Michelle M. Meyers (SBN 236387)
Lisa J. Nicholes (SBN 242852)
SINGLETON SCHREIBER, LLP
1414 K Street, Suite 300
Sacramento, CA 95814
Tel: (916) 248-8478
Fax: (619) 255-1515
mmeyers@singletonschreiber.com
lnicholes@singletonschreiber.com

Willliam R. Pletcher (SBN 212664)
Pamela M. Pressley (SBN 180362)
CONSUMER WATCHDOG
6330 San Vicente Blvd., Suite 250
Los Angeles, CA 90048
Tel: (310) 392-0522
Fax: (310) 392-8874
will@consumerwatchdog.org
pam@consumerwatchdog.org

Attorneys for Petitioner/Plaintiff
Every Fire Survivor's Network

BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of the Certificate of Authority of: **STATE FARM GENERAL INSURANCE COMPANY,** Respondent.	File No. OSC-2026-00001 **PETITION OF EVERY FIRE SURVIVOR'S NETWORK FOR LEAVE TO INTERVENE/ PARTICIPATE; VENUE REQUEST**

Distortion.

Isolated incidents.

Weaponization.

Political attack.[1]

1. This is how State Farm General Insurance Company ("State Farm") would have this proceeding characterize the California Department of Insurance's ("CDI") Market Conduct Examination. Those words are not answers. They are not accountability. They are a litigation strategy.

2. For more than one year, January 2025 Los Angeles Fire survivors have been saying something very different. They paid for protection from State Farm. In return, they lost homes, savings, stability, and time they will never get back. Then they were forced to fight their own insurer for the coverage they were promised.

3. The Market Conduct Examination confirms what survivors have said from the beginning. This was not a few bad files. This was not paperwork. This was not an administrative footnote. This was a claims-handling failure with real consequences for real people.

4. The only way to test State Farm's story is to hear from the people who lived it.

5. Survivors know what happened. They know what was delayed. They know what was denied. They know what it took to rebuild while the company they trusted minimized their losses and defended its process.

6. State Farm cannot dismiss the survivors' experiences as isolated, administrative, or process-related and then ask that those same survivors be excluded from this proceeding. If State Farm wants to say there was no broader failure, survivors must be allowed to answer with the evidence only they can provide.

7. Their participation is not a distraction. It is the accountability this proceeding requires. Without survivors, State Farm controls the story. With survivors, the record reflects the truth. Accordingly, Every Fire Survivor's Network ("EFSN") petitions for leave to intervene in this proceeding as a full party so that it may directly dispute State Farm's claims set the record straight with firsthand

[1] State Farm LA Wildfire Response, State Farm Newsroom (May 4, 2026); https://newsroom.statefarm.com/state-farm-is-here-to-help-california-customers-impacted-by-wildfires/.

accounts and their true lived experiences.

8. A CDI whistleblower with decades of experience aptly observed, State Farm has been handling Fire claims as though it were a company in financial distress: delaying, denying, resisting, and ignoring its claims obligations. Yet, State Farm is a corporation with hundreds of billions of dollars in assets. During the very year it engaged in this "shoddy" and "shameful" misconduct, the company increased its surplus by $25 billion, bringing its total surplus to approximately $170 billion.

9. Against this backdrop, the CDI's proposed $2 million fine is utterly deficient. It neither reflects the scale of the misconduct nor serves as a meaningful deterrent.

10. According to State Farm's 2025 Annual Report to Mutual Policyholders,[2] the State Farm property and casualty insurance entities hold $270 billion in total assets and generated $6.2 billion in investment gain in 2025 alone — approximately $708,000 per hour, every hour, every day. The proposed $2 million fine is erased by State Farm's investment earnings in less than three hours. At an institution of this financial scale, a penalty representing less than 0.001 percent of total assets does not deter. It signals that the conduct can continue.

11. EFSN's participation is imperative to ensure a full, fair, and stronger record to ensure that State Farm is fully held to account for its significant wrongdoings to Fire survivors. EFSN seeks insurance accountability not just for Los Angeles fire survivors, but for all Californians.

12. This Petition rests on the most basic possible ground: EFSN's members are the policyholders, CDI charges State Farm with harming. They are the insureds named in the claim files the Market Conduct Examination reviewed, parents and caregivers whose children were pressured back into homes testing positive for lead, the families who maxed out credit cards and drained retirement accounts while State Farm stalled, the unhoused who remain displaced and forced to live in their cars or in unsustainable short-term rentals because State Farm has unlawfully delayed and denied the repair and rebuilding of their homes. Their lives, their homes — or what's left of them — and their health and wellbeing are the subject of every finding in this proceeding. This petition asks that they be heard and allowed to participate fully as parties in proceedings that will determine their future.

13. The California Administrative Procedure Act ("APA") requires intervention where the

[2] https://www.statefarm.com/content/dam/sf-library/en-us/secure/legacy/pdf/2025-annual-report.pdf

movant's legal rights will be substantially affected. EFSN plainly meets that standard, without any need to resolve contested questions of statutory interpretation. Under the APA, as a representative of the affected community, EFSN is entitled not only to a seat at the table, but to full party participation. Furthermore, the administrative court's discretion to permit intervention as part of its managerial powers should be exercised in EFSN's favor because its participation will sharpen the record, not burden it.

14. EFSN respectfully requests full party status pursuant to Government Code sections 11405.10, 11405.60 and 11500 including the rights available under Government Code sections 11340 *et seq*., which include rights to receive all filings and discovery, conduct discovery consistent with Government Code sections 11507.6, and 11507.7, submit briefing, introduce evidence including survivor testimony and documentary evidence survivor testimony and documentary evidence drawn from EFSN's compiled accounts of more than 1,600 Eaton and Palisades State Farm policyholders, cross-examine witnesses, present oral argument, and participate in any prehearing conference, settlement discussions, or mediation.

BACKGROUND

A. Every Fire Survivor's Network

15. Immediately following the fires in January 2025, EFSN organized the survivor documentation and advocacy efforts whose compiled evidence will now before this proceeding.

16. In February 2025, EFSN migrated its survivor community from WhatsApp to Discord and created dedicated channels organized by insurer. EFSN leadership observed that the State Farm channel was generating complaints at a volume and rate disproportionate to every other insurer channel — survivors reaching out independently, with no prompting and no structured questions. That organic pattern became the evidentiary foundation of what followed. EFSN sought to bring this documented evidence directly to Insurance Commissioner Ricardo Lara through a public webinar; his office declined but offered Deputy Insurance Commissioner Tony Cignarale instead.

17. In March 2025, EFSN hosted that public webinar with Deputy Insurance Commissioner Cignarale. Survivors put their complaints on record. EFSN demanded CDI freeze all State Farm rate hikes pending a full investigation of claims handling misconduct.[3]

[3] https://www.youtube.com/watch?v=95ZQiq6GpWM

18. In April 2025, on the 100-day anniversary of the fires, EFSN held a press conference in front of State Farm's catastrophe tent in Pasadena, placing survivors' specific documented accounts of delays, denied smoke testing, and lowballed estimates into the public record.[4]

19. In May 2025, during a public online forum for hundreds of survivors, EFSN confronted Insurance Commissioner Ricardo Lara directly, pressing him to commit to investigating complaints before approving any rate hikes.[5] Days later, EFSN delivered nearly 400 firsthand survivor accounts to Commissioner Lara, organized into seven documented misconduct patterns, and demanded he defer rate hikes pending investigation.[6] Without responding, Commissioner Lara granted State Farm its requested rate hike the following day.

20. The *New York Times* covered CDI's decision to open the market conduct examination on June 12, 2025 by centering EFSN's evidence and quoting EFSN Executive Director Joy Chen directly on the patterns EFSN had documented: rotating adjusters forcing survivors to restart their claims from scratch, rebuild estimates at a fraction of actual cost, and smoke damage denials leaving families unable to return home. The investigation that followed — the one that produced the 398 violations now before this ALJ — was opened in direct response to those complaints.[7]

21. In July 2025, on the sixth-month anniversary of the Eaton and Palisades fires, EFSN organized a press conference and postcard campaign in which over 400 survivors sent 1,500 handwritten cards to Commissioner Lara and Governor Newsom demanding enforcement.[8]

22. In August 2025, EFSN published a legally grounded five-action enforcement framework for Insurance Commissioner Lara which included the completion of the State market conduct exam prior to any further rate hikes;[9] all four state legislators representing the Eaton and Palisades fire zones co-

[4] https://www.efsurvivors.net/media
[5] https://youtu.be/-pDKO9P50jQ
[6] https://static1.squarespace.com/static/67f5687fc4ea480d5d201fe5/t/6906dd9d9732490b0a175868/1762057629332/EFSN+Package+for+Commissioner+Lara+051225.pdf
[7] https://www.nytimes.com/2025/06/12/realestate/state-farm-california-insurance-investigation.html
[8] https://www.efsurvivors.net/6month
[9] https://static1.squarespace.com/static/67f5687fc4ea480d5d201fe5/t/68a9fd81b9558b11989b75b8/1755970945688/EFSN+5+Actions+Stop+Insurer+Misconduct.pdf

signed, and the *Los Angeles Times* covered the joint press conference.[10]

23. In November 2025, EFSN organized a press conference at which survivors demanded that state leaders enforce consumer protection laws and compel insurers, including State Farm, to pay outstanding claims. The *New York Times* covered the event and quoted Joy Chen: "Our entire housing market will collapse if families can't buy or renew insurance, and if those who have it can't get the benefits they've paid for."[11]

24. Later that month, EFSN brought its compiled State Farm evidence directly to LA County Counsel, which opened a formal civil investigation into State Farm's claims handling under the Unfair Competition Law. The *Los Angeles Times* quoted Joy Chen: "In the absence of state leadership, today's county investigation is a major step forward. It matters not only for Los Angeles fire survivors, but for every Californian who pays premiums and expects the protection they paid for when disaster strikes."[12]

25. In December 2025, a *San Francisco Chronicle* investigation that drew on EFSN Discord accounts and survivors EFSN connected to reporters uncovered internal State Farm claims manuals revealing systematic practices to reduce payouts; that work was later awarded the Pulitzer Prize.[13]

26. In January 2026, on the one-year anniversary of the fires, EFSN convened a press conference focused squarely on insurer accountability: one year in, thousands of families remained displaced, thousands of claims remained unresolved, and State Farm remained the insurer at the center of the documented misconduct.[14]

27. In May 2026, when CDI released the market conduct exam findings, EFSN's op-ed ran in the *California Post*. [15] The *New York Times* reported on the findings and quoted Joy Chen directly: "This illegal conduct has been happening for 16 months — people have suffered needlessly. We have filed thousands of complaints with CDI and it has been a black box. Now that they finally acknowledge the problem, we have a nominal fee of $2 million, while these companies have been profiteering this whole

[10] https://www.latimes.com/business/story/2025-08-25/local-politicians-and-january-fire-survivors-hold-press-conference-over-insurance-claims-payments
[11] https://www.latimes.com/business/story/2025-11-13/la-county-opens-probe-into-state-farms-handling-of-wildfire-claims
[12] https://www.latimes.com/business/story/2025-11-13/la-county-opens-probe-into-state-farms-handling-of-wildfire-claims
[13] https://www.sfchronicle.com/projects/2025/california-insurance-hidden-rules/
[14] https://www.efsurvivors.net/one-year-press-conference
[15] https://nypost.com/2026/05/05/opinion/california-vs-state-farm-better-late-than-never/

time."[16] The *Los Angeles Times* featured EFSN survivors on its cover and quoted Joy Chen speaking about State Farm: "They have the money to fulfill their obligations to L.A. fire survivors."[17]

28. This is the evidentiary record EFSN built. This proceeding is its product.

29. EFSN has compiled more than 1,600 firsthand policyholder accounts of State Farm's claims-handling practices — submitted by named, identified State Farm policyholders through EFSN's website over thirteen months. These accounts were not solicited through a structured survey; policyholders reached out on their own initiative to share their experiences. Every count is therefore a floor, not a ceiling.

B. The January 2025 Fires

30. On January 7, 2025, near hurricane-force winds swept down the mountains outside Los Angeles, transforming small wildland ignitions into catastrophic wildland-urban interface fires in Pacific Palisades and Altadena. Within days they became the most destructive urban wildfires in California history. The Palisades Fire ultimately burned approximately 23,448 acres across Pacific Palisades, Malibu, and surrounding communities.[18] The Eaton Fire burned approximately 14,117 acres across Altadena, Pasadena, and Sierra Madre. Together, they destroyed more than 16,000 structures - the overwhelming majority of them homes - forced more than 200,000 residents to evacuate, and killed at least 31 people.[19] Governor Newsom declared a State of Emergency on January 7, 2025, triggering the extended consumer protections applicable to fire insurance claims under a declared emergency, including the 24-month suit limitation of Insurance Code section 2071(a).[20]

31. The fires caused an estimated $250 billion to $275 billion in total economic losses, making them among the costliest natural disasters in United States history.[21] Insured losses are estimated between

[16] https://www.nytimes.com/2026/05/04/realestate/california-state-farm-fires-insurance.html
[17] https://www.latimes.com/business/story/2026-05-04/state-farm-wild-fires-fines-regulators-license-mishandling-fire-claims-eaton-palisades
[18] Maaz Alin, Recovery From 2025 Wildfires Gaining Ground But Challenges Remain, New Report Finds, Santa Monica Daily Press (June 10, 2026), https://www.smdp.com/recovery-from-2025-wildfires-gaining-ground-but-challenges-remain-new-report-finds/.
[19] *Id.*
[20] Governor Gavin Newsom, Proclamation of a State of Emergency, Palisades Fire and Windstorm Conditions (Jan. 7, 2025), https://www.gov.ca.gov/wp-content/uploads/2025/01/SOE_Palisades-Fire_1-7-25_Formatted.pdf
[21] Russ Mitchell, Estimated Cost of Fire Damage Balloons to More Than $250 Billion, L.A. Times (Jan. 24, 2025), https://www.latimes.com/business/story/2025-01-24/estimated-cost-of-fire-damage-balloons-to-more-than-250-billion.

$35 billion and $45 billion.[22] As of the filing of this Petition, seventeen months after the fires, thousands of families remain displaced. Thousands of claims remain open, contested, or unresolved. The insurance system was the primary mechanism available to fire survivors to fund their recovery. For EFSN's members who held State Farm policies, that mechanism failed them.

C. State Farm Failed its Policyholders and Falsely Claimed Hardship Amidst a Record-Breaking $170 Billion Surplus

32. State Farm is duly licensed to conduct business in California and actively operates within the State of California, including in the County of Los Angeles. State Farm has conducted business in California since 1928. State Farm is the "largest private insurer of homes in California and Los Angeles County."[23]

33. State Farm seeks sympathy, claiming that "[o]ver the last nine years, the lack of alignment between price and risk [in California] means that for every $1.00 collected in premium, State Farm paid $1.26, resulting in over $5 billion in cumulative underwriting losses."[24] State Farm "anticipate[s]" that it will ultimately "pay between $6-7B in losses from these fires[,]" i.e., the January 2025 Eaton and Palisades Fires in Los Angeles County.[25]

34. State Farm likes to paint a gloomy picture about their purported devastating losses, which they disingenuously claim threaten to put them out of business. They claim the only sensible response is to retreat by dropping policies and by hiking premiums for policyholders whose policies are not terminated via non-renewal. Insurance companies use complex bookkeeping schemes to prop up this misleading narrative. In reality, however, property insurers in the United States cleared nearly $25.4 billion in underwriting profit in 2024, and their net investment income surged to $164.3 billion.[26]

---

[22] LA Wildfires: CoreLogic Initial Insured Loss Estimate Is $35bn to $45bn, Artemis (Jan. 2025), https://www.artemis.bm/news/la-wildfires-corelogic-initial-insured-loss-estimate-is-35bn-to-45bn/.

