant's* attorneys. In such circumstances, it remains the duty of the *insurer* to provide the notice required by § 38.2-236 of the Code of Virginia to the *claimant* within 5 days *after* the *defense attorney* sends such settlement check to the *claimant's* attorney.**

Motor Vehicle Claims

Failure to give a copy of the repair estimate to the claimant. Subsection D of 14 VAC 5 400-80 (Rules Governing Unfair Claim Settlement Practices) requires that if an insurer prepares an estimate of the cost to repair an automobile, the insurer must give a copy of the estimate to the claimant. This may be a documentation problem as most insurers have procedures that require the estimate to be given to the claimant. However, if the examiners find no evidence in the file that the insurer followed its procedures, then the insurer will be cited for failing to comply with the regulation.

Failure to properly pay the sales and use taxes on a totaled automobile when the insured retains the salvage. The personal automobile policy forms provide for the payment of the applicable state and local sales and use tax when the insurer settles a claim by paying the actual cash value of the automobile. Examiners frequently find insurers fail to pay these taxes when the insured retains the salvage. There is nothing in any of the policies that excludes payment of these taxes when the insured retains the salvage. The insurer should review its claim handling guidelines to ensure that the proper payments are being made. **NOTE**: The current rate is 4.15%. (See § 58.1-2402 of the Code of Virginia.) The minimum sales and use tax is $75.00 unless the vehicle is listed as one of the exemptions set forth in § 58.1-2403 of the Code of Virginia. (See § 58.1-2400 et seq. of the Code of Virginia for more information.)

Failure to handle Uninsured Motorist (UM) claims correctly. The standard private passenger automobile and commercial automobile policies in Virginia provide that UMPD coverage is **excess over any other property coverage applicable to the vehicle**. Accordingly, claims involving property damage caused by an uninsured motorist (as defined in § 38.2-2206 of the Code) should be paid **first** under any physical damage/other property coverage, applying the appropriate deductible, applicable to the motor vehicle.

(1) For example, if an insured has collision coverage with a $500 deductible sustains $1,000 of collision damage caused by a **known** uninsured motorist, the insurer pays $500 under the collision coverage ($1000 less $500) and $500 under the UMPD coverage. In contrast, if the uninsured motorist is **unknown**, the insurer pays $500 under the collision coverage and $300 under the UMPD coverage ($500 less the $200 UMPD deductible).

(2) If the insured has no collision coverage, all damage is paid under UMPD coverage. If the uninsured motorist is unknown, then the insurer applies the $200 UMPD deductible.

(3) If the insured has collision coverage with a $100 deductible and damage of $1000, the insurer first pays the collision coverage after applying the $100 deductible ($900 paid) and then pays $100 under UMPD (if the uninsured motorist is known) or pays nothing ($0) under UMPD if the uninsured motorist is unknown.

(See § 38.2-2206 of the Code of Virginia.) (See also Commercial Automobile Standard Forms and Personal Automobile Standard Forms.)

UMPD Coverage and Rental Reimbursement. Another area of UMPD coverage where the examiners frequently see problems involves paying rental expenses. If the insured is entitled to recover for the damage to a motor vehicle, he would also be entitled to rental expenses incurred (§ 8.01-66 of the Code of Virginia). Again, UMPD would be **excess over any first party rental reimbursement coverage or transportation expense coverage** that the insured has available. Rental/transportation costs are first paid under that coverage; once that coverage is exhausted, rental/transportation charges are paid under UMPD until that limit has been exhausted.

Medical Expense Benefits-Terminology. The 2015 General Assembly amended Section 38.2-2201 by striking the term "ambulance" and replacing it with "emergency medical services vehicle" as defined in § 32.1-111.1. This was not intended to be a substantive change, just a change in terminology. The motor vehicle standard forms were amended to reflect this change in the Code. e

Assignment of Medical Expense Benefits. Section 38.2-2201 D of the Code of Virginia provides the circumstances under which assignments of medical expense benefits are valid. To be valid, any assignment of medical expense benefits must comply with this section of the Code. The covered injured person who makes an assignment of medical expense benefits must be notified in writing by the health care provider of the effect of the assignment at the time that such assignment is made. Such notice is required to include a statement that the person may want to consult his

insurance agent or attorney before signing the form and that he is not required to execute the form to receive care. No such assignment is valid unless it is signed by the covered injured person (or his representative) and is dated. A copy of the notice and the assignment must be given to the covered injured person. **No such person is required to make an assignment of his medical expense benefits.**

No claim may be paid under an assignment of medical expense benefits unless a copy of the executed assignment of benefits and the notice (if on a separate form) is provided to the motor vehicle insurer. **All assignments of benefits including all directions to pay, must comply with this section, regardless of whether the insured has health insurance.**

Duties of a medical expense benefits insurer when paying claims. If the insured injured person is covered by a health care policy and the health care provider is an in-network provider who has submitted the claim for services to the health insurer, then the medical expense benefits insurer, upon receipt of a copy of the explanation of benefits, remittance advice, or similar documentation from the health care provider and **evidence of a valid assignment**, shall pay directly to the health care provider, from any medical expense benefits available to the injured person under a motor vehicle insurance policy, any copayments, coinsurance, or deductibles owed by the injured person to the health care provider. The remaining benefits under the injured person's medical expense benefits coverage shall be paid directly to the injured person, subject to the balance of the allowable charges for the medical services, as evidenced by the explanation of benefits, remittance advice, or similar documentation. ***Absent a valid assignment of benefits, all charges including copayments, coinsurance, deductibles and any amount the health insurer paid to the provider shall be paid to the injured person***. Medical expense benefits insurers should always request the explanation of benefits or remittance advice from the provider/injured person before paying a claim. The explanation of benefits provides the amount that the injured person has incurred and, consequently, is entitled to collect under his medical expense benefits coverage. See Section 38.2-2201 of the Code of Virginia**.**

Paying medical expense benefits when the injured person has health insurance and is treated by an in-network provider. Examiners frequently see insurers failing to pay medical expense benefits claims properly when the injured person has health insurance and the insured sought treatment from an in-network provider. When an insurer becomes aware of potential injuries in a motor vehicle accident and the injured person is entitled to medical expense benefits coverage, the following outlines an insurer's duties with respect to adjusting these claims.

1. The adjuster must ask the injured person(s) if they have health insurance.
2. The adjuster must tell the injured person that he has the right to (i) the benefits under his health insurance policy for his medical expenses and (ii) be reimbursed for those same bills under his medical expense benefits coverage as well. The medical expense benefits adjuster must explain to the injured person that the medical expense benefits coverage will pay to that person his copays and deductibles as well as the amounts owed to providers, if the provider is in-network under the injured person's health insurance. Subsection 14 VAC 5-400-40 A of the Administrative Code provides that insurers must fully disclose to a first party claimant all pertinent benefits, coverage or other provisions of the policy under which the claim is made.
3. The adjuster must then request all explanations of benefits (EOB) received by the injured person from his health insurer in order to pay his medical expense benefits claim. The EOB sets forth the amount that is owed under the medical expense benefits—the amount paid to the provider under the health insurance policy plus any copays and deductibles that the injured person is responsible for paying.
4. If the in-network health care provider fails to submit the charges to the health insurance carrier as required in § 8.01-27.5 of the Code of Virginia, then the provider's claim is extinguished and there is no basis for a medical expense benefits claim. In other words, for all in-network providers, if no EOBs have been issued for a claim where the injured person has health insurance applicable to his injuries, then there are no medical expense benefits due for that claim.

[**Note**: Section 8.01-27.5 of the Code of Virginia was enacted in 2013 in conjunction with the changes to assignments of benefits in § 38.2-2201 to support the new requirements for such assignments. Section 8.01-27.5 requires an in-network health care provider to submit its claims for health care services to the applicable in-network health insurer, subject to certain conditions, within not fewer than 21 business days before the deadline for submitting such claims

pursuant to its provider agreement with the health insurer. The patient is obligated to provide the network provider with enough information for the provider to verify coverage. ***Failure of the in-network provider to submit its claims to the health insurer pursuant to the provider contract negates any benefits due under that contract and negates any amount otherwise owed by the injured person to the in-network provider.***

If the injured person is not covered under a health care policy, or the health care provider is **not an in-network provider**, or the injured person is covered by a self-insured employee welfare benefit plan subject to ERISA that requires medical expense benefits to be primary, or the injured person is covered by a federal or state assistance program, the motor vehicle insurer providing medical expense benefits must research it obligations carefully. For example, if upon receipt of a valid assignment of benefits (as required in § 38.2-2201 D) and documentation that the injured person does not have health insurance or is covered by a self-insured or a self-funded plan subject to ERISA, the medical expense benefits insurer shall pay medical expense benefits available to the injured person directly to the health care provider subject to the usual and customary fee charged in that community for the health care services rendered. If the medical provider did not obtain a valid assignment of benefits, all medical expense benefits shall be paid to the injured person unless these benefits are subject to liens.

A motor vehicle insurer shall be held harmless for making payments to a health care provider instead of the insured pursuant to a valid assignment of benefits.

Nothing prohibits the payment of medical expense benefits due to a covered injured person directly to any federal or state assistance program that has provided medical benefits to such person when the injury arises out of the ownership, maintenance, or use of a motor vehicle.

Incorrectly handling physical damage claims when the damaged vehicle has custom equipment. The exclusion for "custom equipment" in the PAP applies to pickup trucks and vans. Insurers often deny coverage for custom equipment on private passenger automobiles and other vehicles to which the exclusion does not apply. A private passenger motor vehicle's equipment is covered on an ACV basis. (See Personal & Commercial Automobile Standard Forms.)

Appraisals of cost of damage to automobiles. Insurers are required under § 38.2-510 A 17 of the Code of Virginia to base *initial* estimates on the cost of repairing a motor vehicle on (i) *personal inspections* of a vehicle by the insurer or the repair facility or (ii) photographs, videos, or digital imagery of the damage. Supplemental repair estimates for additional/hidden damage may be documented using photographs, videos, or electronically transmitted digital imagery provided that if the repairs are in dispute, a personal inspection by the insurer or the repair facility is required. The 2016 General Assembly added the provision that damage to a motor vehicle may be documented in an appraisal using photographs and digital imagery.

Treating paint and materials guidelines as caps on what the insurer will pay. Section 38.2-517 A 6 of the Code of Virginia forbids the use of arbitrary paint and materials caps. Any guideline an insurer uses must be reasonably related to the type and size of the vehicle, the amount of damage, and the type and color of paint used on the vehicle and any other materials reasonably related to the repair of the damaged vehicle.

Failing to provide the information required by § 38.2-517 A 3 to insureds and claimants in connection with a glass claim arising under a motor vehicle insurance policy. Section 38.2-517 A 3 of the Code of Virginia requires an insurer to provide certain information to insureds and claimants prior to being referred to a third-party representative in connection with a glass claim. The information that the third party is not the insurer and is acting on behalf of the insurer must be given *prior* to sending the insured or claimant to the third-party representative's telephone system or internet page. The Bureau has noted many instances where insurers have technical violations of the statute.