[23] State Farm and the California Insurance Marketplace, State Farm Newsroom (Nov. 15, 2025, updated May 4, 2026), https://newsroom.statefarm.com/state-farm-in-california-understanding-the-issues

[24] *Nov. 13, 2025 – State Farm Responds to LA County Investigation*, available at https://newsroom.statefarm.com/state-farm-general-insurance-company-update-on-california-2-2025/

[25] *Id.*

[26] Kenny Stancil, Don't Let Home Insurers Fool You. They're More Profitable Than Ever, Revolving Door Project (July 14, 2025), https://therevolvingdoorproject.org/mapping-the-home-insurance-crisis-underwriting-profits/.; Nat'l Ass'n of Ins. Comm'rs, 2024 Annual Property/Casualty and Title Insurance Industries Analysis Report (2024); https://content.naic.org/sites/default/files/2024-annual-property-casualty-and-title-insurance-industries-analysis-report.pdf

Property casualty insurers ended 2024 with a record-breaking $169 billion in profit.[27]

35. Despite State Farm's repeated claims of financial distress, its publicly reported financial results reveal a markedly different reality. In 2025, State Farm's property and casualty insurance companies reported a combined underwriting profit of approximately $1.5 billion on earned premiums of $111.6 billion. When combined with $7.0 billion in investment and other income, State Farm generated a pre-tax operating profit of $8.5 billion, representing a dramatic reversal from an operating loss of $111 million in 2024 and operating losses exceeding $8 billion in each of the two preceding years.[28]

36. State Farm's overall financial position strengthened significantly in 2025. Total revenue increased to $132.3 billion, a 7.5% increase from 2024, and net income more than doubled to $12.9 billion, bolstered in part by $2.0 billion in realized capital gains. As a result, State Farm Mutual's net worth rose to approximately $170.0 billion by year-end 2025, up from $145.2 billion the prior year, driven primarily by operating profits and increased valuation of its property and casualty investment portfolios.[29]

37. Even as State Farm raked in massive profits, it sought to exploit California policyholders by demanding a staggering 30% increase in homeowners' insurance rates. After months of litigation, State Farm was forced to retreat from its most extreme position, agreeing (subject to regulatory approval) to reduce the proposed hike to a 17% increase.[30] This brazen push for higher premiums, occurring alongside systemic claim mishandling and widespread underpayment and denial of covered losses, underscores State Farm's profit first strategy and its disregard for its obligations to insureds, like the EFSN community of survivors. Business is booming for State Farm, while policyholders are subjected to delayed, underpaid, and improperly denied claims and left suffering in the wake of insurers' unlawful and bad faith claim handling practices.[31]

D. The Market Conduct Examination and the Order to Show Cause

38. Following sustained advocacy by EFSN, the Insurance Commissioner authorized a formal Market Conduct Examination ("MCE") on June 12, 2025, pursuant to Insurance Code section 790.04.

[27] https://www.justice.org/resources/research/insurance-industry-is-quietly-making-record-profits
[28] https://www.carriermanagement.com/news/2026/02/26/285059.htm
[29] *Id.*; https://newsroom.statefarm.com/state-farm-reports-2025-financial-results/
[30] https://abc7.com/post/california-says-state-farm-violated-law-handling-insurance-claims-2025-la-wildfires/19037952/
[31] https://therevolvingdoorproject.org/mapping-the-home-insurance-crisis-underwriting-profits/

The MCE analyzed a random selection of 220 State Farm first-party claims arising from the January 2025 fires. The final MCE Report adopted May 1, 2026 ("Adopted Report") and transmitted to State Farm on May 4, 2026, found 398 alleged violations across 26 violation categories, found 398 alleged violations in 114 of the 220 examined claims; a violation in over half of the claims and an average of 3.49 violations in each claim wherein a violation was found. (The Adopted Report is **Exhibit A** to the Accusation and OSC and the Adopted Report separately attached hereto as **Exhibit A**.)

39. The violations documented in the Adopted Report fall into five broad categories. *First, delay:* State Farm systematically failed to begin investigations within 15 days, failed to accept or deny claims within 40 days, and failed to pay accepted claims within 30 days, including 79 violations for failure to send required status letters alone. *Second, adjuster churning:* State Farm reassigned adjusters without establishing primary contacts, in violation of Insurance Code section 14047, leaving policyholders cycling through a succession of strangers with no continuity and no accountability. *Third, underpayment:* State Farm offered unreasonably low settlement amounts, improperly depreciated structural components not subject to ordinary wear, and withheld hygienist and environmental testing costs from policyholders while charging them against policy limits. *Fourth, misrepresentation:* State Farm sent closing letters stating a one-year statute of limitations, misrepresented its "Right to Inspect" provision as grounds to deny hygienist testing reimbursement, and made other misstatements about policy terms and coverage. *Fifth, systemic process failure:* State Farm failed to maintain adequate claim file documentation, failed to train its handlers consistently, and failed to implement the prompt investigation and processing standards required by law.

40. The Adopted Report documents State Farm's responses to each of the 30 findings compiled during the examination process. In those responses, State Farm agreed with the underlying factual findings in the majority of charged instances — conceding, among others, that it failed to send required status letters (Finding 1), erroneously named payees on indemnity checks (Finding 2), failed to advise policyholders of the 24-month extended statute of limitations applicable to declared-emergency losses in all 29 charged instances (Finding 3), failed to provide required written denials in 20 of 24 charged instances (Finding 7), misrepresented policy provisions to claimants in each of the seven charged instances (Finding 15), and failed to maintain adequate claim documentation in all three charged

instances (Finding 21). In each instance, State Farm's position was that the conceded conduct does not constitute a "general business practice" under Insurance Code section 790.03(h). State Farm's June 2, 2026 public letter addressed to the CDI Field Claims Bureau Chief and acknowledging receipt of the Adopted Report reiterates that position across all 30 findings, stating that "none of the Report's allegations rise to the level of a 'general practice' by the Company in violation of Section 790.03(h) of the Insurance Code, nor were they knowingly performed." (See **Exhibit C**: State Farm's June 2, 2026 letter.) The central factual and legal dispute in this proceeding is whether hundreds of violations across 52 percent of a random claim sample reflect State Farm's general practice. EFSN's 1600-plus member accounts from the full 11,000-claim population provides the most direct evidence on that question.

41. The Adopted Report also documents a separate pattern of particular consequence to EFSN's members. In at least 12 instances in the 220-claim sample, State Farm sent denial letters citing the policy's "Right to Inspect" provision as the basis for denying hygienist testing reimbursement. The Adopted Report records State Farm's acknowledgment that the cited policy section "was not the appropriate section to justify claim denials" and "will not be used as such in future events," even as State Farm denies any general business practice. Whether 12 instances in a 220-claim sample represent the floor or the ceiling across 11,000 claims is precisely what EFSN is positioned to prove.

42. Confronted with these failures, State Farm deflected, attacking and blaming the very Californians it purports to serve while calling California's homeowners insurance market "the most dysfunctional in the country."[32] In its June 2, 2026 public letter, State Farm generally dismissed the 398 violations documented across 52 percent of the examined claims as "primarily administrative and procedural errors." That characterization is itself evidence of why independent policyholder participation is necessary. The violations the Department documented include misrepresenting the statute of limitations to disaster victims, using an inapplicable policy provision to deny contamination testing reimbursement to families in smoke-damaged homes, and failing to pay accepted claims within the regulatory timeline — conduct that directly determined whether EFSN's members could afford to test their homes, rebuild their lives, or preserve their legal rights. EFSN members are in the best position to demonstrate to the ALJ that what State Farm callously dismisses as "administrative and procedural

[32] https://newsroom.statefarm.com/state-farm-is-here-to-help-california-customers-impacted-by-wildfires/

errors" are in fact systemwide unlawful policies and practices with devastating human costs for policyholders.

43. State Farm's June 2 letter argues that the MCE was "unprecedented," noticed just five months after the catastrophe while the Company was still in the "very early stages" of handling claims. That assertion confirms, rather than excuses, CDI's findings of delay. The MCE documented 79 violations for failure to send required status letters, 27 violations for failure to pay accepted claims within 30 days, and 18 violations for failure to accept or deny claims within 40 days. If State Farm was still in the "very early stages" five months after the fires, EFSN's members living that delay in real time — without determinations, without payments, without required communications — were experiencing the statutory violations State Farm now speciously describes as timing context. Separately, State Farm's June 2 letter announces new "customer commitments" including "assigning a single point of contact for each customer with an open wildfire claim" — the precise remedy the Adopted Report found State Farm had failed to provide. State Farm cannot, in the same letter, claim its team-based approach was "compliant with the statutory requirement" while announcing it will replace that approach with individual point-of-contact assignments. That remedial commitment is an implicit concession that the prior practice was inadequate.

44. State Farm's June 2 letter states that it sent corrective correspondence to all affected policyholders with the correct 24-month suit limitation "on or before April 1, 2026." The fires occurred January 7, 2025. That corrective correspondence issued nearly sixteen months after the fires — and only after CDI's examination. The Adopted Report documents two distinct SOL failures during that window: in 18 instances State Farm sent no required notice of the 24-month limitation at all; in 11 additional instances it sent notices affirmatively stating the wrong one-year period (Finding 3, 29 instances total). Separately, in three instances State Farm sent closing and denial letters advising policyholders that "the action must be started within one year after the date of loss or damage" (Finding 18). EFSN's members who made legal decisions in reliance on a limitations period State Farm misrepresented as half of the time actually available (one year instead of two), cannot be made whole by a corrective letter sent sixteen months later. Their accounts of what they did and did not do during that window are critical evidence for this proceeding.

45. On the fraud warning findings (Finding 6), State Farm argues in its June 2 letter that Insurance Code section 1871.2(a) "does not set forth a legal requirement that the fraud language be included on forms that do not constitute 'notice' as contemplated in the statute" and that CDI "provides no legal basis" for concluding otherwise. Yet the OSC and the Adopted Report records that, during the examination, State Farm told CDI it "will add the fraud language to these forms," even as it now publicly insists it had no legal obligation to include that language. State Farm cannot credibly maintain that no legal requirement exists while simultaneously committing to comply with it. The contradiction between State Farm's public legal position and its MCE process conduct is precisely the kind of issue that benefits from adversarial development by a party with a direct stake in the outcome.

46. The Accusation, Order to Show Cause ("OSC"), Notice of Penalties, Notice of Hearing (collectively referred to as the "Accusation and OSC") filed and served May 4, 2026 under Insurance Code sections 704, 790.03, 790.05, and 790.035 incorporated the Adopted Report violation findings, and seeks suspension of State Farm's certificate of authority for up to one year, a cease-and-desist order, and civil penalties of up to $10,000 per willful act. (See **Exhibit B**: Accusation and OSC.) The Accusation and OSC further notified State Farm "that a hearing shall be held at a time and place to be determined by the Commissioner. The hearing shall not be less than 30 days after service of this Accusation and Order to Show Cause. (Ins. Code, § 790.05)."

AUTHORITY FOR PETITION TO INTERVENE/PARTICIPATE

47. The APA mandates EFSN's participation. This is an adjudicatory enforcement proceeding that will determine legal rights and obligations, and the APA gives parties with a direct and substantial interest the right to be heard. It does not relegate consumer participation to when it is convenient, or to rate cases or any narrow subset of proceedings insurers prefer.

I. The Administrative Procedure Act Requires Intervention.

48. Government Code section 11440.50(b)[33] directs that the presiding officer "shall grant a

[33] Insurance Code section 790.05 directs that the hearing on the Order to Show Cause "shall be conducted in accordance with the Administrative Procedure Act, Chapter 5 (commencing at Section 11500)" of the Government Code, and that "the commissioner and the appointed administrative law judge shall have all the powers granted under the Administrative Procedure Act." Government Code section 11501, subd. (c) — a provision within Chapter 5 — in turn provides that "Chapter 4.5 (commencing with Section 11400) applies to an adjudicative proceeding required to be conducted under this chapter, unless the statutes relating to the proceeding provide otherwise." Section 11440.50 sits in Chapter 4.5. Nothing in Insurance Code sections 790.03 through 790.08 prescribes a contrary intervention rule, so nothing "provide[s] otherwise."

motion for intervention" when four conditions are satisfied: (A) the motion is in writing and served on the parties; (B) it is made as early as practicable in advance of the hearing, and of any prehearing conference and should be resolved at the prehearing conference; (C) it states facts showing that the movant's "legal rights, duties, privileges, or immunities will be substantially affected by the proceeding"; and (D) the presiding officer "determines that the interests of justice and the orderly and prompt conduct of the proceeding will not be impaired by allowing the intervention."[34] EFSN's Petition satisfies each.

A. The Members of EFSN's Legal Rights Will Be Substantially Affected.

49. EFSN realleges and incorporates by reference each and every preceding paragraph of this Petition. Many of EFSN's members hold open State Farm claims — active legal obligations running from State Farm to them under binding insurance contracts. This proceeding will directly determine: (1) whether State Farm's challenged practices violated the Unfair Insurance Practices Act; (2) what remedial measures State Farm must implement; (3) what corrective notices must issue; (4) whether State Farm's license is suspended; and (5) the penalty framework that will govern CDI's enforcement posture toward State Farm going forward.

50. Each of these determinations will have direct legal consequences for EFSN's members' pending claims and their legal relationship with their insurer. A finding that State Farm's practices were a general business practice violating section 790.03(h) would help establish the predicate that victims' related civil claims may borrow under *Zhang v. Superior Court* (2013) 57 Cal.4th 364, while a finding that they were not could be turned against those same victims by State Farm. A final order requiring corrective notice, file reopening, and re-adjustment would restore coverage and benefits the members may not know they are owed, while a consent order that omits those terms leaves them unaware of their rights and lets closed underpayments stand. A penalty set to strip the profit from underpayment would change State Farm's handling of their pending and future claims, while a penalty set too low preserves the economic incentive to keep doing what produced their losses. The outcome here will "substantially affect" EFSN victims' rights, and Section 11440.50 requires their participation.

Incorporating Chapter 5 therefore incorporates section 11501(c)'s command that Chapter 4.5 — and with it section 11440.50 — applies.

[34]Gov. Code § 11440.50(b).

B. This Petition Is Made as Early as Possible, Prior Even to Any Hearing Notice.

51. EFSN realleges and incorporates by reference each and every preceding paragraph of this Petition. The Accusation and OSC was filed and served on May 4, 2026. This Petition is filed and served on the Parties within the initial prehearing period, before any responsive pleadings have been ordered and well before any hearing date has been set or any prehearing conference has been held. No party will be prejudiced by EFSN's intervention.

C. EFSN and Its Members' Substantial Interest in the Proceeding

52. EFSN realleges and incorporates by reference each and every preceding paragraph of this Petition. EFSN is a nonprofit organization representing more than 10,000 Eaton and Palisades Fire survivors and allies.

53. A Department of Angels 2025 survey of 2,335 fire survivors found that 82 percent of State Farm policyholders reported their recovery was being derailed by State Farm's delays and denials, the most shocking and worst results of any insurer surveyed.[35]

54. EFSN's members' accounts are not anecdotal. They are consistent, specific, and directly corroborative – and more -- of the violations the Adopted Report documented. They document a breadth and severity of harm that the 220-claim examination sample does not fully capture. Section III of this Petition describes in detail the evidence EFSN will offer and the arguments it will make if admitted.

55. At least the following seven patterns run through the 1600-plus accounts:

- Families who paid premiums for decades, some for as long as 35 to 60 years, found their claims delayed indefinitely, their calls unreturned, and their contractors' estimates reduced without explanation.
- Policyholders were reassigned to five, six, seven, or more adjusters over a period of months, forced to restart the claims process from scratch each time, in direct violation of Insurance Code section 14047.
- State Farm refused to authorize hygienist testing for smoke and ash contamination, pressured families back into homes testing positive for lead, arsenic, and chromium, and charged the cost of testing policyholders paid for themselves against their policy limits.
- Rebuild estimates were cut to fractions of actual cost. One member received an $11,000 remediation offer for a five-bedroom house that cost $83,000 to remediate; others received rebuild estimates of under $300 per square foot when actual costs exceeded $400.

[35] https://static1.squarespace.com/static/6792c245599ed84703227b1e/t/68ed2b627a9ca31da2b0512b/1760373602671/UPDATED+Dept+of+Angels+Community+Voices+LA+Fire+Recovery+Report+-+October+2025.pdf

- Families maxed out credit cards, emptied retirement accounts, and moved their children through six or more temporary living situations while State Farm held submitted receipts unreviewed for months.
- The sustained stress of the claims process inflicted documented physical and psychological harm: weight loss, hair loss, panic attacks, marital strain, and in multiple accounts, descriptions of the claims process as more devastating than the fire itself.

56. EFSN's members are the people, the survivors, this proceeding is about - they have a direct interest in this proceeding to ensure that State Farm is held appropriately accountable for its claims handling violations and have a right to participate in it.

D. EFSN's Participation Will Further the Interests of Justice and Conduct of the Proceeding.

57. EFSN realleges and incorporates by reference each and every preceding paragraph of this Petition. EFSN's participation will not impair the interests of justice or the prompt and orderly conduct of the proceeding. It will enhance these principles. The central legal dispute is whether State Farm's violations reflect a "general business practice" under section 790.03(h). CDI's evidence for that proposition comes from 220 randomly selected files. State Farm's defense is that those files represent isolated errors. EFSN has 1600-plus documented accounts from the broader 11,000-claim population. Those accounts are consistent, specific, and directly corroborative of the MCE's findings across a far larger sample.

58. EFSN will also present evidence and argument on issues neither CDI nor State Farm is positioned to develop fully, including but not limited to: the real-world human-cost adequacy of State Farm's proposed corrective measures; the practical and real effect and impact of adjuster churning on families in crisis; the consequence of charging hygienist testing costs against Coverage A on rebuilding capacity; and the systemic nature of the verbal-denial practice — documented by the San Francisco Chronicle's Pulitzer Prize-winning investigation into internal State Farm claims manuals,[36] and subject to discovery EFSN will seek if admitted — across the full claim population. This is not duplicative of CDI's case, but rather the evidence that transforms CDI's sampling exercise into a full record.