Failing to provide the information required by § 38.2-517 A 4-5 to insureds and claimants in connection with a claim arising under a motor vehicle insurance policy. Sections 38.2-517 A 4 and 5 of the Code of Virginia require insurers to provide certain information to insureds and claimants in connection with a motor vehicle claim. Section 38.2-517 A 4 of the Code of Virginia requires insurers to tell insureds and claimants *at the time* that the insurer recommends the services of a designated motor vehicle repair or replacement facility or the products of a designated manufacturer that the insured or claimant is under no obligation to use the services of a designated motor vehicle repair or replacement facility or the products of a designated manufacturer. Section 38.2-517 A 5 of the Code of Virginia

requires insurers to disclose to insureds and claimants that the insurer has a financial interest in a repair or replacement facility *at the time* that the insurer recommends the services of such motor vehicle repair or replacement facility.

Failing to properly pay rental reimbursement/transportation expense claims. Claims for rental reimbursement and transportation expenses are governed by § 8.01-66 of the Code of Virginia and 14 VAC 5-400-80 I of the Virginia Administrative Code as well as the provisions of the motor vehicle policy. Insurers settling claims for loss or damage to a motor vehicle must provide a reasonable time for the claimant to receive payment for the repairs to the vehicle before terminating rental/transportation expense claims. When settling total loss claims on motor vehicles, insurers are required to provide a reasonable time for the claimant to receive payment for the replacement vehicle prior to terminating any rental/transportation expenses.

Handling collision damage waivers and supplemental liability protection in rental claims. Section 8.01-66 of the Code of Virginia provides that anyone who is entitled to recover for damage to or destruction of a motor vehicle may also recover the reasonable cost that is actually incurred in hiring a comparable substitute while the vehicle is being repaired or replaced. Additionally, the standard private passenger motor vehicle policy contains an option to purchase transportation expense coverage to cover the reasonable cost of renting a comparable substitute vehicle. A question often arises as to when supplemental charges are reasonable expenses under the Code as well as the policy language.

Supplemental Liability Protection (SLP) is a reasonable expense when *required* by the vehicle rental agency because the renter does not carry liability limits equal to the minimum limits in the state the vehicle is rented. However, with respect to reasonable charges incurred in renting a substitute vehicle, there are no circumstances where Personal Accident Insurance (PAI) would be reasonable because this coverage is not required to rent a motor vehicle.

Collision Damage Waiver (CDW) **is** a reasonable expense and must be paid when a third-party claimant rents a vehicle because of a loss caused by the insured, and that claimant does not have collision and/or comprehensive/other than collision coverage on his own motor vehicle. In addition, CDW is a reasonable expense and must be paid when an insured rents a vehicle as a result of a loss caused by an uninsured or underinsured motorist, and the insured does not carry collision and/or comprehensive/other than collision coverage on his motor vehicle involved in the loss.

When the insurer refuses to pay for CDW on the basis that it is not a reasonable expense, the insurer must document its files to reflect that the insurer made a reasonable effort to explain to the claimant that such expense would not be covered as well as the reason for the insurer's decision before the claimant has incurred the expense. These details should document the conversation with the insured or claimant as to why CDW would be denied, including why the expenses are not considered reasonable for the purposes of payment. In the absence of such documentation, the insurer must send a denial letter to the insured or claimant for the charges on the rental bill that the insurer is not going to pay. The insurer must provide the specific reason for the denial of such charges. Statements that such charges are not covered, not reasonable, or similar statements are inadequate. ***However, insurers should be aware that if the required explanation to the claimant does not occur prior to the costs being incurred and/or the required documentation is not in the file, then they must pay the CDW costs.***

Failure to pay towing claims. Insurers licensed to write motor vehicle policies on vehicles principally garaged or used in or that are issued or delivered in the Commonwealth are not paying claims for some at-fault accidents correctly. The at-fault insurer is responsible for payment of the reasonable costs of clean-up, recovery, and certain towing expenses under the terms of the property damage liability coverage of the motor vehicle policy that requires coverage for "all damages the insured is legally obligated to pay." See Administrative Letter 2020-06.

Homeowners' Claims

Failure to properly pay replacement cost claims. Section 38.2-2108 of the Code of Virginia allows for the establishment of standards for the content of any policy or endorsement used in connection with any policy insuring owner-occupied dwellings in the Commonwealth. The Bureau has promulgated a regulation (14 VAC 5-340-10 et seq.) that provides the minimum standards for homeowners' policies issued in the Commonwealth. Each of the standards for homeowners' policies provide for replacement cost coverage on insured dwellings. In addition, the insured may purchase replacement cost on his personal property. Most insurers and rate service organizations have filed homeowners' policies that allow for the payment of the actual cash value (ACV) prior to replacement. The insured has *six months* from the date of the last ACV payment to *assert a claim* for the difference between the ACV and the replacement cost of the damaged property. (See § 38.2-2119 B of the Code of Virginia.) However, this does not mean that the insured must replace the damaged property within six months after the last ACV payment is made, only that he asserts a claim for the difference between the ACV and replacement cost within that time period.

Examiners frequently find that insurers incorrectly advise insureds that replacement cost claims must be made within 180 days of the date of the loss. This statute was amended effective July 1, 1992 to provide that insureds have six months to assert a replacement cost claim. The insurer should review all policy forms that provide replacement cost coverage to ensure that the language of the form is correct. The insurer should also review its claims handling procedures and all form letters that address this situation to ensure that they refer to *six months* rather than *180 days*.

Failure to pay certain mold claims. Companies are denying certain ***ensuing mold*** claims that are ***covered*** under property policies. For example, if there is a fire in the home that is extinguished by the fire department and mold ensues as a result of the water sprayed in the home, the homeowners' policy covers the damages caused by the ensuing mold. Insurers should ensure that they are properly handling damages caused by ensuing mold when handling claims under homeowners', tenants' personal property, dwelling fire, condominium, farmowners, and commercial fire policies. Damage from mold that develops as a result of a covered direct cause of loss is covered under the policy.