[36] https://www.sfchronicle.com/projects/2025/california-insurance-hidden-rules/; https://www.sfchronicle.com/about/newsroomnews/article/sfchronicle-wins-pulitzer-prize-22240679.php

II. EFSN's Proposed Scope of Participation Is Reasonable.

59. EFSN's participation will remain within the existing scope of this proceeding and support its prompt resolution. EFSN proposes to participate on issues already before the ALJ, including the existence and general-practice character of State Farm's violations, the adequacy of proposed remedial measures, and the appropriate penalty. The presiding officer will retain full authority to manage EFSN's participation to prevent delay or duplication.

A. Survivor Witness Testimony

60. EFSN will present testimony from members whose individual experiences directly corroborate, and often exceed in severity, the violations documented in the Adopted Report as well as the OSC and Accusation. The following accounts, drawn from EFSN's collected testimony of more than 1,600 Eaton and Palisades State Farm policyholders, are representative of the type of witnesses who EFSN will make available and prepared to testify. These accounts were not gathered through structured questions about specific violation types. Policyholders reached out on their own initiative and wrote what was most acute for them, often the single most pressing grievance, and moved on. Every count that follows is therefore a floor, not a ceiling. When the same conduct (rotating adjusters that reset claims, estimates cut and falsely attributed to contractors, ALE terminated before families can return home) appears spontaneously across unconnected survivors, unconnected adjusters, and unconnected channels over 13 months, that convergence is not coincidence. It is institutional practice. EFSN member testimony will include important accounts like the following:

- Duration and economic impact of State Farm's conduct: "We paid State Farm premiums for 35 years. Now, State Farm isn't just delaying our recovery. They're making our suffering worse, day after day." This testimony goes directly to willfulness: an insurer that spent 35 years collecting premiums and then systematically denied the benefits those premiums purchased cannot claim inadvertence.
- State Farm's adjuster-churning pattern (Ins. Code § 14047, MCE found 15 violations): "My claim has been reassigned to 5 different adjusters. Each time, we've had to start over. Right when you think you're getting somewhere, there is a lag in communication and you find out you have a new adjuster — buying State Farm more time to stall." EFSN will present multiple witnesses whose accounts corroborate that adjuster cycling was an operational practice, not a series of administrative accidents — directly countering State Farm's "file-specific error" defense.
- Hygienist testing denial (MCE found at least 12 violations and State Farm's own examination-process response acknowledged rested on an inapplicable policy provision): "State Farm is pressuring us to put our 19-month-old baby and 5-year-old kindergartner back into a home contaminated with dangerous levels of lead dust. We paid over $10,000

for licensed experts. The results: toxic ash, high lead, arsenic, chromium and other risks." This testimony speaks to the real-world consequence of a denial practice State Farm defends as immaterial.

- Payment delay (MCE found 27 violations for failure to tender payment within 30 days of claim acceptance): "My family has slept in 6 beds since the fire with a 7th on the way. State Farm is holding $35,000 in submitted receipts, none of which have been reviewed or reimbursed. It has been over 3 months since the fire and State Farm has done absolutely nothing."
- Penalty severity: "You can't imagine the pain that State Farm has caused us. The fire was the worst thing that had ever happened to me — until I had to deal with my insurance. Now, that experience has taken its place. Dealing with my insurance has been more devastating than the fire itself." The Commissioner's discretion to fix penalties within the section 790.035 ceiling should be informed by the human cost the violations imposed, not only their regulatory categorization.

B. EFSN's Compiled Policyholder Accounts: Documentary Evidence of Systemic Conduct

61. EFSN will introduce its compilation of more than 1,600 firsthand accounts submitted voluntarily by named, identified Eaton and Palisades State Farm policyholders through EFSN's website over thirteen months submitted voluntarily by named State Farm policyholders — as evidence of the systemic character of State Farm's misconduct. Each account maps to specific violations of the Insurance Code and California Code of Regulations. Taken together, they demonstrate across a large, independently gathered dataset that the practices the MCE found in 114 of 220 randomly selected claims were not aberrations, but rather the standard operating procedure State Farm applied to its entire Eaton and Palisades claim book.

62. An earlier internal analysis of EFSN's collected accounts, conducted in August 2025 on a dataset of between 400 and 500 Eaton and Palisades State Farm policyholder accounts, based on categorization of each account against the MCE's violation taxonomy, identified the following patterns of each account against the MCE's violation taxonomy, identifies the following patterns: approximately one-third of accounts describe systemic delays and stall tactics, mapping to the MCE's findings under CCR sections 2695.5(b) and 2695.7(b); approximately 29 percent describe serial adjuster reassignment with forced restart of the claims process, corroborating the MCE's 15 violations of Insurance Code section 14047; approximately 20 percent describe refusal or delay in authorizing hygienist testing, corroborating the MCE's general finding on hygienist cost classification; approximately 16 percent describe misrepresentation of policy terms and coverage, corroborating the MCE's seven violations of

section 790.03(h)(1); and approximately 15 percent describe lowballed construction and remediation estimates, corroborating the MCE's 20 violations of CCR section 2695.7(g) and 21 violations of CCR section 2695.9(f). These figures represent EFSN's internal categorization and will be subject to expert review and verification if EFSN is admitted. Because these figures were derived from an earlier subset of EFSN's collected accounts, they are conservative estimates. EFSN's dataset has since grown to more than 1,600 firsthand accounts. Because those accounts were submitted as written narratives by Eaton and Palisades State Farm customers describing specific violations, without structured prompting, each figure represents the minimum prevalence of the identified pattern across even that earlier dataset. Every count is a floor, not a ceiling. EFSN will submit updated analysis of the full 1,600-plus account dataset if admitted to this proceeding.

63. The pattern of corroboration across this independently gathered dataset is evidence of willfulness. When the same practices appear consistently across hundreds of voluntarily submitted accounts from claimants acting independently, the inference that those practices were not inadvertent errors but deliberate operational choices is available to the ALJ, and EFSN will develop it.

C. Statistical Challenge to the MCE Sample and Its Penalty Implications

64. EFSN will also develop expert statistical evidence to fully understand the scope and breadth of State Farm's significant violations.

1. The Sample Is Too Small to Fully Evidence State Farm's Actual Violations

65. The MCE examined 220 claims from a total claim population that the Department's own data places at approximately 12,300 eligible fire claims. At a 95 percent confidence level with a margin of error of ±5 percent (the standard threshold for statistically reliable population inference) a minimum sample of approximately 372 claims is required. The MCE's 220-claim sample produces a margin of error of approximately ±6.6 percent. The MCE is not statistically adequate to bound State Farm's actual violation rate across the full claim population.

66. Applying the observed 52 percent violation rate to the full 12,301-claim population implies violations in approximately 6,396 claims. With 398 documented violations across 114 violated claims, the MCE found an average of approximately 3.49 violations per violated claim. Extrapolating

that rate to the full population implies approximately 22,321 total violations — roughly 56 times the 398 documented in the examination record. The 398 violations CDI documented represent, at best, approximately 1.8 percent of State Farm's likely total violations. EFSN presents these figures as working estimates requiring confirmation by a retained statistical expert, whose report EFSN will submit if admitted to this proceeding. The order-of-magnitude conclusion, however, is robust across any defensible calculation methodology.

2. The MCE's Design Creates Additional Analytical Problems

67. The MCE's design — 70 closed claims, 70 open claims, 70 smoke and ash claims, and 10 corporate complaints — introduces category-specific problems the MCE Report does not address. The smoke and ash subcategory produced 134 violations in 70 claims, a density of 191 violations per 100 claims — nearly double the overall rate. With a population of 2,900 smoke and ash claims, that subcategory alone implies approximately 5,539 violations not captured in the examination record. The 70-claim smoke and ash sample carries a margin of error of approximately ±11.7 percent at 95 percent confidence — too wide to support reliable extrapolation without category-specific statistical analysis the MCE Report does not provide.

68. EFSN will seek through discovery the underlying data necessary for category-specific population inference, which includes: the total unduplicated claim count, the breakdown by claim type and status, and State Farm's own internal records of adjuster reassignments, payment timelines, and hygienist testing denials. The Department's examination record is a starting point; EFSN's participation makes it possible to build on it.

3. The Legal Consequences: Penalty Calibration and Willfulness

69. Insurance Code section 790.035(a) provides a penalty ceiling of $5,000 per non-willful act and $10,000 per willful act, with the Commissioner retaining discretion to define what constitutes an "act."[37] Calibrating the penalty requires knowing: (a) the actual scale of State Farm's misconduct across

[37] See also Cal. Code Regs., tit. 10, § 2695.12: a) In determining whether to assess penalties and if so the appropriate amount to be assessed, the Commissioner shall consider admissible evidence on the following: (1) the existence of extraordinary circumstances; (2) whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of applicable law and the licensee has complied with the provisions of Section 1872.4 of the California Insurance Code; (3) the complexity of the claims involved;(4) gross exaggeration of the value of the property or severity of the injury, or amount of damages incurred; (5) substantial mischaracterization of the circumstances surrounding the loss or the alleged default of the principal;(6) secreting of property

the full claim population, not merely what the 220-claim sample captured; (b) whether the violations were willful; and (c) what amount will actually deter future misconduct at an insurer of State Farm's financial scale.

70. On all three questions, the MCE record alone is insufficient. A penalty calculated from 398 violations at $5,000 per act produces approximately $1.99 million, a figure that, measured against State Farm's own acknowledgment that it issued over $5.9 billion in wildfire claim payments, represents approximately 0.03 percent of the claims it processed. That amount is insufficient as a matter of deterrence and proportionality. It is a rounding error that ignores the full scope of harm inflicted on thousands of affected policyholders. EFSN will show that an adequate penalty must reflect the breadth of State Farm's misconduct across all impacted claims, not just the limited sample identified to date. It will further demonstrate, based on the evidentiary record developed through discovery, that the violations are willful and systemic, and that the Commissioner's discretion to define "acts" should be exercised to capture that systemic misconduct rather than reduce it to isolated file-specific occurrences.

4. Remedial Design: What an Adequate Cease-and-Desist Order Requires

71. A cease-and-desist order that merely instructs State Farm not to repeat conduct it has already committed is insufficient to remedy the harm State Farm has already inflicted on its policyholders. EFSN will argue that any order issued in this proceeding must include affirmative remedial measures to address the violations at issue. Drawing on the Farmers noncompliance consent order (CDI File No. NC03029253) as a model for the scope of available relief, EFSN will seek:

- A systematic review of all State Farm Eaton and Palisades Fire claims closed without full payment, focused on the violation categories the MCE identified, with a requirement that State Farm reopen and remediate files identified as improperly resolved;

---

which has been claimed as lost or destroyed; (7) the relative number of claims where the noncomplying act(s) are found to exist, the total number of claims handled by the licensee and the total number of claims reviewed by the Department during the relevant time period; (8) whether the licensee has taken remedial measures with respect to the noncomplying act(s); (9) the existence or nonexistence of previous violations by the licensee; (10) the degree of harm occasioned by the noncompliance; (11) whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter; (12) the frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter; (13) whether the licensee's management was aware of facts that apprised or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures; and (14) the licensee's reasonable mistakes or opinions as to valuation of property, losses or damages. (b) This section shall not bar, obstruct or restrict any right to administrative due process an insurer may be afforded under California Insurance Code Sections 790.05, 790.06, and 790.07.

- Reclassification of hygienist and environmental testing costs as loss adjustment expenses rather than charges against policy limits, for all open and identified closed claims, with repayment of any amounts wrongly charged against Coverage A;
- Corrective notice to all Eaton and Palisades Fire policyholders who received closing or denial letters stating the one-year suit limitation, confirming in writing the correct 24-month period applicable under Insurance Code section 2071(a) and the date from which it runs;
- Claims-level reporting obligations requiring State Farm to disclose, on a periodic basis, adjuster assignment histories, payment timelines, and denial reasons for all open Eaton and Palisades Fire claims, to enable CDI and EFSN to verify ongoing compliance; and
- A follow-on targeted market conduct examination within two years, with results published on the CDI website pursuant to Insurance Code section 12938.

72. EFSN will also seek to participate in any settlement discussions and to evaluate the adequacy of any proposed consent order before it is presented to the Commissioner for adoption. The Mercury enforcement proceeding — where settlement occurred over Consumer Watchdog's objections on terms that intervenor counsel concluded were inadequate — illustrates the consequence of excluding policyholder voices at that stage of the proceeding.

E. Discovery EFSN Will Seek

73. EFSN will seek discovery targeted to the evidence necessary to support the arguments identified above, pursuant to Government Code section 11507.6. Specifically, EFSN will seek:

- State Farm's complete claim-level data for all Eaton and Palisades Fire claims, including claim numbers, dates of loss, first contact dates, investigation commencement dates, adjuster assignment histories, payment dates and amounts, denial reasons, and claim status;
- All internal State Farm communications, guidelines, and training materials governing Eaton and Palisades Fire claim handling, including instructions on hygienist testing reimbursement, ALE approval, smoke damage scope, and adjuster reassignment procedures;
- All contracts and communications between State Farm and Servpro or other preferred vendors in connection with Eaton and Palisades Fire claims, including instructions on estimation methodology and scope-of-loss assessment;
- State Farm's internal escalation and approval records for hygienist testing reimbursement denials, to establish the organizational level at which such denials were made and authorized;
- State Farm's financial records sufficient to calculate aggregate underpayment to Eaton and Palisades Fire policyholders resulting from the violation categories the Department charged; and
- Stat Farm's claims reserve data for Eaton and Palisades Fire claims, to evaluate whether reserves were set at levels consistent with full payment of covered losses or at levels calibrated to suppress payment.

III. Evidentiary Hearings Should Be Conducted in Los Angeles

74. EFSN requests that all evidentiary hearings be conducted in Los Angeles County. Government Code section 11508(a) provides that the agency "shall fix" the time and place of the hearing. The Commissioner has full authority to designate Los Angeles as the hearing venue and should exercise it.

75. Every witness with firsthand knowledge of State Farm's claims-handling practices lives in Los Angeles County. Every property at issue is in Los Angeles County. The MCE itself was conducted at CDI's Los Angeles offices. Many of EFSN's members remain displaced, are managing active claims and contractor negotiations, and/or are caring for families in upheaval. They cannot realistically travel to Sacramento or Oakland to testify or must do so at much greater difficulty and personal cost than any State Farm or CDI personnel. Requiring them to do so will, as a practical matter, reduce the number of survivor witnesses able to participate and impoverish the record on critical issues such as penalty severity, remedial adequacy, and the human cost of the violations, which are precisely the issues the existing parties cannot supply. A Los Angeles venue keeps the proceeding connected to the harm it adjudicates.

CONCLUSION

76. EFSN's members are not spectators of this proceeding. They are the policyholders whose claim files were examined, whose homes and lives were affected by the practices charged in the OSC, and whose pending rights will be shaped by the outcome. The APA requires their participation because this proceeding will substantially affect their legal rights. And, at minimum, the ALJ should exercise their authority to permit intervention because EFSN's participation will make the record stronger, fuller, and fairer.

77. The reason is practical as well as legal. CDI has the examination record. State Farm has its defenses. EFSN has what neither side can fully supply: firsthand survivor testimony, more than 400 documented policyholder accounts, and proposed statistical and expert evidence. EFSN is best positioned to evaluate remedial proposals addressing the real-world consequences of State Farm's conduct. Its participation bears directly on the central dispute in this case, whether State Farm's violations were isolated errors or a general business practice under Insurance Code section 790.03(h), and on the adequacy of any cease and desist order, corrective notice, penalty, settlement, or other remedy.

78. EFSN therefore respectfully requests that the ALJ grant this Petition, admit EFSN as a full party intervenor with the rights identified above, and order that evidentiary hearings be conducted in Los Angeles County, where the fires occurred, where the policyholders live, and where the evidence is.

Dated: June 16, 2026

SINGLETON SCHREIBER, LLP

By: _____
MICHELLE M. MEYERS

CONSUMER WATCHDOG

By: _____
WILLIAM R. PLETCHER
PAMELA M. PRESSLEY

Attorneys for Petitioner/Plaintiff
Every Fire Survivor's Network

PROOF OF SERVICE
BY OVERNIGHT OR U.S. MAIL, FAX TRANSMISSION,
EMAIL TRANSMISSION AND/OR PERSONAL SERVICE

State of California, City of Sacramento, County of Sacramento

I am employed in the City and County of Sacramento, State of California. I am over the age of 18 years and not a party to the within action. My business address is 1414 K Street, Suite 300, Sacramento, California 95814, and I am employed in the city and county where this service is occurring.

On June 16, 2026, I caused service of true and correct copies of the document entitled

PETITION OF EVERY FIRE SURVIVOR'S NETWORK FOR LEAVE TO INTERVENE/PARTICIPATE; VENUE REQUEST

upon the persons named in the attached service list, in the following manner:

1. If marked FAX SERVICE, by facsimile transmission this date to the FAX number stated to the person(s) named.

2. If marked EMAIL, by electronic mail transmission this date to the email address stated.

3. If marked U.S. MAIL or OVERNIGHT or HAND DELIVERED, by placing this date for collection for regular or overnight mailing true copies of the within document in sealed envelopes, addressed to each of the persons so listed. I am readily familiar with the regular practice of collection and processing of correspondence for mailing of U.S. Mail and for sending of Overnight mail. If mailed by U.S. Mail, these envelopes would be deposited this day in the ordinary course of business with the U.S. Postal Service. If mailed Overnight, these envelopes would be deposited this day in a box or other facility regularly maintained by the express service carrier, or delivered this day to an authorized courier or driver authorized by the express service carrier to receive documents, in the ordinary course of business, fully prepaid.

I declare under penalty of perjury that the foregoing is true and correct. Executed on June 16, 2026 at Sacramento, California.

Kathy A. Bailey

Service List

Insurance Commissioner Ricardo Lara c/o Acting Special Counsel Kim Morimoto Office of the Commissioner **California Department of Insurance** 300 Capitol Mall, 16th Floor Sacramento, CA 95814 Tel.: (916) 492-3500 Fax: (916) 445-5280 Kim.Morimoto@insurance.ca.gov Abigail.Gomez@insurance.ca.gov	☐ FAX ☐ U.S. MAIL ☐ OVERNIGHT MAIL ☐ HAND DELIVERED ☒ EMAIL
Brennain Garber Darrel Secrest **California Department of Insurance** 1901 Harrison St., 4th Floor Oakland, CA 94612 Telephone: (415) 538-4111 Brennain.garber@insurance.ca.gov Darrel.Secrest@insurance.ca.gov	☐ FAX ☐ U.S. MAIL ☐ OVERNIGHT MAIL ☐ HAND DELIVERED ☒ EMAIL
Margaret Hosel Public Advisor Office of the Public Advisor **California Department of Insurance** 300 Capitol Mall, 17th Floor Sacramento, CA 95814 Tel.: (916) 492-3705 Fax: (510) 238-7830 Publicadvisor@insurance.ca.gov Margaret.Hosel@insurance.ca.gov	☐ FAX ☐ U.S. MAIL ☐ OVERNIGHT MAIL ☐ HAND DELIVERED ☒ EMAIL
Rebecca Vang Agent for Service of Process **State Farm General Insurance Company** 2710 Gateway Oaks Drive Sacramento, CA 95833	☐ FAX ☐ U.S. MAIL ☐ OVERNIGHT MAIL ☒ HAND DELIVERED ☐ EMAIL
COURTESY COPY Paula Lutes **State Farm General Insurance Company** Paula.Lutes@statefarm.com P.Lutes@statefarm.com	☐ FAX ☐ U.S. MAIL ☐ OVERNIGHT MAIL ☐ HAND DELIVERED ☒ EMAIL

EXHIBIT A

[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938, THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]

WEBSITE PUBLISHED REPORT OF THE TARGETED MARKET CONDUCT EXAMINATION OF THE CLAIMS PRACTICES OF

STATE FARM GENERAL INSURANCE COMPANY
NAIC # 25151 CDI # 1714-5

RELATED TO THE PALISADES AND EATON FIRES

AS OF JULY 31, 2025 - INCLUSIVE OF OPEN CLAIMS

ADOPTED MAY 1, 2026

STATE OF CALIFORNIA

CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

TABLE OF CONTENTS

FOREWORD

This report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer's proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report.

While this report contains violations of law that were cited by the examiners, additional violations of CIC § 790.03 or other laws not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company's responses, if any, have not undergone a formal administrative or judicial process.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

SCOPE OF THE EXAMINATION

Under the authority granted in Part 2, Chapter 1, Article 4, Sections 730, 733, and 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, a targeted examination was made of the claim handling practices and procedures in California of:

State Farm General Insurance Company
NAIC # 25151

Group NAIC # 0176

Hereinafter, the Company listed above also will be referred to as SFGIC, or the Company. The California Department of Insurance will be referred to as CDI or the Department.

This examination reviewed the Company's handling of claims filed as a result of the January 2025 Palisades and Eaton Fires in Los Angeles County.

The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claim files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results, including a review of consumer complaints and inquiries to CDI about the Company.

The review of the sample individual claim files was conducted at the offices of the California Department of Insurance in Los Angeles, California.

EXECUTIVE SUMMARY

In January of 2025, Los Angeles County experienced major wildfires – the Eaton Fire in Altadena and surrounding areas, and the Palisades Fire in Pacific Palisades. The examination was initiated as a result of consumer complaints and concerns received from wildfire survivor groups about State Farm General Insurance Company's handling of claims for these fires, and specific patterns of activity including the frequent reassignment of adjusters with little continuity of communication with homeowners, inadequate record keeping or information sharing among claims teams, delays in investigating claims and receiving payment, inconsistencies in the handling of claims, including those for Additional Living Expenses ("ALE"), re-working of prior estimates to lower payments, and processes for handling claims for smoke damage.

The examiners randomly selected a total of 220 SFGIC claim files for examination which included 70 closed claims, 70 open claims, 70 smoke and ash claims, and 10 claims with corporate complaints. These 10 claims with corporate complaints were cases in which the claimant complained directly to State Farm and did not also file a complaint with CDI. The examiners cited 398 alleged violations of the California Insurance Code and the California Code of Regulations from this sample file review. The examination found the following:

- Re-assignment of multiple adjusters without providing the claimant with a primary point of contact for continuity;
- Delays in commencing investigations, in making determinations to accept or deny, and in paying claims upon acceptance thereof;
- Failure to consistently include all appropriate payees on settlement checks;
- Failure to timely respond to communications, and failure to consistently send required status letters;
- Verbal denials of claims instead of the required written denial, including for claims for the cost of hygienist and environmental testing in cases of smoke damage;

- Charging payments for hygienist and environmental testing against the policy limit instead of treating these costs a loss adjustment expenses;
- Underpayments, including cases where depreciation was taken on structural components not normally subject to repair or replacement during the property's useful life;
- Misrepresenting to policyholders that the policy's "Right to Inspect" provision justified denial of claims for the cost of hygienist testing.

Details regarding all violations alleged during the examination are provided in the final section of this report.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

SFGIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD***	**SAMPLE FILES REVIEWED**	**NUMBER OF ALLEGED VIOLATIONS**
Smoke and Ash (closed and open)	2,900	70	134
Closed Claims	5,336	70	71
Open Claims	3,978	70	181
Claims with Corporate Complaints	87	10	10
General Findings	--	--	2
TOTALS		**220**	**398**

* The figures displayed in this column are based on the claim population data provided by State Farm in response to the Department's request for listings of claims in each of the identified categories.

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	SFGIC Number of Alleged Violations
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days until a determination is made.	79
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	41
CIC §2071 *[CIC §790.03(h)(1)]	The Company failed to properly advise the insured that the time limit to bring suit under the policy is extended to 24 months after inception of the loss related to a declared state of emergency.	29
CCR §2695.7(h) *[CIC §790.03(h)(5)]	The Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.	27
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed, upon receiving a communication from a claimant, to furnish the claimant with a response within 15 calendar days. The Company failed, in responding to a communication from a claimant, to furnish the claimant with a complete response based on the facts as then known.	22 4
CIC §1871.2(a) *[CIC §790.03(h)(3)]	The Company failed to include the California fraud warning on insurance forms.	25
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.	24
CCR §2695.9(f) *[CIC §790.03(h)(5)]	The Company applied betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property.	21
CIC §§2051 and 2051.5/CCR §2695.9(f) *[CIC §790.03(h)(3)]	The Company failed to document in the claim file all justification for the adjustment of the amount claimed because of betterment, depreciation, or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property.	3
CCR §2695.7(g) *[CIC §790.03(h)(5)]	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	20

Citation	Description of Allegation	SFGIC Number of Alleged Violations
CCR §2695.7(b) *[CIC §790.03(h)(4)]	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	18
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	18
CIC §14047(a) *[CIC §790.03(h)(3)]	The Company failed, after assigning three or more adjusters within a six-month period to a claim under a policy of residential insurance arising as a result of a declared state of emergency, to in a timely manner assign a real or personal property claims adjuster to be primarily responsible for a claim, provide the insured with a written status report, establish a primary point of contact for the insured, and provide the insured with one or more direct means of communication with the primary point of contact.	15
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to include a statement in its claim denial that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	11
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	7
CIC §14046(b)(1) *[CIC §790.03(h)(3)]	The Company failed to provide the claimant with a copy of the most recent notice describing the most significant California laws pertaining to property insurance policies, including those related to a declared state of emergency, as defined in Section 8558 of the Government Code, or other emergency declared by a public official no later than 15 calendar days from the date on which the insurer received notice of the claim.	5
CCR §2695.5(e)(2) *[CIC §790.03(h)(3)]	The Company failed, upon receiving notice of claim, to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.	4
CIC §790.03(h)(15)	The Company misled a claimant as to the applicable statute of limitations.	3
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.	3

Citation	Description of Allegation	SFGIC Number of Alleged Violations
CCR §2695.5(e)(3) *[CIC §790.03(h)(3)]	The Company failed, upon receiving notice of claim, to begin any necessary investigation within 15 calendar days.	3
CCR §2695.3(a) *[CIC §790.03(h)(3)]	The Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.	3
CIC §395 *[CIC §790.03(h)(2)]	In two instances, the Company failed to provide, free of charge, a complete copy of the insured's current insurance policy or certificate within 30 calendar days of receipt of a request from the insured after a covered loss.	2
CIC §2695.9(d)(3) *[CIC §790.03(h)(3)]	The Company failed to supply the claimant with a copy of the insurer adjusted estimate from the repair individual or entity of the insured's choice.	2
CCR §2695.9(d) *[CIC§790.03(h)(3)]	The Company settled the claim on the basis of a written scope and/or estimate without supplying the insured with a copy of each document upon which the settlement was based. The Company failed to prepare the estimate in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction.	1 1
CCR §2695.4(a) *[CIC §790.03(h)(1)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	2
CIC §790.034(b)(1) *[CIC §790.03(h)(3)]	The Company failed, upon receiving notice of claim, to provide the insured with a copy of §790.03 of the California Insurance Code within 15 calendar days.	1
CCR §2695.7(f) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim.	1
CIC §10103.7(b)(1) *[CIC §790.03(h)(5)]	The Company failed to offer a payment under the contents (personal property) coverage in an amount no less than 30 percent of the policy limit applicable to the covered dwelling structure, up to a maximum of two hundred fifty thousand dollars ($250,000), without requiring the insured to file an itemized claim if the residence was furnished at the time of the loss.	1

Citation	Description of Allegation	SFGIC Number of Alleged Violations
CIC §790.03(h)(5) General Finding	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	1
CIC §790.03(h)(1) General Finding	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	1
Total Number of Alleged Violations		**398**

***DESCRIPTIONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES**

CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
CIC §790.03(h)(2)	The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
CIC §790.03(h)(4)	The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.
CIC §790.03(h)(13)	The Company failed to provide promptly a reasonable explanation of the bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company should address corrective action for other jurisdictions when applicable.

Money recovered within the scope of this report was $41,914.90 as described in section numbers 7, 9, 10, 11, and 15 below.

1. In 79 instances, the Company failed to provide written notice of the need for additional time every 30 calendar days until a determination is made. The Company failed to transmit status letters in 44 instances. In the 35 remaining instances, the status letters were sent late. The Department alleges these acts are in violation of CCR §2695.7(c)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings of non-compliance with CCR §2695.7(c)(1). The Company states these were unintentional oversights by claim handlers and were file-specific errors. The Company conducted team meetings in the 4th Quarter of 2025 and reminded claim handlers of the need to send timely status letters, and the importance of following established processes and procedures in compliance with California regulations. The Company states it does not believe these instances rise to the level of a violation of CIC §790.03(h)(3).

2. In 41 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Company did not name the correct payees on indemnity checks as follows:

- In 19 instances, not all the named insureds were listed as payees.
- In 10 instances, the Company erroneously named non-insureds as payees.

- In 7 instances, the "Trust" account was not named as a payee
- In 5 instances, the mortgagee and/or an additional mortgagee was not named as a payee

The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees to the findings that indemnity payments were not accurately paid to all correct payees, and/or that the Company was not properly paying all pertinent legal homeowners with financial interest. The Company held team meetings to remind the California claim handlers that all legal payees should be included in indemnity settlements.

3. In 29 instances, the Company failed to properly advise the insured that the time limit to bring suit under the policy is extended to 24 months after inception of the loss related to a declared state of emergency. The Department alleges these acts are in violation of CIC §2071 and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges that in a state of emergency, the statute of limitation is extended to 24 months. In these instances, the Company agrees that no required written notice was sent in 18 instances; in 11 instances, the notice provided incorrectly stated the time period to be one year. The Company discussed this non-compliance issue in team meetings conducted in the 4th Quarter of 2025. The Company does not believe that these instances rise to the level of a violation of CIC §790.03(h)(3).

4. In 27 instances, the Company failed, upon acceptance of the claim, to tender payment within 30 calendar days. The Company issued payments on accepted claims beyond the regulatory timeline. The Department alleges these acts are in violation of CCR §2695.7(h) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: In 22 instances, the Company agrees with the findings. The Company states these were file-specific errors and does not believe they rise to the level of a violation of CIC §790.03(h)(5). These were unintentional oversights on the part of the claim handlers. As a result of these findings, the Company conducted team meetings with California claim handlers for compliance reinforcement in the 4th quarter of 2025.

In five (5) instances, the Company believes it did not violate CCR §2695.7(h) which requires the payment of an accepted claim within 30 days. The Company states status letters were sent requesting additional time to review estimates in these instances.

Summary of the Department's Evaluation of the Company's Response: There were undisputed portions of these claims that the Company had accepted. Therefore, the undisputed amounts should have been paid within 30 days of the acceptance. Instead, the Company made repeated extensions to review estimates after accepting the claim for periods extending up to four months before issuing payment. This is an unresolved issue.

5. In 26 instances, the Company failed to comply with the requirements of §2695.5(b) as described below:

a) **In 22 instances, the Company failed, upon receiving a communication from a claimant, to furnish the claimant with a response within 15 calendar days.**
In these instances, the Company received communications and failed to respond within the regulatory timeline.

b) **In 4 instances, the Company failed, in responding to a communication from a claimant, to furnish the claimant with a complete response based on the facts as then known.**
In two instances, the Company failed to furnish timely a copy of the policy to an insured's attorney in one case, and to an insured's Public Adjuster in the other. In the third instance, the Company failed to furnish supporting documents requested on a claim denied to an insured's Public Adjuster. In the fourth instance, the Company failed to respond to a request for deductible information.

The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response to a): In 14 of 22 instances, the Company agrees that communications were not responded to within 15 calendar days. These were unintentional oversights on the part of the claim handlers. The Company conducted team meetings in the 4th Quarter of 2025 for compliance reinforcement. The Company further states it does not believe these instances rise to the level of a general business practice violation of CIC § 790.03(h)(2).

However, the Company does not agree to the following eight (8) of 22 instances:

- In three instances, the Company states it received communications from Public Adjusters referencing earlier correspondence to the Company. However, there is no record in the claim file documents of prior communication unanswered.

- In two instances, the Department alleges the Company received an email from the insured's attorney on April 22, 2025, stating that a phone message wasn't

responded to within 15 days; and on July 11, 2025, stating that another email was not responded to within 15 days. The Company disagrees that it was not engaged in continuous communication with the insured's attorney prior to, and after receiving the attorney's email that was referenced by the Department. The Company further states it did not receive any correspondence from the attorney as claimed in the email. The Company states it responded within 15 days to correspondence that is documented in the file.

- In one instance, the Department alleges the Company responded six months after receiving a lease agreement for temporary location. The Company disagrees. The Company requested documentation within the regulatory timeframe. To date, the Company has not received documentation. The Company has offered and remains available to address the reasonably necessary increase in costs incurred by the insured to maintain their normal standard of living.

- In one instance, the Department alleges the Company did not respond to the insured's request to obtain liability/Renter's policy as part of the lease agreement. The Company disagrees and states it has requested documentation of the incurred fee. To date, the Company has not received documentation. The Company has offered and remains available to address the reasonable and necessary increase in costs incurred by the insured to maintain their normal standard of living.

- In one instance, the Department states the insured requested a certified copy of her policy and was instead given an uncertified copy 28 days later. The Company does not believe it is required to provide the insured with a certified copy of the policy and cites CIC §2071 which states in part, "an insurer shall provide to the insured, free of charge, a complete, current copy of their policy within 30 calendar days of receipts of a request from the insured. The policy must include the full insurance policy, any endorsements, and the declarations page."

Summary of the Company's Response to b): In three instances, the Company agrees that it failed to respond to a communication with a complete response based on the facts as then known. These were unintentional oversights on the part of the claim handlers. The Company conducted team meetings in the 4th Quarter of 2025 for compliance reinforcement.

The Company, however, does not agree in one instance pertaining to an insured attorney's request for confirmation of the insured's deductible. The Company states the Claim Specialist left a message for the insured attorney within the regulatory timeframe. Further, the Company states it does not believe this instance is a violation of CIC § 790.03(h)(2).