Failure to properly pay debris removal claims. Examiners find that insurers are depreciating debris removal costs in claims where the insured has already incurred the costs of removing the debris. For example, a windstorm causes many trees to fall in an area and the insured hires a tree removal service to remove the trees from the insured's home. As the insured has already incurred these costs, the insurer must reimburse the insured for the full cost of the tree removal when the insured presents the bill. There should be no depreciation of these costs.

Forms Requirements

PLEASE NOTE: All insurers writing private passenger automobile insurance in Virginia should review Administrative Order 12113 *and* 12113 Memo. This administrative order sets forth the new standard automobile forms that **may be used in Virginia for policies effective on or after 1/1/2021 and must be used by all insurers as of 1/1/2022**. All prior standard forms are withdrawn for all policies effective on or after 1/1/2022. (See Personal & Commercial Automobile Standard Forms.) The Bureau suggests that companies take advantage of the Notify Me of Updates to this Page feature to get notice of new forms approved by the Bureau.

Copies of the commercial automobile standard forms may be found on the Bureau's website (Personal & Commercial Auto Standard Forms). These are the forms that insurers should be using currently.

Using forms that have not been filed or that have been superseded. The most frequent problem that the examiners find when reviewing policy forms is the use of forms that have not been filed with and approved by the Bureau of Insurance. The Bureau also finds that insurers will use previously approved forms that have been superseded. Virginia has standard forms for motor vehicle policies, and these forms are approved by administrative order. Examiners find that insurers are not using the current version of the form in violation of § 38.2-2220 of the Code of Virginia. All other forms must be approved by the Bureau prior to use. The insurer should review all forms to ensure they are either the correct standard form or that the insurer has filed and received approval from the Bureau. Please refer to the Property and Casualty Filing Guidelines Handbook for more specific guidance.

Failure of insurers to put all conditions pertaining to the insurance in their policies. Section 38.2-305 A of the Code of Virginia provides the requirements for the information that must be included in an insurance policy. Examiners frequently find that insurers do not include all the conditions of the policy by failing to attach a specific policy form or by failing to refer to a form applicable to the policy on the declarations page. Section 38.2-305 ***specifically*** **requires that all form numbers for all applicable policy forms and endorsements must be listed on the declarations pages of a policy. If the policy form or endorsement number is not a unique identifier of such forms, then the edition date of the forms must also be listed.** Insurers are **not** required to list *notices* and other pieces of *correspondence* that they send to policyholders. This statute applies to all classes of insurance except those exempted in § 38.2-300 of the Code of Virginia and except as specifically noted in subsection E of § 38.2-305 of the Code of Virginia.

Failure of insurers to incorporate the provisions of the claims-made regulation in claims-made forms. The Bureau of Insurance promulgated a regulation that governs claims-made liability policies issued in Virginia. See 14 VAC 5-335-10 et seq. of the Virginia Administrative Code. The regulation became effective January 1, 2005. The Bureau of Insurance continues to find that companies have not made filings to update their claims-made forms to comply with the regulation. Insurers that issue claims-made forms in Virginia should audit those forms and confirm that the forms comply with the regulation. Any forms not in compliance should immediately be updated and filed with the Bureau of Insurance.

Failure to file inland marine forms and obtain approval of the forms prior to use. Insurers writing certain commercial inland marine coverages must file their forms pursuant to § 38.2-317 of the Code of Virginia: accounts receivable, cameras, camera and musical instrument dealers, cleaners, dyers and laundries bailee's customers, equipment dealers, film, floor plan, installment sales or conditional sales floater, mail, mobile agricultural equipment and livestock, motor truck cargo, musical instruments, physicians' and surgeons' equipment, signs and street clocks, theatrical property, and valuable papers and records as set forth in Administrative Order 9078, dated January 7, 1986. All other commercial inland marine forms are exempted from filing pursuant to Administrative Order 9078.

Failure to properly apply the manuscript forms and endorsements exception. Administrative Order 11936 expands the lines of commercial insurance for which insurers may use manuscript forms or endorsements for all commercial lines, except workers' compensation policy forms. The order also clarifies that an insurer may manuscript a form or endorsement without filing it if (i) it is written on a particular risk, (ii) the form or endorsement broadens coverage or the policy provisions contained in the basic contract to which the forms and endorsements are to be attached, and (iii) the form is used no more than four times in a 12-month period. Rates used for forms an insurer

manuscripts under Administrative Order 11936 do not have to be filed until such form is required to be filed with the Bureau.

Volunteer fire department service charge coverage. Insurers writing fire policies, or fire policies in combination with other coverages, must provide coverage of at least $250 for the cost of services provided by volunteer fire departments, which are not fully funded by real estate taxes or other property taxes. Section 38.2-2130 of the Code of Virginia applies to charges for services to save or protect property insured under the policy for a peril insured against. This coverage does not apply to service charges made in response to a call outside of the volunteer fire department's fire protection district, city, or municipality pursuant to a contract. The statute also provides that volunteer fire departments shall bill the owner of the property and may not charge more than the coverage provided under the property owner's insurance policy.

The policies to which this statute applies include all fire policies and fire policies in combination with other coverages, including but not limited to mobile home policies, dwelling fire policies, homeowners' policies, renters policies, farmowners policies, commercial fire policies, commercial package policies providing fire coverage, and master policies (providing mortgage force-placed fire coverage) that are issued in Virginia. This statute does not apply to surplus lines policies nor does it apply to mutual assessment fire policies.

Posting policy forms and endorsements on insurer's website permitted by § 38.2-325. Section 38.2-325 of the Code of Virginia permits property and casualty insurers to post policy forms and endorsements that do not contain personally identifiable information on their public websites, in lieu of any other method of delivery. Such forms and endorsements must be posted so that they may be readily printed and downloaded without charge and without the use of any special program. Any insurer using this method to provide its policy forms and endorsements must provide a method for the insured to obtain, without charge, a paper or electronic copy of such forms and endorsements. Additionally, such insurers must provide notice, in the way in which it normally communicates with its policyholder, of any changes to the forms and endorsements as well as notice of the policyholder's right to receive, without charge, a copy of such forms and endorsements.