Summary of the Department's Evaluation of the Company's Response: In the eight (8) disputed alleged violations under (a), the files reflect that the Company did not respond to communications. In the one (1) disputed allegation under (b), the file reflects the Company did not respond to the communication. These are unresolved issues.

6. In 25 instances, the Company failed to include the California fraud warning on insurance forms. In 18 instances on the Attestation in Support of Personal Property Total Loss Advance form and in one (1) instance on the Designation Authorization form the Company failed to include fraud warning language. In six (6) instances Company claim forms included fraud warning language, however the language used did not align with the requirements of California law. The Department alleges these acts are in violation of CIC §1871.2(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings and states that the six (6) that contained incorrect language were unintentional oversights on the part of the claim handlers. The Company held team meetings to reiterate the importance of sending correct form letters with correct California fraud language in all written communications to the insureds.

The Company further states that it believes the Attestation in Support of Personal Property Total Loss Advance and the Designation Authorization forms do not fall within the requirements of CIC §1871.2(a); however, the Company will add the fraud language to these forms.

Department's Evaluation of the Company's Response: The Department believes the claim forms require fraud language per CIC § 1871.2(a).

7. In 24 instances, the Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given. These instances pertained to the Company's failure to provide written denials in whole or in part, on claims for Additional Living Expenses (ALE) and other items such as damage to contents, medical expenses, claim for wage loss, air purifiers, valet parking, spa treatments, resort fees, haircuts, reimbursement for additional mileage incurred, a privacy screen, a request for a neighborhood security guard with cost split among neighbors, cost for a storage unit, and the cost of hygienist and safety testing for contaminants.

The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company responds to the findings as follows:

The Company agrees with the findings in 20 of the instances that it failed to provide written denials in whole or in part and/or made verbal denials of claims. The Company states these were unintentional oversights on the part of the claim handlers. The Company further stated that each claim is investigated based on the facts, circumstances, location, environmental history and evidence presented. The Company reopened claims as applicable and has continued to review claims presented. In one case involving the claim for the cost of hygienist testing, the Company has determined this to be covered and has issued payment of $1,260 to the insured.

The Company conducted training in the 4th Quarter of 2025 for its claim handlers for compliance reinforcement with the requirements of the regulation. The Company stated that it does not believe these instances rise to the level of a violation of CIC §790.03(h)(13).

In the remaining four instances, the Company does not agree with the findings. The Company stated these four instances pertained to wear and tear damage to vehicles, a claim for increased coverage, spa services and haircuts, and a status letter was sent instead of a denial letter. The Company does not agree that it violated this regulation because it was in the process of determining what claims were part of the ALE claim. The Company has since followed up with the insureds to determine what will be paid, and what will be denied in writing.

Summary of the Department's Evaluation of the Company's Response: The regulation requires where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing. The Company failed to do so in the disputed instances. This is an unresolved issue.

8. In 21 instances, the Company applied betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property. These instances pertain to the depreciation of the dwelling/structural components. In each instance, the Company applied depreciation to one or more structural components not normally subject to repair and replacement during the useful life of the property and/or during the items' lifespan. The Department alleges these acts are in violation of CCR §2695.9(f) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company disagrees with the findings. The Company states all physical property has a useful life expectancy. In these cases of partial loss to the structure, a deduction for physical depreciation applied only to components of a structure that are normally subject to repair and replacement during the useful life of that structure. Depreciation was taken based on the average life expectancy, age and condition of the items needing to be replaced in accordance with the insureds' Rental Dwelling Policy.

Summary of the Department's Evaluation of the Company's Response: The Company depreciated components such as insulation, foundations, concrete piers, steel rebar, sheathing, framing, lumber, baseboards, molding, sub-flooring, lath & plaster, wiring, masonry and stone, a meter mast for overhead power, a meter conduit extension for underground power, a grounding rod, sheathing, weatherproofing, siding, drywall, paneling, wood floors, marble/granite countertop, shower pan, toilet, etc. Although the Regulations do not delineate what types of specific structural components are normally subject to repair and replacement or property that is excluded from depreciation, these examples have a useful life/life expectancy of decades or more years and will not depreciate during the items' lifespan absent some known reason such as damage sustained in a prior loss. This is an unresolved issue.

9. In three instances, the Company failed to document in the claim file all justification for the adjustment of the amount claimed because of betterment, depreciation, or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property. These instances are described below:

a) In one instance, the Company applied "average" condition on all items of the insured's personal property inventory when there was higher than average condition for some items.
b) In one instance, the Company erroneously deducted depreciation to its settlement amount and refunded it back upon discovery of its mistake. However, there is no documentation on the claim file to justify the original amount paid.
c) In one instance, the Company applied depreciation across the board at 0.15 (15%) in the amount of $16,792.78 from Coverage B (Personal Property). The claim file notes were void of any specific documentation regarding each item's age, life expectancy, and condition.

The Department alleges these acts are in violation of CIC §§2051 and 2051.5, and CCR §2695.9(f), and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings as described below:

a) The Company reopened the claim and issued $169.53 as the Payment Tracker Worksheet has been updated to reflect the condition of all personal property items as provided by the insured.
b) The Company indicates depreciation was inadvertently withheld and this error has now been corrected with the insured notified in writing.
c) The Company has reopened the claim and reached out to the insured on February 12, 2026, to review the depreciated items in question. The insured expressed no interest in pursuing the matter and claim has been closed.

The Company states these were file-specific errors by its claims handler and do not reflect a general business practice. The Company does not believe these instances are indicative of the pattern and practices of the Company's overall claim handling and therefore do not rise to the level of a violation of CIC §790.03(h)(3).

10. In 20 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. These instances are described as follows:

a) Home supplies and furniture rental invoices were not paid.
b) The contents claim was considered business use and not paid.
c) An estimate for dwelling damage was underpaid.
d) A line-item estimate for HEPA Vacuuming (PER SF) is missing square footage resulting in $0.00 payment.
e) Mileage claim for 1,100 miles was not paid.
f) Miscalculation of mileage reimbursement rate resulted in underpayment.
g) Loss of Rent calculation resulted in a 21.55% reduction in benefits.
h) Perishable food in the refrigerator due to power outage was not considered.
i) Damage to the sprinkler system was not paid.
j) The dwelling extension smoke damage cleaning of the garage was not paid.
k) The hygienist report of the insured's Public Adjuster was not considered by the Company for an independent assessment of damage.
l) A $500.00 single limit of liability was incorrectly applied to the Company's estimate on Trees/ Shrubs/ Other Plants
m) An "Internal Use Only" document reflects an additional $2,500.00 was available but not paid to the insured under Coverage B, Contents.
n) A privacy screen was not paid.
o) The Company did not confirm damage to a washer and dryer
p) The insured's estimate from his restoration vendor was $159,287.50 which was reduced by the Company by $128,783.32. The Company advised the insured that it would not pay for applying odor counteractants, seal stud for odor control, cleaning cabinetry, hydroxyl odor counteractant, vapor odor counteractant. The Company downgraded the smoke damage assessment from "heavy" to "light" damage and informed the insured that it would only pay for contents cleaning and only content manipulation from one room to another.
q) Regarding reimbursement of meals while eating out, the Company verbally advised the insured multiple months into the claim that meals out would not be covered under Additional Living Expense (ALE) because the insured had access to a kitchen.
r) The Company's estimate paid on April 22, 2025 did not account for overage and the insured's deductible of $3,000.00 was applied. Additionally, the estimate for Code upgrades of only $18,334.16 appeared low for the age of the home (78 years old). Finally, the policy coverage shows an additional $2,500.00 available for jewelry under contents, although the Company did not pay it.

s) The estimate did not include reasonable and necessary replacement of non-salvageable items observed during inspection such porous material items like bedding, pillows, and mattress' given the severity of the loss and the insured's health issues.
t) The insured's policy limit for Coverage A of $575,295.00 was reduced by the estimated damages for landscaping in the amount of $13,377.69 which on a 1,300 square foot house the Company has only allowed about $432.00/square foot.

The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees to 15 of the findings and issued payments as described below:

a) Home and furniture rental invoices for $1,237.30 have now been paid.
b) The contents claim for purchases from Best Buy has now been reimbursed $156.45.
c) An additional payment of $2,922.16 was issued for the difference in dwelling damage.
d) The Company reached out to the named insured to confirm the square footage of the attic. Upon determination of the appropriate measurements, the Company will update the estimate and issue payment for the supplement.
e) The Company has now paid $491.40 to reimburse for the 1,100 miles.
f) The appropriate form was not used to calculate mileage. However, the Coverage C policy limits had already been exhausted.
g) The adjuster improperly deducted from the Loss of Rent (LOR) settlement and the claim was reopened to issue a supplemental LOR payment of $96,039.53 including a letter explaining the LOR revision and payment. The Company issued this supplemental payment on August 29, 2025 prior to the Department's inquiry.
h) The policyholders were contacted regarding their food loss and payment for $500.00 was issued.
i) The Company contacted the insured to obtain status on the sprinkler system on October 29, 2025. The insured responded that they did not wish to pursue additional funds for the sprinkler system.
j) The Company issued payment of $2,098.76 for the dwelling extension smoke damage cleaning of the garage.
k) The hygienist report submitted by the insured's Public Adjuster was not reviewed and this was a file-specific error by the adjuster. The Company reopened the claim for further evaluation of coverage, and any additional reports will be provided to the insureds and their Public Adjuster as they become available.
l) The Company's estimate has been updated to reflect the correct application of the single limit of liability per tree. An additional payment of $2,242.09 was issued.
m) The Company inadvertently overlooked payment for the Option limit of $2,500.00. The Company reopened the claim to issue payment to the insured for $2,500.00.

n) The privacy screen is necessary and reasonable to maintain their standard of living. This was a file-specific error by the claim handle, and the Company has now paid the insured $254.00.
o) The washer and dryer were rented with the condominium. ServPro provided the list for the named insured's appliances that need to be discarded due to lead. Payment for the replacement of appliances to include the washer and dryer was issued in the amount of $1,756.00.

The Company does not agree to the findings in the remaining five instances as described below:

p) The Company wrote an estimate for light cleaning of all three levels. The scope of damages contained in "Level 3" was an error by the claim handlers who mistakenly copied the contractor's scope for "Heavy" damage which resulted in overpaying the insured.

q) It was not until June 17, 2025, that the claim handler had access to review ALE documentation provided by the Public Adjuster. Once this information was reviewed, the Company communicated settlement under the ALE portion of the claim.

r) The Company's estimate dated April 22, 2025, did account for the amounts over limit on coverage lines. The estimate provided to the insured will show the policy deductible regardless of how much over the limit a particular coverage line is. Also, Payment of Coverage B – Option Jewelry/Furs (Option JF) is currently premature. The Company included all necessary lines for the new "build" based on what the Company knows at this time and current codes. However, as a result of the Department's inquiry, the Company paid the insured $1,338.61 for additional living expenses.

s) The status letter of June 27, 2025, includes the Company's request for an estimate to clean the insured's personal property and an inventory of non-salvageable items. The status letter of August 8, 2025 outlines the pending personal property inventory and offers our assistance.

t) The Company continues to be available to discuss this estimate with the insureds if they have additional information to present. The Company believes the estimate accurately reflects the information available when written. The Company estimate was only a draft copy at that time prior to review on February 10, 2025, wherein the labor efficiency used was determined to be incorrect. The Company has since changed the labor efficiency from restoration/remodel/service to "New" so that the revised estimate becomes accurate.

Summary of the Department's Evaluation of the Company's Response:

p) The Company acknowledges that the claim handler mistakenly copied the contractor's scope for heavy damage which it claimed resulted in overpaying the insured. However, the Company failed to explain to the insured its assessment of damage as light cleaning versus the contractor's assessment of heavy damage.

q) The claim file does not reflect that the Company disclosed the insured's applicable coverages, specifically advising the insured under Coverage C that increased meal expenses for eating out would not be covered when a kitchen is available to the insured at their temporary displacement location during the contact call on January 14, 2025. The file documentation reflects that this coverage limitation was not communicated to the insured until June 18, 2025, at which time the Company explained that meal expenses would not be reimbursed. By then the insured had already relied to their detriment that these "incurred expenses" would be covered. The insured had been incurring meal costs for eating out and submitting receipts from the onset of the loss; however, the Company did not tell them these additional living expenses would not be covered over 5 months at which time it appears the Company was estopped from asserting this policy language.

r) The deductible taken from the exhausted limit from Coverage A should have been absorbed using other available coverages on the policy.

s) The Company inspected the property on January 22, 2025 and the inspection notes state there was heavy smoke odor with ash and soot present. The parking garage, and the buildings behind and to the side of the insured's property were 100% total fire losses. The Company did not assign a vendor to at least assess the insured property damage, and the supplement did not use the current labor rate for when it was written.

t) The Company acknowledges that it incorrectly used a labor efficiency rate of restoration/remodel/service instead of new, however it did not explain this error to the insured. While the Company continues to be available to discuss this estimate with the insureds if they have additional information to present and believes that the estimate accurately reflects the information available when written, its estimate to rebuild is not consistent with the likely cost to rebuild give the demands for labor and materials in the Palisades area.

These issues are unresolved.

11. <u>In 18 instances, the Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.</u> The Company received proof of claim for Additional Living Expenses (ALE), damage to personal property, cleaning estimates, repair estimates, lost jewelry, a signed lease agreement, smoke radiation, personal property pack, environmental testing expenses, landscaping repairs, and debris removal. The Company did not accept or deny these claims in whole or in part within 40 calendar

days of receipt. The Department alleges these acts are in violation of CCR §2695.7(b) and are unfair practices under CIC §790.03(h)(4).

Summary of the Company's Response: The Company acknowledges the findings described below:

In 11 instances, the Company agrees that the Company failed to accept or deny the claims within regulatory timelines. The Company states that these were file-specific errors of the claim handlers that are not indicative of the pattern and practices of the Company's overall claim handling. As a result of Department inquiries, the Company reopened one claim and paid $12,923.98 for debris removal fees and $1,316,37 for landscaping fees that were listed in the contractor's estimate, and reopened another claim and paid $1,019.25 for personal property and additional living expenses.

The Company conducted team meetings in the 4th Quarter of 2025 to reinforce the need for compliance with California claims handlers. The Company states it does not believe these instances rise to the level of a violation of CIC §790.03(h)(4).

In seven instances, the Company does not agree with the findings because the claims have since been accepted and paid; the limits were already paid, and no additional funds are available; and/or the Company continues with the process of reviewing the claims.

Summary of the Department's Evaluation of the Company's Response: Regardless of whether the claims have ultimately been accepted or paid or remain to be paid in the disputed seven instances, the Company is required by regulation to accept or deny them within the regulatory timeline of 40 days. In these instances, the Company did not accept or deny the claims until well beyond 40 days. Examples among these instances include: pool and driveway damages were accepted 94 days late; the pool bid, balcony bid, and window bid accepted 85 days late; the roof area inspection accepted 86 days late; and interior and exterior testing accepted 87 days late.

The Company has not stated how it intends to ensure that future claims will be accepted or denied within the 40-day regulatory timeframe. Any ongoing discussions with the insureds or their representatives do not excuse non-compliance, unless they are clearly documented as to the basis of additional time needed. This is an unresolved issue.