Failing to notify the Bureau when forms filed by a rate service organization (RSO) on behalf of the insurer will not be used. Insurers are required to use forms that they file or that are filed on their behalf by an RSO. Failure to use the filed forms or to timely delay adoption of them is a violation of § 38.2-317 of the Code of Virginia. A timely filing to delay adoption of forms filed on behalf of the insurer is on or before the RSO filing effective date.

Notice Requirements

Failure to provide the IMPORTANT INFORMATION TO POLICYHOLDERS notice providing insurer and Bureau contact information. Section 38.2-305 B of the Code of Virginia requires that a specific notice be provided with each new or renewal insurance policy, contract, certificate, or evidence of coverage issued to a policyholder, covered person, or enrollee. This notice must read substantially the same as the notice in the Code. Examiners frequently find that this notice is not given when policies are renewed or when a renewal certificate is issued. The insurer should ensure that this notice is being given when required. This notice applies to all classes of insurance except those exempted in § 38.2-300 of the Code of Virginia and except as specifically noted in subsection E of § 38.2-305 of the Code of Virginia.

Failure to provide an adverse underwriting decision (AUD) notice. Section 38.2-610 of the Code of Virginia requires agents and insurers to provide AUD notices when they make an "adverse underwriting decision." AUD's include the failure of an agent to place an applicant in the specific insurance institution requested by the applicant, the placement of the insured by the agent or the insurance institution with a residual market mechanism or an unlicensed insurer, the declination (in whole or in part) of requested coverage, the termination of coverage, and the charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished. (See § 38.2-602 of the Code of Virginia for definitions.) In addition, the AUD notice must (1) provide the specific reason(s) for the AUD or advise the insured or applicant that, upon written request, he may receive the reason(s), (2) provide the insured or applicant with a summary of his rights as set forth in §§ 38.2-608 of the Code of Virginia (the right to access recorded personal information) and 38.2-609 of the Code of Virginia (the right to correct, amend, or delete recorded personal information), and (3) inform the insured or applicant that he must request further information about the adverse underwriting decision within 90 business days from the date of the mailing of the AUD notice or other communication of the AUD to the applicant or insured. (See also Administrative Letter 2015-07.) The requirement to provide an AUD notice applies only to insurance purchased primarily for personal, family, or household purposes.

Failure to advise insured of right to appeal the application of points or increase in premium as a result of a motor vehicle accident. Section 38.2-1905 A of the Code of Virginia requires that an insurer increasing the premium or applying points to an insured's motor vehicle policy as a result of a motor vehicle accident provide the insured with a notice of his right to appeal the increase in premium/application of points to the Commissioner of Insurance within 60 days of the mailing of the notice from the insurer. The 2016 General Assembly amended this statute to clarify that insurers must provide in the notice to the insured the requirements that the appeal be in writing and made within 60 days of the receipt of the notice of any premium adjustment or any point charge from a motor vehicle accident. For new business policies, such notice is only required when the accident is discovered after the policy is issued or the information is different from that which was on the application or the quote.

Failure to provide the notice offering the insured medical expense benefits coverage. Section 38.2-2202 A of the Code of Virginia requires that an insurer issuing a new business policy of insurance covering liability arising from the ownership, maintenance, or use of any motor vehicle enclose with the policy the IMPORTANT NOTICE provided in the statute. (See also Administrative Letter 2016-06.) **The notice must be in boldface type, in all capital letters, and read exactly as stated in the statute.** Examiners often find that this notice is not given when new policies are issued or that the notice is not worded as required by the statute.

Failure to inform the insured that he may reduce his uninsured/underinsured motorist coverage limits to less than his liability limits. Section 38.2-2202 B of the Code of Virginia requires insurers issuing new policies covering the ownership, maintenance, or use of a motor vehicle to provide a notice informing the insured that he may reduce his uninsured/underinsured motorist limits to limits less than his liability limits and that an election to do so by one named insured is binding on all insureds on a policy. The notice must be in **boldface type, in all capital letters,** and read ***exactly*** as stated in the statute. If a named insured wants to increase these limits, the named insured must make a specific request to the insurer. Insurers must document this request in their files. The notice also cautions insureds to carefully consider the protections provided by uninsured/underinsured motorist coverage before reducing the limits of such coverage. See also Administrative Letter 2016-06.

Failure to provide the notice offering rental reimbursement/transportation expense coverage. Section 38.2-2230 of the Code of Virginia requires that every insurer issuing a new or renewal policy of motor vehicle insurance as defined in § 38.2-2212 of the Code of Virginia, which provides comprehensive ("other than collision") or collision coverage, must advise the insured of the option to purchase rental reimbursement coverage. The insurer should ensure that this offer is being made as required. *An insurer offering coverage for transportation expenses satisfies this requirement.* Examiners find insurers fail to offer this coverage on new and renewal policies of motor vehicle insurance.

Failure to provide warning concerning cancellation on application for motor vehicle liability insurance. Section 38.2-2210 of the Code of Virginia requires that a specific notice be in boldface type and printed on or attached to the automobile application form. Examiners frequently find that this notice is not provided. The insurer should review its application to ensure compliance with all the requirements of this section of the Code. This requirement only applies to applications for liability insurance on motor vehicles as defined in § 38.2-2212 of the Code of Virginia. See also Administrative Letter 2016-06.

Failure to provide the insurance credit score disclosure notice-automobile policies. Any insurer issuing or delivering a private passenger automobile policy that uses credit information contained in a consumer report for underwriting, tier placement, or rating an applicant or insured shall disclose on the insurance application, at the time the application is taken, or at renewal if no previous notice has been given, the information required by § 38.2-2234 A 1 of the Code of Virginia. The notice should specify that the insurer "will" review the applicant/insured's credit history instead of "may use" this information.

Failure to ~~offer~~ provide the insurance credit score adverse action notice on-automobile policies. Section 38.2-2234 A 2 of the Code of Virginia requires any insurer that takes an adverse action based in whole or in part upon credit information to provide notice to the applicant or insured that the adverse action was based in whole or in part on credit. The notice must also provide a statement of the primary factors or characteristics that were used as the basis for the adverse action or notify the applicant or insured that he may request such information. For the purposes of § 38.2-2234 of the Code of Virginia, an adverse action is defined as a denial, refusal to renew, or cancellation of, an increase in any charge for or refusal to apply a discount, placement in a less favorable tier, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with underwriting, tier placement, or rating, where the reason for any of these actions is the insured's credit information. If the insurer would have taken the same action(s) had the insured's credit information **not** been a factor, then **no** adverse action has occurred.

Failure to provide the replacement cost notice. Section 38.2-2118 of the Code of Virginia requires every insurer writing insurance policies on owner-occupied dwellings and appurtenant structures that have replacement cost provisions to provide with all new and renewal policies a notice outlining the minimum coverage requirement necessary to make the replacement cost provision fully effective and the effect on a claim payment on not meeting the minimum coverage requirement. See also Administrative Letter 2016-05.

Failure to provide the notice offering coverage for loss caused by back up through sewers and drains. Section 38.2-2120 of the Code of Virginia requires any insurer that issues or delivers a new or renewal homeowners' policy to offer coverage for loss caused by water that backs up through sewers or drains. See also Administrative Letter 2016-05. Insurers should ensure that this offer is being made as required. The offer does not have to be made for policies that already provide the coverage at a limit of at least 100% of the Building/Residence Coverage A limit. Insurers may not refuse to provide this coverage to their policyholders when this coverage is requested; however, insurers are no longer prohibited from suspending the writing of these coverages on existing policies during *the same period that they suspend the writing of new business policies*, when a loss-producing event is imminent. Any requests by insureds for these coverages during the temporary moratorium should be honored once the moratorium has been lifted.

Failure to provide the notice offering ordinance and law coverage. Section 38.2-2124 of the Code of Virginia requires any insurer that issues a policy of fire insurance, or fire insurance in combination with other coverage, to offer coverage for the repair or replacement of property in accordance with applicable ordinances or laws that regulate construction, repair, or demolition. This offer must be made with all new and renewal policies. The offer does not have

to be made for policies that already provide the coverage at a limit of at least 100% of the Building/Residence Coverage A limit. The insurer should ensure that this offer is being made as required. An insurer may not refuse to provide this coverage to their policyholders when this coverage is requested; however, insurers are no longer prohibited from suspending the writing of these coverages on existing policies during *the same period that they suspend the writing of new business policies*, when a loss-producing event is imminent. Any requests by insureds for these coverages during the temporary moratorium should be honored once the moratorium has been lifted.

Failure to provide the flood notice. Section 38.2-2125 of the Code of Virginia states that any insurer that issues a policy of fire insurance or fire insurance in combination with other coverage that excludes coverage for damage due to flood, surface water, waves, tidal water, or any other overflow of a body of water shall provide written notice that explicitly states that flood damage is excluded, that information regarding flood insurance is available from the from the insurer, the insurance agent, or National Flood Insurance Program, and that coverage for loss to contents is available on the flood policy for an additional premium.

Failure to provide the insurance credit score disclosure notice–owner-occupied dwelling fire (including homeowners') and tenant policies. Any insurer issuing or delivering an owner-occupied dwelling fire (including homeowners') policy or tenant policy that uses credit information contained in a consumer report for underwriting, tier placement, or rating an applicant or insured shall disclose, on the insurance application, at the time the application is taken, or at renewal if no previous notice has been given, the information required by § 38.2-2126 A 1 of the Code of Virginia.

Failure to provide the insurance credit score adverse action notice–owner-occupied dwelling fire (including homeowners') and tenant policies. Section 38.2-2126 A 2 of the Code of Virginia requires any insurer that takes an adverse action, based in whole or in part, upon credit information must provide notice to the applicant or insured that the adverse action was based in whole or in part on credit. The notice must also provide a statement of the primary factors or characteristics that were used as the basis for the adverse action or notify the applicant or insured that he may request such information. For the purposes of § 38.2-2126 of the Code of Virginia, an adverse action is defined as a denial, refusal to renew, or cancellation of, an increase in any charge for or refusal to apply a discount, placement in a less favorable tier, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with underwriting, tier placement, or rating, where the reason for any of these actions is the insured's credit information. If the insurer would have taken the same action(s) had the insured's credit information **not** been a factor, then **no** adverse action has occurred. The notice should specify that the insurer "will" review the applicant/insured's credit history versus "may use" this information.

Failure to provide the notice of change in deductible-homeowners' policies. When an insurer unilaterally changes a deductible in a policy written to insure owner-occupied dwellings, the insurer must provide a written notice that (i) explicitly states that the deductible has changed and (ii) explains how the new deductible will be applied (§ 38.2-2127 of the Code of Virginia). The law prohibits the insurer from changing the deductible except at renewal.

NOTE: Insurers are prohibited from changing a deductible unilaterally during the policy term, including the 90-day underwriting period, once coverage is bound. Where the need arises to make a change in a deductible during the underwriting period, insurers must cancel the policy and offer to write with a different deductible. However, insurers may make changes, such as increasing deductibles or increasing limits, during the underwriting period if the insured agrees to such changes, or if the application, signed by the insured, advises the insured that the deductible may be changed.