12. In 18 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. These instances are described as follows:

a) The Company delayed assigning a hygienist for 88 days after receiving a repair estimate.
b) There was no active investigation documented in the file for 88 days.

c) The Company handled the claim inconsistently which resulted in overpayment for displacement, the use of varying rates to calculate mileage, and unclear settlement letters to the insured.
d) The claim file lacked clear documentation of the insured's displacement locations, dates, and whether they included a kitchen. It is unclear if the insured incurred additional ALE expenses beyond the advance, and if additional payments were owed.
e) The Company did not review the insured's Covenants, Conditions and Restrictions (CC&Rs) claim file to evaluate the responsibility of the insured versus the Homeowners Association. (HOA).
f) The adjuster failed to explain the breakdown of the Loss of Rent (LOR) despite multiple email requests from the insured. The Team Manager also instructed the adjuster to contact the insured which was not done.
g) There was a delay of over two months (April 16, 2025 to June 24, 2025) in inspecting a property after the First Notice of Loss (FNOL), despite multiple follow-ups from the insured's attorney.
h) The Company failed to set reserves for a Loss of Rent (LOR) claim following a tenant evacuation.
i) The Company did not actively pursue necessary documentation for a Loss of Rent (LOR) claim, and the file was noted as "No LOR noted". This resulted in the claim file being prematurely closed before investigation was complete.
j) The insured's home was a total burn, and he was incurring Additional Living Expenses (ALE) for lodging as of January 7, 2025. He provided the Company with a signed lease agreement in April 2025. The Company sent multiple notices advising it needed additional time and did not validate the ALE claim for $18,000.00 per month until July 2025.
k) The Company inspected the insured's property on February 14, 2025. The insured's attorney provided proof of claim for pack-out expenses, demolition and repairs on March 26, 2025. Following this date, the attorney sent multiple emails inquiring about delays, while the Company sent numerous letters stating a need for additional investigation time.
l) There was no adjuster activity in the file for the period of 30 days between May 5, 2025 and June 4, 2025.
m) The Company did not follow its process for the insured's LOR claim which caused delays and confusion, an incorrect settlement amount, a referral to the wrong team, and telling the insured a check was ready to be picked up at the Catastrophe tent when it was not approved. The Company did not advise the insured that a Schedule E tax form was needed to calculate the settlement.
n) The insured informed the Company that he replaced his garage door due to wind damage; however, the Company closed the file without following up on documentation to pay the claim. The Company has an affirmative duty to investigate and a duty to follow up on missing information rather than closing the claim.

o) The Company did not explain the LOR breakdown to the insured, despite the insured's multiple emails requesting clarity. There was also a manager's direction to call the insured which the adjuster failed to do.
p) The insured's attorney sent multiple emails to set up an inspection and asserted the Company did not communicate back for two months.
q) The insured obtained an estimate from Servpro to inspect the property on January 13, 2025. Servpro wrote an estimate for smoke damage remediation in the amount of $72,488.30 that included asbestos mitigation in the amount of $18,250. The Company assigned Servpro in April to write an estimate on its behalf on April 16, 2025. Servpro wrote an estimate for the same damages in the amount of $44,373.18. Six months elapsed to resolve the claim.
r) The Company assigned the claim to Servpro to inspect the property on January 20, 2025, however it did not follow up until March 1, 2025, only after a management review (40 days). Further, the Company did not prepare an itemized estimate after receiving Servpro's bulk cleaning estimate which delayed reconciliation of estimates. The Company also delayed inspection of personal property items. This inaction contributed to additional issues when the Company later discovered that Servpro had bagged and disposed of said items while not clearly documenting the items discarded. As of August 19, 2025, the personal property portion was not settled, and the Company advised the public adjuster that it could not agree to all items being claimed at that time.

The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees to the findings that it failed to conduct a diligent, thorough, and fair investigation in the 16 instances labeled (a) through (p) above. The Company stated that these were file-specific errors, and conducted team meetings during the 4th quarter of 2025 to reiterate requirements and the need for compliance with California claim handlers. Where applicable the Company has now reopened claims and otherwise followed up with insureds to complete appropriate investigation and in one of these instances, as result of the Department's inquiry, paid the insured $5,500.00 for lost rent.

In the last two instances, the Company does not believe it failed to conduct a diligent, thorough and fair investigation as described below:

q) The Company does not agree with the finding and states the first Servpro provider assigned did not conduct an inspection, and his identity is not known. The Servpro estimate conducted for the Company was received on April 11, 2025. The Company, upon settlement discussions with the insured settled the smoke damage remediation on May 16, 2025. The Company further states it is a normal process to have reconciliation with the contractor for differences in opinion. The claim for asbestos remediation was reconciled and settled on December 1, 2025.

r) The Company does not agree with the finding. The Company created an estimate-only assignment on January 25, 2025, and informed the insured the same day. Follow-up contact occurred on February 28, during which the insured did not disclose they were using a new vendor. The Company first received the new vendor information on March 5 and the estimate on March 7. The bid was reconciled and accepted on March 21, however it remained within the previously issued advance payment. All other issues were resolved within 14 days of receiving the contractor's estimate. The file shows multiple offers to help the insureds complete their personal property inventory, including offers for in-person assistance.

Summary of the Department's Evaluation of the Company's Response: With respect to item q), a standard reconciliation process where the insurer and the Public Adjuster (PA) collaborated to refine the claim scope should not take several months particularly on the issue of asbestos abatement, which was evident from the onset of the claim. It took almost a year to get settled and the Company's use of a preferred vendor Servpro may present a conflict of interest. The Company has not proposed corrective action.

With respect to item r), the lack of contact with Servpro and the Company's failure to prepare an itemized estimate after receiving Servpro's bulk cleaning estimate delayed reconciliation of estimates. The Company has not proposed corrective action.

These issues are unresolved.

13. In 15 instances, the Company, after assigning three or more adjusters within a six-month period to a claim under a policy of residential insurance arising as a result of a declared state of emergency, failed to in a timely manner assign a real or personal property claims adjuster to be primarily responsible for a claim, provide the insured with a written status report, establish a primary point of contact for the insured, and provide the insured with one or more direct means of communication with the primary point of contact. The Department alleges these acts are in violation of CIC §14047(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings and responds as follows:

In 11 instances, the Company agrees it did not provide the insureds with a primary point of contact following the assignment of a third or subsequent claims adjuster. The Company indicates these were file-specific errors on the part of the claim adjusters and are not indicative of the pattern and practices of the Company's overall claim handling. The Company conducted refresher training in team meetings held in the 4th Quarter of 2025.

In four instances, the Company does not agree it failed to comply with CIC §14047(a). The Company admits there were 4 to 5 adjusters assigned to three of these claims, and a team consisting of seven members assigned to the fourth. "Other performers" were also assigned to aid in claim handling for these teams. The Company stated it considers the entire team to be the claim owner, and is therefore the primary point of contact regardless of which team member is communicating with the insured. The Company further stated that reassignment and/or status letters were sent when claims were given to a new claim owner.

Summary of the Department's Evaluation of the Company's Response: The Company's process in these cases failed to provide the insureds with a written status report and/or to establish a primary point of contact with one or more direct means of communication, and instead created confusion for the insureds who were left feeling like they were given the "run around" by the Company. The Company has not proposed any change in process to ensure compliance. This is an unresolved issue.

14. In 11 instances, the Company failed to include a statement in its claim denial that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that the right to review by the California Department of Insurance was not referenced in its denial letter. In nine instances, the Company provided the referral language in revised letters to the insureds. In two instances, the claims were reopened and paid.

The Company held team meetings in the 4th Quarter of 2025 with California claim handlers to reiterate the need to include this required communication in its denial letters. The Company does not believe these instances rise to the level of a violation of a CIC §790.03(h)(3).

15. In seven instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. These instances are described below:

a) In two instances on one claim, the Company sent denial letters for hygienist testing stating that the testing was not payable because it would be considered a safety inspection. The initial invoice for $4,125.00 was denied on March 6, 2025 and the supplemental invoice for $5,985.00 was denied on June 10, 2025.
b) In one instance, the Company misrepresented to the insured's son that payments under Coverage C – Loss of Rents would be issued only as incurred.

c) In one instance, the Company issued a $100,000.00 advance payment, coded under personal property (COV B). The Company, however, misrepresented that it had to withhold $10,000.00 to account for the insured's deductible.
d) In one instance, the Company misrepresented that the policy does not pay for temporary housing outside the country.
e) In one instance, the Company misrepresented that air testing may be approved if completed before mitigation, although not afterward due to the "contamination exclusion."
f) In one instance, the Company advised the insured that he would not be entitled to the Loss of Rent benefit if the tenant decided to cancel the lease.

The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges the findings as follows:

a) The Company revised the State Farm estimate and had already issued payment on November 26, 2025 for the initial invoice. As the result of the Department's inquiry, an additional payment was issued on December 20, 2025 for $5,985.00.
b) The Company agrees with the findings and states that this was a file-specific error and is not indicative of the pattern and practices of its overall claim handling. State Farm has provided payment for our insured's entire claim under Coverage C – Loss of Rents during an in-person meeting on April 29, 2025, in accordance with the applicable policy language.
c) The Company agrees that the withholding of $10,000.00 was an error which was then corrected on February 5, 2025, with an additional payment of $10,000.00.
d) The Company agrees with the finding and is currently working with the insured on their incurred additional living expenses, including but not limited to housing costs, which may have been incurred while they resided outside the United States.
e) The Company agrees with the finding regarding this inquiry of post-cleaning testing and states it was an unintentional oversight on the part of the claim handler.
f) The Company agrees with the finding about the incorrect information provided regarding the Loss of Rents policy provision. The claim was re-opened, and the correct Loss of Rents policy provision information was provided to the insureds in a letter dated August 29, 2025.

The Company states that team meetings were held in the 4th quarter of 2025 with all California claim handlers for compliance reinforcement. The Company states it does not believe the above instances are indicative of the pattern and practices of the Company's overall claim handling and therefore do not rise to the level of a CIC 790.03(h)(1) violation.

16. In five instances, the Company failed to provide the claimant with a copy of the most recent notice describing the most significant California laws pertaining to property insurance policies, including those related to a declared state of

emergency, as defined in Section 8558 of the Government Code, or other emergency declared by a public official no later than 15 calendar days from the date on which the insurer received notice of the claim. Specifically, the Declared Disaster Forms were not sent in four (4) instances and were sent beyond the statutory timeline in one (1) instance. The Department alleges these acts are in violation of CIC §14046(b)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings and states that team meetings were held in the 4th quarter of 2025 with all California claim handlers to reiterate the need to send required documentation timely. The Company however does not believe these instances rise to the level of a CIC §790.03(h)(3) violation as these were file-specific errors by the claim handlers.

17. In four instances, the Company failed, upon receiving notice of claim, to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. These instances are described below:

a) The Company failed to provide the insured within 15 calendar days the necessary instructions regarding Loss of Rent, such as what documentation is required and steps to receive payment.
b) The Company provided the insured the contents form 48 days after the claim was reported.
c) The Company did provide proper reasonable assistance upon notice of claim. The Company did not assign its preferred mitigation vendor, Servpro, to assess smoke damage, which is the Company's standard process for smoke and ash claims.
d) The Company did not give instructions on the process of food abatement within 15 calendar days which would impact on the insured's meal reimbursements. The claim was reported on January 10, 2025; however, the Company did not provide documentation on the food abatement process until March 21, 2025 via status letter – 70 days after the claim was reported

The Department alleges these acts are in violation of CCR §2695.5(e)(2) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings as follows:

a) The Company agrees the claims handler failed to address the Loss of Rent coverage and this was a file-specific error by the claim handler.
b) The Company agrees the Contents form was provided late and states this was an unintentional oversight by the claim handler.

The Company conducted team meetings in the 4th quarter of 2025 to remind its claim handlers of the importance of following required regulatory timelines.

c. As to item (c) above, the claim was reported late on May 19, 2025, 131 days after the date of loss, which presented a potential breach of contract by the insured. Thus, the loss was handled under a Reservation or Rights which on June 4, 2025 while the Company was investigating coverage issues.
d. As to item (d) above, the claim handler explained ALE coverage and how it applied on January 25, 2025. The Company's file note of March 5, 2025 reflects "NI (*insured*) to keep a list and receipts of expenses…."

Summary of the Department's Evaluation of the Company's Response: The Department's position on items (c) and (d) are as follows:

c) A Reservation of Rights for late notice of claim does not absolve the Company of its duty to perform and assist the insured as required by this regulation.

d) As to food abatement, the following notes on the file reflect there was no instruction or assistance within the 15-day regulatory timeline The claim was reported on January 10, 2025. The Company's file note from claim dated July 7, 2025, includes team manager's input when stating "CO discussed food not being abated by prior adjuster from 1/7/25-2/28/25. TM advised CO to only abate most recent food receipts since no one discussed abatement with PH's. CO has deleted individual line entries for food and moved the total cost of food pre-abatement to misc. CO will add food receipts from May to ALE WS for abatement".

These issues remain unresolved.

18. In three instances, the Company misled a claimant as to the applicable statute of limitations. The Company sent closing and denial letters to the insured advising of statute of limitation and stating that "the action must be started within one year after the date of loss or damage." The Department alleges these acts are in violation of CIC §790.03(h)(15).

Summary of the Company's Response: The Company agrees with the findings and states that these were file-specific errors by the claim handlers. The Company reopened the pertinent claims to send updated letters to the insureds regarding the statute of limitation. The Company reiterated this requirement to its California claim handlers through its team meetings conducted in the 4th quarter of 2025. The Company does not believe these instances rise to the level of a violation of a CIC §790.03(h)(15).

19. In three instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. These instances are described below in one instance each:

a) The Company sent communication and payment to the insured's uninhabitable address.
b) The Company prematurely closed the claim with significant items outstanding, including need for cleaning of the swimming pool and the need to remove and replace the attic insulation, instead of following up with the insured to obtain estimates.
c) The Company initially advised the insured that it was unable to issue any advance payment under ALE because the house was still "standing". Following receipt of a corporate complaint, however, the Company decided to approve six months of ALE without proof that there was a long-term lease, and/or that lodging expenses would be incurred.

The Department alleges these acts are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings as follows:

a) The Company agrees it mailed communication to the wrong address. The Company has reiterated the importance of accuracy in the mailing address selection in team meetings.
b) The Company states that the claim was closed on May 19, 2025. Since the claim was in a closed status for this time period, there was no active claim handling necessary. Claim handling continued when the claim was re-opened for new mail submitted into the claim on August 4, 2025.
c) The Company believes it followed its own practices and procedures wherein a Team Manager approved reasonable costs under this coverage based on verbal conversations with the insured and their son wherein the Company concluded that the insureds stayed in numerous Airbnb locations. The Company admits that despite repeated requests, the insureds have failed to submit copies of signed leases or Airbnb receipts to charge back against the ALE advances.

Summary of the Department's Evaluation of the Company's Response: With respect to item b), this claim was closed prematurely, when the Company knew that it had not resolved the smoke damage claims for pool cleaning and attic insulation. The Company should have been diligently working to resolve these claims instead of shifting that responsibility to its insured. The Company did not present a plan for corrective action.

With respect to item c), the Company did not follow its own established practices and procedures as documented in this file and many others that involved ALE claims for smoke damage only losses. The Company repeatedly told insureds, including this one, that it could not issue advanced payments for ALE if the house was still standing and that ALE is "an incurred coverage;" however, in this instance the Company deviated from that practice and issued 6 months of projected ALE with no documented evidence that a lodging expense for this amount had been or would be incurred. It appears the Company made an exception for this insured because they filed a corporate complaint.

These are unresolved issues.

20. <u>In three instances, the Company failed, upon receiving notice of claim, to begin any necessary investigation within 15 calendar days.</u> These instances were as follows:

a) The Company failed to assign and complete an inspection until 34 days after the notice of claim.
b) The Company received notice of claim on January 14, 2025 and closed the claim. The Company began its investigation 91 days after the claim was reopened.
c) The Company delayed the hygienist process from April 29, 2025, to June 4, 2025 – a total of 36 days.

The Department alleges these acts are in violation of CCR §2695.5(e)(3) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of Company's Response:</u> The Company acknowledges the findings that these instances were all outside of the regulatory timelines to conduct necessary investigation: The Company further stated:

a) While the claim was reported by the policyholder on February 7, 2025, the inspection of the damage took place on March 13, 2025.
b) The Company agrees the claim was inadvertently closed by its claim handler on January 14, 2025 and was reopened for an inspection on April 21, 2025.
c) Given the size and nature of this large event, the timing and hiring of the hygienist seem reasonable.

The Company conducted team meetings in the 4th Quarter of 2025 to reinforce compliance with the need to timely initiate and conduct investigations. The Company does not believe these instances rise to the level of a CIC 790.03(h)(3) violation.

21. <u>In three instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.</u>

a) In the first instance, the Additional Living Expense (ALE) Worksheet was not provided with the initial Coverage C payment.
b) In the second instance, the insured reported to the reassigned adjuster that the prior adjuster had approved interior and exterior testing. There are no claim file notes or records on this agreement.
c) In the third instance, the insured requested withdrawal of his claim on January 14, 2025; however, there is no documentation in the file that the insured was sent a letter confirming this request.

The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings as follows:

a) In the first instance, the Company agrees that no ALE worksheet was provided with the initial Coverage C payment. This was an oversight on the part of the claim handler.
b) In the second instance, the Company acknowledges there were discrepancies in the file notes documented by the prior adjuster.
c) In the third instance, the Company agrees with the finding and sent a confirmation letter to the insured on January 7, 2026.

Further, for these 3 file-specific errors, coaching was provided regarding the requirements of CCR § 2695.3(a). The Company does not believe these instances rise to the level of a CIC § 790.03(h) violation.

22. In two instances, the Company failed to provide, free of charge, a complete copy of the insured's current insurance policy or certificate within 30 calendar days of receipt of a request from the insured after a covered loss. The Department alleges these acts are in violation of CIC §395 and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company acknowledges the findings and states that these were file-specific errors of the claims handler and are not indicative of the pattern and practices of the Company's overall claims handling. As a result of the examination, the Company sent a copy of the insurance policy to the insured's son on November 15, 2025 in the first instance, and to the Public Adjuster on February 23, 2026 in the second instance.

The Company has reiterated the need for compliance to California claim handlers during its team meetings held in the 4th Quarter of 2025. The Company believes these instances do not rise to the level of a violation of CIC §790.03(h)(2).