Failure to provide the earthquake notice. Section 38.2-2129 of the Code of Virginia requires any insurer that issues a policy of fire insurance, or a policy of fire in combination with other coverage, that excludes coverage for damage due to earthquake to provide written notice that explicitly states, "earthquake coverage is excluded unless purchased by endorsement." This notice must state that information regarding such coverage is available from the insurer or the agent if earthquake coverage is otherwise available from the insurer. **Insurers may use notices that unambiguously set forth the information required by the law even if the language of the notice is not in the precise language that is quoted in the law.** (See Administrative Letter 2012-06.) The policies to which this statute applies include all

fire policies, and fire policies in combination with other coverages, including but not limited to mobile home policies, dwelling fire policies, homeowners' policies, renters policies, commercial fire policies, commercial package policies providing fire coverage, and master policies (providing mortgage force-placed fire coverage) that are issued in Virginia. This statute does not apply to surplus lines policies nor does it apply to mutual assessment fire policies.

Notices-Information Collection and Disclosure Practices--Privacy

Notice of Insurance Information Collection and Disclosure Practices. This notice is triggered when the insurer/agent initiates the *collection* of *personal* information. Personal information is defined in § 38.2-602 of the Code of Virginia and includes medical-record information, MVRs, and credit reports. For *applicants*, if personal information is collected by the insurer/agent during the application process, this notice must be provided by the insurer/agent when the collection of personal information is initiated. For example, if the agent obtains a motor vehicle report (MVR) as part of the application process, the notice must be given at that time. If personal information is not collected before the issuance of the policy, the insurer must give the notice when the policy is issued. The notice must be given on renewal when the insurer *collects* personal information about the policyholder unless a notice has been given in the last 24 months. Because the collection of personal information is the event that triggers this notice, if the insurer does not collect personal information about the policyholder for a renewal, the insurer does not have to provide the notice.

The insurer may satisfy the notice requirements with an abbreviated notice. The requirements of this notice are set forth in § 38.2-604 C of the Code of Virginia. **However, every insurer using the abbreviated notice must make available to an applicant or policyholder a long notice.** The requirements for the long notice are set forth in § 38.2-604 B of the Code of Virginia. These notices must be in writing or, if the policyholder agrees, in electronic format. ***Insurers that only use the long notice do not have to have an abbreviated notice; however, insurers who provide the short notice must have a long notice available.***

Notice of Financial Information Collection and Disclosure Practices. This notice is triggered by the *disclosure* of *financial* information. Financial information includes personal information other than medical-record information or the record of payments for the provision of health care to an individual. For *applicants*, this notice must be given before financial information is *disclosed* to nonaffiliated third parties if the disclosure is made outside of the exceptions set forth in § 38.2-613 of the Code of Virginia. If the insurer only discloses financial information to affiliates and/or non-affiliated third parties within the exceptions in the Code, no notice is required to the *applicant*. If an applicant becomes a *policyholder* and the insurer has not yet provided a financial information and disclosure notice, the insurer must provide the policyholder with a notice ***no later*** than when the policy is issued or delivered.

For both *applicants* and *policyholders*, insurers must provide the long notice set forth in § 38.2-604.1 B of the Code of Virginia. However, for *applicants* only, the insurer may provide the short notice set forth in § 38.2-604.1 D of the Code of Virginia if the insurer provides the applicant a reasonable means to obtain the long notice. ***If an insurer shares financial information outside of the exceptions in § 38.2-613 of the Code of Virginia, then the insurer must also send the opt-out notice set forth in § 38.2-612.1 A of the Code of Virginia with either the short or long notice.*** Finally, the applicant or policyholder must be given 30 days to notify the insurer that he does not want his financial information disclosed.

However, if the insurer does not disclose and does not wish to reserve the right to disclose financial information about *policyholders* and *former policyholders* to affiliates and non-affiliated third parties outside of the exceptions, the insurer may use the notice set forth in § 38.2-604.1 C of the Code of Virginia.

For renewals, the insurer must give *policyholders* the notice(s) that reflect its practices for the collection and disclosure of financial information not less than once each calendar year. The notice must be in writing or, if the policyholder agrees, in electronic format. For more information, see Administrative Letter 2001-5.

Problems Found during the Review of the Notices:

- *Both* notices are required because ***triggers*** are different.
  - *Collection* of personal information triggers notice required in § 38.2-604 of the Code of Virginia.
  - *Disclosure* of financial information triggers notice required in § 38.2-604.1 of the Code of Virginia.
- Insurers create a national/regional GLBA notice and do not review the requirements of Virginia law.

- Combining these notices is:
  - Permissible.
  - Difficult because triggers are different.
  - Difficult because information required to be in the two notices is different.
- GLBA notice may be combined with any Fair Credit Reporting Act Notice the financial institution is required to provide.
- Insurers are not providing these notices at the proper time.
- Insurers' notices do not contain all the information required by the relevant statute(s).
- Some insurers mistakenly think that the GLBA notice required by § 38.2-604.1 of the Code of Virginia takes the place of the notice required by § 38.2-604 of the Code of Virginia.

Federal Simplified Model Privacy Notices

Administrative Letter 2012-04 provides new forms and instructions for insurers and agents who wish to use the federal simplified privacy notices. These notices may be used (*they are not required to be used*) in lieu of the privacy notices that insurers and agents are currently using pursuant to § 38.2-604.1 of the Code of Virginia. In order to receive a safe harbor of compliance in the use of the simplified privacy notices, insurers and agents must strictly comply with the instructions set forth in the administrative letter and the attached Virginia instructions.