23. In two instances, the Company failed to comply with the requirements of CCR §2695.9(d) as described below:

a) In one instance, the Company failed to prepare the estimate in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction.

b) **In one instance, the Company settled the claim on the basis of a written scope and/or estimate without supplying the insured with a copy of each document upon which the settlement was based.**

The Department alleges these acts are in violation of CCR §2695.9(d) and are unfair practices under CIC §790.03(h)(3)

Summary of the Company's Response: The Company agrees with the findings and stated these were unintentional oversights by the claim handlers. The Company conducted team meetings in the 4th Quarter of 2025 to reinforce requirements for compliance with claims staff. In addition, for item (b) above, the Company reopened the claim to send a copy of the Payment Worksheet to the insured. The Company does not believe the above instances rise to the level of a violation of CIC §790.03(h)(3).

24. In two instances, the Company failed to supply the claimant with a copy of the insurer adjusted estimate from the repair individual or entity of the insured's choice. In one instance, the adjuster subtracted three line items from an estimate for hard goods cleaning, however the Company failed to provide the insured with a copy of the revised estimate. In the second instance, the Company failed to supply the insured with a copy of the adjusted estimate from the repair entity of the insured's choice. The Department alleges these acts are in violation of CCR §2695.9(d)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees to the findings and held team meetings with all California claim handlers in the 4th Quarter of 2025 to reiterate the need to send the required documentation. As a result of this examination, the Company sent the revised estimates to the insureds. The Company does not believe the above instances rise to the level of a violation of CIC § 790.03(h)(3).

25. In two instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. In the first instance, the Company failed to provide the insured with disclosure of the applicable coverage on the initial contact dates of January 13, 2025 and the following day when the insured requested the claim to be reopened. In the second instance, the Company provided the insured with an inaccurate time limit (deadline) for eligibility of recoverable depreciation within two years. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company agrees with the findings. In the first instance, the Company confirmed that it did not complete its Quality First Contact until April 15, 2025, or more than 3 months from initial contact. In the second instance, the Company agrees that an incorrect date (timeline) was provided in the initial letter to the insured. As a result of this finding, the Company has provided the insured

with the correct date (timeline) on October 16, 2025. The Company has also reinforced compliance with its California claim handlers in team meetings during the 4th Quarter of 2025. The Company does not believe these instances rise to the level of a violation of CIC §790.03(h)(1).

26. In one instance, the Company failed, upon receiving notice of claim, to provide the insured with a copy of §790.03 of the California Insurance Code within 15 calendar days. The insured was not provided with a copy of the required notice. The Department alleges this act is in violation of CIC §790.034(b)(1) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with this finding and states this was a file-specific error by the claim handler. The Company conducted team meetings in the 4th Quarter of 2025 and emphasized compliance to its California claim handlers.

27. In one instance, the Company failed to provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. The Company sent the insured a letter advising it is unable to pay the insured's claim however, it failed to provide written notice of a time period requirement or statute of limitation upon which the Company may rely to deny a claim. The Department alleges this act is in violation of CCR §2695.7(f) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states it did not deny the claim because at that time, the claim was below the insured's deductible. However, in response to the Department's inquiries the Company reopened the claim to send an updated letter to the insured with this statute of limitation (SOL) notice on December 19, 2025.

28. In one instance, the Company failed to offer a payment under the contents (personal property) coverage in an amount no less than 30 percent of the policy limit applicable to the covered dwelling structure, up to a maximum of two hundred fifty thousand dollars ($250,000), without requiring the insured to file an itemized claim if the residence was furnished at the time of the loss. The maximum amount of $250,000.00 was not met in this instance. However, the Company stated that "…no additional amounts for personal property will be paid without documentation consistent with policy requirements". The Department alleges this act is in violation of CIC §10103.7(b)(1) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges this finding and states that the initial advance was provided to the insured for immediate needs on January 15, 2025. An additional advance was paid on January 18, 2025 when the Company realized it did not comply with the requirement of CIC §10103.7(b)(1), Further,

the Company also erroneously applied the deductible amount against the advance payment thus this was refunded back to the insured on February 5, 2025. However, the Company does not believe this instance constitutes a violation of CIC §790.03(h)(5).

GENERAL FINDINGS

29. The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear, by charging the cost of hygienist and environmental testing in smoke damaged dwellings against the insured's policy limit of indemnity instead of treating it as a loss adjustment expense. Six cases where this occurred were observed in the examination sample. This practice reduces the amount of Coverage A available to the insured to rebuild or replace the dwelling and fails to properly classify costs associated with determining the scope of loss.

The Department alleges this is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company does not agree with this finding. The Company stated it did not request the testing in these cases, but rather the insureds hired the testing company on their own behalf. The Company did not rely upon the information provided within the reports for the adjustment of the claims. Since the Company did not rely upon the insureds' reports to write estimates or adjust claims, it did not consider these to be loss adjustment expenses.

Summary of the Department's Evaluation of the Company's Response: Charging the insured's testing costs against the limit of indemnity unfairly disadvantages the insured by reducing policy coverage. It should also be noted that the Company primarily uses Servpro vendors to perform assessments of smoke damage and prepare estimates for remediation. These vendors serve the Company's interests in managing claims for cost control and efficiency, which may conflict with additional information that speaks to the scope of the loss as obtained through hygienist or environmental testing, whether that testing is secured by the insured or by the Company. The Company has not taken steps to revise this practice. This issue is unresolved.

30. The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue by sending denial letters to insureds seeking reimbursement for hygienist and environmental testing that cite to the "Right to Inspect" provision of the policy as the basis for denial. This provision of the policy speaks to the Company's right to inspect a property to verify its insurability for underwriting purposes. The Company's use of this provision as grounds to deny a claim is a misrepresentation. At least 12 cases where this occurred were observed in the examination sample.

The Department alleges this is an unfair practice under CIC §790.03(h)(1).

Summary of the Company's Response: The Company agrees the section of the policy cited was not the appropriate section to justify claim denials and the section will not be used as such in future events. However, the Company maintains its position that these instances do not rise to the level of a general business practice and, thus, do not constitute a CIC § 790.03(h)(1) violation.

EXHIBIT B

BRENNAIN GARBER (SBN 295770)
DARREL SECREST (SBN 232263)
CALIFORNIA DEPARTMENT OF INSURANCE
1901 Harrison St., 4th Floor
Oakland, CA 94612
Telephone: (415) 538-4111
E-mail: Brennain.garber@insurance.ca.gov

Attorneys for the California Department of Insurance

BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of the Certificate of Authority of: STATE FARM GENERAL INSURANCE COMPANY, Respondent.	File No. OSC-2026-00001 ACCUSATION, ORDER TO SHOW CAUSE, NOTICE OF PENALTIES, NOTICE OF HEARING

The California Department of Insurance ("Department") alleges:

BACKGROUND

1. STATE FARM GENERAL INSURANCE COMPANY ("SFG") was, at all relevant times, an insurer licensed by the California Insurance Commissioner ("Commissioner") to transact insurance in California.

STATEMENT OF CHARGES/ACCUSATION

2. In January of 2025, Los Angeles County experienced major wildfires – the Eaton Fire in Altadena and surrounding areas, and the Palisades Fire in Pacific Palisades ("January 2025 Fires"). The January 2025 Fires spread into heavily populated areas, destroying over 18,000 structures, many of them single-family homes.

3. On January 7, 2025, Governor Gavin Newsom signed a Proclamation of State of Emergency related to the January 2025 Fires.

4. Subsequent to the January 2025 Fires, the Department's Consumer Services

Division ("CSD") received and investigated numerous complaints from SFG's insureds related to their handling of January 2025 Fire claims. Upon review, CSD found that SFG committed numerous violations of the Insurance Code and Code of Regulations, as set forth herein.

5. On June 12, 2025, the Commissioner authorized a formal Market Conduct Examination (Attached as Exhibit A), expanding the Department's investigation into SFG's claims handling practices in the wake of the January 2025 Fires.

6. The allegations herein arise from the more than 430 violations regarding SFG's claims handling cited by CSD and in the Market Conduct Examination.

Department's Market Conduct Examination

7. The Market Conduct Examination consisted of a review of a random selection of two-hundred-and-twenty (220) first party claims related to the January 2025 Fires. The randomly selected claims were broken down to include seventy (70) closed claims, seventy (70) open claims, seventy (70) smoke and ash claims, and ten (10) claims with corporate complaints. Violations were found in over half (52%), or 114 of the 220 claims examined. In total, 398 violations were discovered as a result of this examination.

8. The examination showed a troubling pattern of claims handling practices by SFG, including: slow and inadequate investigations of claims; underpayment of claims; numerous instances where multiple claims adjusters were assigned, over a short period, causing policyholder confusion; a lack of reasonable standards for prompt investigation and processing of claims, including in regards to smoke damage; and/or, delayed or inadequate communication with policyholders. These practices failed to comply with applicable laws regulating the fair handling of claims and related regulations resulting in unfair and unlawful burden to policyholders during a declared state of emergency.

9. During the course of the Market Conduct Exam, the Department prompted SFG to reopen claims and correct violations, resulting in several insureds receiving additional monetary recovery.

10. Examples of the types of violations found in the Market Conduct Exam are included below.

Slow and Inadequate Investigations of Claims

11. The Department found multiple claims wherein SFG failed to, upon receiving proof of claim, accept or deny the claim within the statutorily-required 40 calendar days; provide written notice of the need for additional time every 30 calendar days; and, upon receiving notice of a claim, begin any necessary investigation within the statutorily-required 15 calendar days in violation of Insurance Code §§ 790.03(h)(2), (3) and (4); and, California Code of Regulations Title 10 §§ 2695.5(e)(3), 2695.7(b), (c)(1) and (d).[1]

Individual Claim Number **-***5-78V

12. On January 14, 2025, SFG's insured, opened a claim resultant from the January 2025 Fires.

13. The Department reviewed this claim as part of the Market Conduct Examination and, in addition to other violations, made the following findings:

a. SFG failed to conduct and diligently pursue a thorough, fair and objective investigation, waiting eighty-eight (88) days to investigate the claim and only after being prompted by their insured who was forced to follow up regarding the lack of activity. The almost three-month delay violates both Insurance Code § 790.03(h)(3); and, Regulation §§ 2695.5(e)(3) and 2695.7(d).

b. During the delay, SFG's insured was not provided a single status update, nor did SFG advise their insured as to why a determination could not be made with an estimate as to when it would be, in violation of Insurance code § 790.03(h)(3); and, Regulation § 2695.7(c)(1).

c. When SFG did finally investigate the claim, they partially denied multiple parts of the claim without providing their insured with written legal justification for the denials. These denials included a denial of their insured's request for an industrial hygienist. SFG's conduct was in violation of Insurance Code § 790.03(h)(3); and, Regulation § 2695.7(b)(1).

d. Thereafter, on April 24, 2025, SFG attempted to settle their Insured's claim

[1] Unless otherwise specified, all further citations to Regulations are to Title 10 of the California Code of Regulations.

by making a settlement offer that was unreasonably low in violation of Insurance Code § 790.03(h)(5); and, Regulation § 2695.7(g).

e. Also, while the claim was open, SFG reassigned the claim more than three times within a six-month period. However, despite this, SFG failed to provide a written status report to the insured, establish a primary point of contact for the insured and to provide the insured one or more direct means of communication with that primary point of contact in violation of Insurance Code § 14047(a).

f. Further, SFG closed the file with a letter to their insured claiming they only had one year, instead of the correct two-year-period, to file suit against SFG in violation of Insurance Code § 790.03(h)(3); and, Regulation § 2071(a).

Underpayment of Claims or Delay in Timely Settlement

14. The Department found multiple claims wherein SFG failed to lawfully settle a claim by offering unreasonably low settlement offers; failed to document adjustments, and/or, failed to timely pay accepted claims within thirty days of acceptance of the claim in violation of Insurance Code §§ 790.03(h)(3) and (5), 2051, 2051.5, 10103.7(b)(1); and, Regulation §§ 2695.7(g) and (h).

Individual Claim Number **-***3-47Z

15. On January 7, 2025, SFG's insured's home was completely destroyed by the January 2025 Fires.

16. On January 13, 2025, SFG's insured opened a claim with SFG.

17. The Department reviewed this claim as part of the Market Conduct Examination and, in addition to other violations, made the following findings:

a. At all relevant times during the pendency of the claim, there was no reasonable dispute that SFG's insured was due additional living expenses to compensate them for accommodations they would need to find due to the loss of their home. On April 21, 2025, SFG's insured sent a lease agreement to SFG which validated their claim for alternative living expenses. However, SFG did not promptly furnish payment due under the policy. Instead, SFG delayed, sending letters requesting additional time to review the

claim in May, June and July of 2025. The letters contained no useful information, did not provide a reasonable explanation as to why the claim was not accepted and did not state what the Company was doing to resolve the claim.

b. SFG's internal claim handler communications acknowledge that their Insured should have been, but was not, promptly compensated for their loss.

c. SFG's conduct in the handling of this claim violated Insurance Code §§ 790.03(h)(3), (4) and (5); and, Regulation §§ 2695.7(b) and (c)(1).

Assignment of Multiple Claims Adjusters Causing Policyholder Confusion

18. The Department found multiple claims wherein SFG failed to timely assign one claims adjuster to be primarily responsible for a claim and have that primary adjuster provide timely communications/reports with their policyholders in violation of Insurance Code §§ 790.03(h)(3) and 14047.

Individual Claim Number **-***3-21S

19. On January 13, 2025, SFG's insured reported damage to his residence related to the January 2025 Fires.

20. The Department reviewed this claim as part of the Market Conduct Examination and, in addition to other violations, made the following findings:

a. SFG's insured's claim was reassigned a total of five times between January 13, 2025, and May 2, 2025, with SFG assigning their insured a total of six different adjusters during that period. Additionally, six other individuals "assisted" the primary claims handler assigned to the file during that period. As such, SFG's insured had to interact with a total of twelve different claims handlers within a four-month period. Further, upon the assignment of the third adjuster, SFG failed to timely provide their insured, in writing, with their primary point of contact and a means to communicate with them in violation of Insurance Code §14047(a).

b. Also, SFG denied a portion of SFG's claim without providing their insured with a prompt explanation, in writing, of the reason(s) for the denial in violation of Insurance Code § 790.03(h)(13); and, Regulation § 2695.7(b)(1).

c. Further, SFG attempted to settle their insured's claim by making a low or unreasonable offer in violation of Insurance Code § 790.03(h)(5); and, Regulation § 2695.7(g).

d. The Department prompted SFG to re-open this claim and address these concerns. This resulted in additional claims handling by SFG and additional recovery by their insured.

A Lack of Reasonable Standards for Prompt Investigation and Processing of Claims, Including in Regards to Smoke Damage, Creating an Undue Burden on Policyholders

21. The Department found multiple claims wherein SFG failed to adopt and implement reasonable standards for prompt investigation and processing of claims (including to provide required written denials of claims for the cost of hygienist and environmental testing in cases of smoke damage), failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear (including in instances of smoke damage and restoration), failed to treat payments for hygienist and environmental testing as loss adjustment expenses and not as against the policy limit, and denied hygienist and environmental testing as not covered without citing applicable policy language as to why and/or to falsely represent to policyholders that their policy's "Right to Inspect" provision justified denial of claims for the cost of hygienist testing in violation of Insurance Code §§ 790.03(h)(3), (5) and (13); and, Regulation § 2695.7(b).

Individual Claim Number **-****9-38K

22. On January 12, 2025, SFG's insured reported a claim resultant from damage caused by the January 2025 Fires.

23. The Department reviewed this claim as part of the Market Conduct Examination and, in addition to other violations, made the following findings:

a. On March 21, 2025, SFG's insured contacted SFG to express concerns about cleaning items without hygienic testing. SFG verbally denied their insured's request for testing, without stating the policy reason why and without including those reasons in writing in violation of Insurance Code §§ 790.03(h)(3), (5) and (13); and, Regulation §

2695.7(b)(1).

b. On April 4, 2025, SFG's insured again sent a strongly worded email requesting hygienic testing. SFG's response was to email their insured claiming hygienic testing was not covered without stating the policy reason why and without including those reasons in writing which constitutes a second violation of Insurance Code §§ 790.03(h)(3), (5) and (13); and, Regulation §§ 2695.7(b)(1).

c. Thereafter, SFG's insured conducted hygienic testing at their personal expense and, on April 14, 2025, sent the bill to SFG along with the Commissioner's March 7, 2025, press release ordering insurers to fully investigate consumers' smoke damage claims resultant from the January 2025 Fires. SFG once again verbally denied the hygienic testing and suggested that their insured take the matter up with their landlord; a third violation of Insurance Code §§ 790.03(h)(3), (5) and (13); and, Regulation §§ 2695.7(b)(1).

d. The Department prompted SFG to re-open this claim and address these concerns. This resulted in additional claim's handling by SFG and additional recovery by their insured.

Inadequate and Delayed Communication with Policyholders

24. The Department found multiple claims wherein SFG failed to timely respond to policyholders regarding their submitted claims, to furnish required notices, to consistently send required status updates, and to provide notice to their policyholders if additional time is needed to make determinations regarding their claims in violation of Insurance Code §§ 395, 790.03(h)(13), 14046(b); and, Regulation §§ 1871.2(a), 2695.5(b) and (e)(2), 2695.7(b)(1), (b)(3), (c)(1), and (f).