Common Problems Identified by the Property and Casualty Market Conduct and Consumer Services Sections

Agent and Agency Licensing and Appointment Issues

Failure to properly appoint agents and agencies. Insurers frequently accept business from agents who are not properly appointed as required by § 38.2-1833 of the Code of Virginia. In addition, the examiners frequently find that insurers are paying commissions to agencies that are not properly appointed as required by § 38.2-1833 of the Code of Virginia.

Doing business with unlicensed agents and agencies. The examiners find instances where the insurers are accepting business from agents who are not licensed as required by § 38.2-1822 of the Code of Virginia and are paying commissions to agencies that are not licensed as required by § 38.2-1812 of the Code of Virginia.

Paying commissions to fictitious names not filed with the Bureau of Insurance. The examiners frequently find that insurers are paying commissions to fictitious names used by agents and agencies that have not been filed with the Bureau of Insurance as required by § 38.2-1812 E of the Code of Virginia. No insurer may pay commissions to a fictitious name unless the entity using the fictitious name has so notified the Bureau of Insurance.

Insurer Offering Insured a Renewal with an Insurer in the Same Group

Notice of Non-Renewal Required Pursuant to §§ 38.2-231, 38.2-2114, and 38.2-2212. Some insurers are offering to write their insureds with a different insurer within the same group of affiliates and are failing to provide a notice of non-renewal as required by § 38.2-231 of the Code of Virginia (applicable to commercial liability and commercial auto), § 38.2-2114 of the Code of Virginia (applicable to owner-occupied dwellings), or § 38.2-2212 of the Code of Virginia (applicable to private passenger auto). When an insurer decides that it will not renew coverage, in most cases the non-renewal notice required by these sections must be sent. The only exception is when an affiliated insurer in the same group has manifested its willingness to provide coverage to the insured at a premium that is lower than that which would have been charged for the same exposures on the expiring policy. The affiliated insurer's policy must have types and limits of coverage at least equal to those of the expiring policy unless the insured has requested a change in the coverage or limits. Additionally, pursuant to §§ 38.2-2114 E 5, 38.2-2212 F 4, and 38.2-231 A 3 of the Code of Virginia, the policy issued by the affiliated insurer is deemed to be a renewal policy.

Notices Required: Renewal of a Policy with Insurer in the Same Group under a Petition Approved by the Commission (§§ 38.2-2114.1 and 38.2-2212.1)

	Private Passenger Automobile Policies	Homeowners' and Owner-Occupied DP Policies	Fire Policies (not owner-occupied with no tenants' personal property coverage)	Fire Policies (tenant-occupied) (DP policies insuring personal property only) and HO-4 type Policies
§ 38.2-305	X	X	X	X
§ 38.2-604	X	X	X	X
§ 38.2-604.1	X	X	X	X
§ 38.2-610	X	X	X	X
§ 38.2-2118 (if replacement cost provision for dwelling and appurtenant structures is on the policy)		X		
§ 38.2-2120		X		X
§ 38.2-2124		X	X	X
§ 38.2-2125		X	X	X
§ 38.2-2126		X		X
§ 38.2-2127		X		
§ 38.2-2128		X		
§ 38.2-2202	X			
§ 38.2-2230	X			
§ 38.2-2234	X			
Notices not Required	**§§ 38.2-2210 (if no application is obtained), 38.2-2208, and 38.2-2212**	**§§ 38.2-2113 and 38.2-2114**	**§§ 38.2-2118, 38.2-2120, 38.2-2126, 38.2-2127, and 38.2-2128**	**§§ 38.2-2118, 38.2-2124, 38.2-2127, and 38.2-2128**

Miscellaneous Information

Statutory record retention requirements in Virginia. The following statutes outline the record retention requirements in the Insurance Code that apply to market conduct.

- Section 38.2-511 of the Code of Virginia requires insurers to maintain a complete record of complaints since the last financial examination was conducted pursuant to § 38.2-1317 of the Code of Virginia.
- There are record retention requirements in various termination statutes: §§ 38.2-231, 38.2-2113, and 38.2-2208 of the Code of Virginia. These statutes require an insurer to maintain all records relating to the cancellation and refusal to renew as well as premium increases greater than 25% and reductions in coverage on policies to which these statutes apply for one year from the date of the action taken by the insurer.
- With respect to claims on policies issued in Virginia, insurers shall maintain all data and documentation for all open and closed files for the current year and, at a minimum, the three preceding calendar years. Insurers should review 14 VAC 5-400-30 for all related requirements.
- Public adjusters operating in Virginia shall retain records pertaining to each claim handled for a minimum of five years after the claim is settled. (See § 38.2-1845.15 of the Code of Virginia.)
- Licensees subject to Chapter 18 of Title 38.2 of the Code of Virginia shall retain all their records relative to insurance transactions for the three previous calendar years unless more specific requirements apply. Records of premium quotations which are not accepted by the insured or prospective insured need not be kept. (See § 38.2-1809 of the Code of Virginia.)

The Bureau of Insurance cautions insurers that they should seek the advice of their counsel when determining how long insurance records should be maintained. For example, consideration must be given to statutes of limitation when making such decisions.

Insurers Responding to Consumer Complaints

Frequently, the P&C Consumer Services Section of the Bureau of Insurance receives late or inadequate responses from insurers to correspondence sent to those insurers on consumer complaints. Some companies are routinely late in responding to such correspondence. This slows the resolution process and, in some cases, causes a hardship on the consumer. Incomplete responses from insurers include failure to respond to specific questions in Bureau correspondence and failure to provide the documents requested by the Bureau, which are needed to resolve the complaint. Insurers should be aware that 14 VAC 5-400-50 B requires every insurer, upon receipt of any inquiry from the State Corporation Commission pertaining to a claim, to furnish an adequate response within 15 working days. While this requirement only applies to correspondence pertaining to *claims,* the P&C Consumer Services Section urges insurers to use this standard when responding to all complaints.