Individual Claim Number **-***1-90K

25. On January 9, 2025, SFG's insured opened a claim resultant from the January 2025 Fires.

26. The Department reviewed this claim as part of the Market Conduct Examination and made the following findings:

a. On February 18, 2025, a representative of the insured sent SFG a detailed

communication which included remediation and pack-out estimates from the insured's contractor of choice. However, SFG failed to furnish a response to the estimate within fifteen days in violation of Insurance Code § 790.03(h)(2); and, Regulation § 2695.5(b).

b. Further, during its review process, the Department determined that multiple estimates provided by the Insured's representatives were either only partially addressed, or not addressed at all by SFG, in violation of Insurance Code § 790.03(h)(3), (4) and (5); and, Regulation § 2695.7(b), (c)(1) and (h).

c. The Department's involvement resulted in additional claim's handling by SFG and additional recovery by their insured.

Total Violations Found in Market Conduct Examination

27. The above examples only show some of the violations. The examination report, adopted as final on May 4, 2026, details all three-hundred-and-ninety-eight (398) violations found during the course of the examination, including:

a. Seventy-Nine (79) violations for SFG's failure to provide timely written notice to their insureds of the need for more time to either accept and/or deny their insured's claim (Regulation § 2695.7(c)(1));

b. Forty-One (41) violations for knowingly (or with frequency to be a business practice) failing to attempt in good faith the effectuation of a prompt, fair and equitable settlement when liability is reasonably clear (Insurance Code § 790.03(h)(5));

c. Twenty-Nine (29) violations for SFG's failure to properly advise the insured that the time limit to bring suit under the policy is extended to 24 months after inception of the loss related to a declared state of emergency utilize the standard form of fire insurance policy (Insurance Code § 2071(a));

d. Twenty-Seven (27) violations for SFG's failure to tender payment within 30 calendar days after acceptance of claim, unless policy provides for waiting period (Regulation § 2695.7(h));

e. Twenty-Six (26) violations for SFG's failure to furnish a claimant with a complete response, based on the facts known to SFG, within 15 calendar days after receipt

of a claim related communication, where a response is reasonably expected (Regulation § 2695.5(b));

f. Twenty-Five (25) violations for SFG's failure to provide fraud warnings of insurance forms, in violation of (Regulation § 1871.2(a));

g. Twenty-Four (24) violations for SFG's failure to clearly document amounts of acceptance/denial, and/or failure to inform claimant in writing of all factual and legal bases and reference to statute or policy provision (Regulation § 2695.7(b)(1));

h. Twenty-One (21) violations for SFG's application of betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property (Regulation § 2695.9(f));

i. Three (3) violations for SFG's failure to document, in the claim file, all justification for the adjustment of the amount claimed because of betterment, depreciation, or salvage (Regulation § 2695.9(f); Insurance Code §§ 2051 and 2051.5);

j. Twenty (20) violations for SFG attempting to settle claims by making an unreasonably low settlement offer (Regulation § 2695.7(g));

k. Eighteen (18) violations for SFG's failure to, upon receipt of proof of claim, accept or deny the claim within forty calendar days (Regulation § 2695.7(b));

l. Eighteen (18) violations for SFG's failure to conduct and diligently pursue a thorough, fair and objective investigation (Regulation § 2695.7(d));

m. Fifteen (15) violations for SFG's failure to, after assigning three or more adjusters within a six-month period to a claim under a policy of residential insurance arising as a result of a declared state of emergency, in a timely manner assign a real or personal property claims adjuster to be primarily responsible for a claim, provide the insured with a written status report, establish a primary point of contact for the insured until the claim is closed or litigation filed, and provide the insured with one or more direct means of communication with the primary point of contact (Insurance Code § 14047);

n. Eleven (11) violations for SFG's failure to include a statement in its claim denial that, if the claimant believes all or part of the claim has been wrongfully denied or

rejected, he or she may have the matter reviewed by the California Department of Insurance (Regulation § 2695.7(b)(3));

o. Seven (7) violations for SFG knowingly (or with frequency to be a business practice) misrepresenting pertinent facts or policy provisions relating to coverage at issue (Insurance Code § 790.03(h)(1));

p. Five (5) violations for SFG's failure to provide the claimant with a copy of the most recent notice describing the most significant California laws pertaining to property insurance policies, including those related to a declared state of emergency, as defined in § 8558 of the Government Code, or other emergency declared by a public official no later than fifteen calendar days from the date on which the insurer received notice of the claim (Insurance Code § 14046(b)(1));

q. Four (4) violations for SFG failing to provide forms, instructions and reasonable assistance within fifteen calendar days of receipt of claim (Regulation § 2695.5(e)(2));

r. Three (3) violations for knowingly (or with frequency to be a business practice) misleading a claiming as to the applicable statute of limitations (Insurance Code § 790.03(h)(15));

s. Three (3) violations for knowingly (or with frequency to be a business practice) failing to adopt and implement reasonable standards for prompt investigation and claims processing (Insurance Code § 790.03(h)(3));

t. Three (3) violations for SFG's failure to begin investigation within 15 calendar days of receipt of claim (Regulation § 2695.5(e)(3));

u. Three (3) violations for SFG's failure to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed (Regulation § 2695.3(a));

v. Two (2) violations for SFG's failure to provide the claimant, free of charge, a complete copy of the policy within 30 days of request after an insured loss (Insurance Code § 395);

w. Two (2) violations for SFG's failure to, supply their insured with a copy of the insurer adjusted estimate from the repair individual or entity of the insured's choice (Regulation § 2695.9(d)(3));

x. Two (2) violations for SFG, after settling a claim on the basis of a written scope and/or estimate without supplying the insured with a copy of each document upon which the settlement was based and/or failing to prepare the estimate in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction (Regulation § 2695.9(d));

y. Two (2) violations for SFG's failure to disclose all benefits, coverage, time limits or other provisions of the insurance policy (Regulation § 2695.4(a));

z. One (1) violation for SFG's failure to provide the insured with notice of Fair Claims Settlement Practices regulations, within 15 calendar days after claim receipt (Insurance Code § 790.034(b)(1));

aa. One (1) violation for SFG's failure to notify a claimant of the statute of limitations (or other time requirement where claim can be denied), which must be given not less than 60 days prior to the expiration date (or immediately if within 60 day period)(or within 30 days to a first party claimant in an uninsured motorist claim) except where the claim was settled by payment (Regulation § 2695.7(f));

bb. One (1) violation for SFG's failure to offer a payment under the contents (personal property) coverage in an amount no less than 30 percent of the policy limit applicable to the covered dwelling structure, up to a maximum of two hundred fifty thousand dollars ($250,000), without requiring the insured to file an itemized claim if the residence was furnished at the time of the loss (Insurance Code § 10103.7(b)(1));

cc. One (1) violation for SFG knowingly (or with frequency to be a business practice) failing to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear (Insurance Code § 790.03(h)(5));

dd. One (1) violation for SFG knowingly (or with frequency to be a business practice) misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue (Insurance Code § 790.03(h)(1));

Consumer Service Division's Investigation Of Complaints

28. In addition to the violations found in the Market Conduct Exam, the Department's CSD identified other violations. Shortly after the January 2025 Fires, the CSD began receiving complaints against SFG, alleging mishandling of claims, on a continual basis.

29. CSD's subsequent investigations determined that SFG committed an additional 34 violations of the Insurance Code and Regulations in its handling of claims where customers submitted consumer complaints to the Department, including:

a. One (1) violation for knowingly (or with frequency to be a business practice) misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue (Insurance Code § 790.03(h)(1));

b. Two (2) violations for knowingly (or with frequency to be a business practice) failing to acknowledge and act reasonably promptly upon communication regarding claims arising under insurance policies (Insurance Code § 790.03(h)(2));

c. Five (5) violations for knowingly (or with frequency to be a business practice) failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies (Insurance Code § 790.03(h)(3));

d. One (1) violation for knowingly (or with frequency to be a business practice) failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement (Insurance Code § 790.03(h)(13));

e. One (1) violation for SFG's failure to document (or allow DEPARTMENT examination of) claim files with all documents that pertain to the claim such that the events and licensee's actions can be determined (Regulation § 2695.3(a)):

f. One (1) violation for SFG's failure to begin investigation within 15

calendar days of receipt of claim (Regulation § 2695.5(e)(3));

g. Three (3) violations for SFG's failure to include a statement in its claim denial that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance (Regulation § 2695.7(b)(3));

h. One (1) violation for SFG's failure to, within 40 calendar days of receipt of proof of claim, clearly document amounts of acceptance/denial, and/or failure to inform claimant in writing of all factual and legal bases and reference to statute or policy provision (Regulation § 2695.7(b)(1));

i. Two (2) violations for SFG's failure to provide proper written responses to Department of Insurance inquires within the statutorily proscribed period (Regulation § 2695.5(a));

j. Five (5) violations for SFG's failure to, after assigning three or more adjusters within a six-month period to a claim under a policy of residential insurance arising as a result of a declared state of emergency, in a timely manner assign a real or personal property claims adjuster to be primarily responsible for a claim, provide the insured with a written status report, establish a primary point of contact for the insured, and provide the insured with one or more direct means of communication with the primary point of contact (Insurance Code § 14047);

k. Five (5) violations for SFG's failure to furnish a claimant with a complete response within 15 calendar days after receipt of a claim related communication, where a response is reasonably expected (Regulation § 2695.5(b));

l. One (1) violation for SFG's failure to conduct and diligently pursue a thorough, fair and objective investigation (Regulation § 2695.7(d));

m. Four (4) violations for SFG's failure to provide timely written notice to their insureds of the need for more time to either accept and/or deny their insured's claim (Regulation § 2695.7(c)(1));

n. Two (2) violations for SFG's failure to provide a claimant with a copy of

the Department's most recent "significant property insurance and state of emergency laws" notice within 15 days from the receipt of a claim under a residential policy resulting from a declared state of emergency (Insurance Code § 14046(b)).

30. These violations again include instances where multiple claims adjusters were assigned over a short period, causing policyholder confusion; a lack of reasonable standards for prompt investigation and processing of claims, including in regards to smoke damage; and/or, delayed or inadequate communication with policyholders.

CAUSE FOR SUSPENSION

31. The facts alleged in paragraphs 2 through 30 above show that Respondent has "not carr[ied] out its contracts in good faith." (Ins. Code, § 704, subd. (b).) This conduct constitutes grounds for the Commissioner to suspend Respondent's certificate of authority under Insurance Code section 704, subdivision (b).

ORDER TO SHOW CAUSE

32. The facts alleged in paragraphs 2 through 30 above provide the Commissioner with good cause to believe that SFG has willfully committed unfair claims settlement practices and/or has "been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in § 790.03" of the Insurance Code and a proceeding by the Commissioner with respect to the allegations in this Accusation and Order to Show Cause would be in the public interest.

33. Now, therefore, SFG is hereby ordered under Insurance Code § 790.05, to show cause why the Commissioner should not issue an order to SFG to pay the monetary penalty imposed by Insurance Code § 790.035, as set forth below, and to cease and desist from engaging in those methods, acts, or practices found to be unfair or deceptive.

NOTICE OF PENALTY

34. SFG is hereby notified that the Commissioner may impose a monetary penalty on SFG under Insurance Code § 790.035, subdivision (a):

> "Any person who engages in any unfair method of competition or any unfair or deceptive act or practice defined in Section 790.03 is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars

($5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act. However, when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for the purpose of this section."

NOTICE OF HEARING

35. SFG is hereby notified that a hearing shall be held at a time and place to be determined by the Commissioner. The hearing shall not be less than 30 days after service of this Accusation and Order to Show Cause. (Ins. Code, § 790.05)

PRAYER

36. DEPARTMENT prays for an ORDER as follows:

a. Pursuant to Insurance Code section 704, suspending Respondent's certificate of authority for a period not to exceed one year;

b. Pursuant to Insurance Code § 790.05, directing SFG to cease and desist from engaging in unfair or deceptive methods, acts, or practices in the insurance business as defined in Insurance Code § 790.03 and outlined above; and,

c. Pursuant to Insurance Code § 790.035, acts in violation of Insurance Code § 790.03 and CCR, Title 10, Chapter 5, Subchapter 7.5, §§ 2695.1 through 2695.14, as set forth above, are subject to a penalty in an amount to be fixed by the Commissioner not to exceed five thousand dollars ($5,000.00) for each non-willful act, or not to exceed ($10,000.00) for each willful act.

DATE: May 4, 2026

CALIFORNIA DEPARTMENT OF INSURANCE

By _____
Brennain Garber
Senior Attorney
California Department of Insurance

EXHIBIT A

[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938, THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]

WEBSITE PUBLISHED REPORT OF THE TARGETED MARKET CONDUCT EXAMINATION OF THE CLAIMS PRACTICES OF

STATE FARM GENERAL INSURANCE COMPANY
NAIC # 25151 CDI # 1714-5

RELATED TO THE PALISADES AND EATON FIRES

AS OF JULY 31, 2025 - INCLUSIVE OF OPEN CLAIMS

ADOPTED MAY 1, 2026

STATE OF CALIFORNIA

CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

TABLE OF CONTENTS

FOREWORD

This report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer's proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report.

While this report contains violations of law that were cited by the examiners, additional violations of CIC § 790.03 or other laws not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company's responses, if any, have not undergone a formal administrative or judicial process.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

SCOPE OF THE EXAMINATION

Under the authority granted in Part 2, Chapter 1, Article 4, Sections 730, 733, and 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, a targeted examination was made of the claim handling practices and procedures in California of:

State Farm General Insurance Company
NAIC # 25151

Group NAIC # 0176

Hereinafter, the Company listed above also will be referred to as SFGIC, or the Company. The California Department of Insurance will be referred to as CDI or the Department.

This examination reviewed the Company's handling of claims filed as a result of the January 2025 Palisades and Eaton Fires in Los Angeles County.

The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claim files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results, including a review of consumer complaints and inquiries to CDI about the Company.

The review of the sample individual claim files was conducted at the offices of the California Department of Insurance in Los Angeles, California.

EXECUTIVE SUMMARY

In January of 2025, Los Angeles County experienced major wildfires – the Eaton Fire in Altadena and surrounding areas, and the Palisades Fire in Pacific Palisades. The examination was initiated as a result of consumer complaints and concerns received from wildfire survivor groups about State Farm General Insurance Company's handling of claims for these fires, and specific patterns of activity including the frequent reassignment of adjusters with little continuity of communication with homeowners, inadequate record keeping or information sharing among claims teams, delays in investigating claims and receiving payment, inconsistencies in the handling of claims, including those for Additional Living Expenses ("ALE"), re-working of prior estimates to lower payments, and processes for handling claims for smoke damage.

The examiners randomly selected a total of 220 SFGIC claim files for examination which included 70 closed claims, 70 open claims, 70 smoke and ash claims, and 10 claims with corporate complaints. These 10 claims with corporate complaints were cases in which the claimant complained directly to State Farm and did not also file a complaint with CDI. The examiners cited 398 alleged violations of the California Insurance Code and the California Code of Regulations from this sample file review. The examination found the following:

- Re-assignment of multiple adjusters without providing the claimant with a primary point of contact for continuity;
- Delays in commencing investigations, in making determinations to accept or deny, and in paying claims upon acceptance thereof;
- Failure to consistently include all appropriate payees on settlement checks;
- Failure to timely respond to communications, and failure to consistently send required status letters;
- Verbal denials of claims instead of the required written denial, including for claims for the cost of hygienist and environmental testing in cases of smoke damage;

- Charging payments for hygienist and environmental testing against the policy limit instead of treating these costs a loss adjustment expenses;
- Underpayments, including cases where depreciation was taken on structural components not normally subject to repair or replacement during the property's useful life;
- Misrepresenting to policyholders that the policy's "Right to Inspect" provision justified denial of claims for the cost of hygienist testing.

Details regarding all violations alleged during the examination are provided in the final section of this report.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

SFGIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD***	**SAMPLE FILES REVIEWED**	**NUMBER OF ALLEGED VIOLATIONS**
Smoke and Ash (closed and open)	2,900	70	134
Closed Claims	5,336	70	71
Open Claims	3,978	70	181
Claims with Corporate Complaints	87	10	10
General Findings	--	--	2
TOTALS		**220**	**398**

* The figures displayed in this column are based on the claim population data provided by State Farm in response to the Department's request for listings of claims in each of the identified categories.

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	SFGIC Number of Alleged Violations
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days until a determination is made.	79
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	41
CIC §2071 *[CIC §790.03(h)(1)]	The Company failed to properly advise the insured that the time limit to bring suit under the policy is extended to 24 months after inception of the loss related to a declared state of emergency.	29
CCR §2695.7(h) *[CIC §790.03(h)(5)]	The Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.	27
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed, upon receiving a communication from a claimant, to furnish the claimant with a response within 15 calendar days. The Company failed, in responding to a communication from a claimant, to furnish the claimant with a complete response based on the facts as then known.	22 4
CIC §1871.2(a) *[CIC §790.03(h)(3)]	The Company failed to include the California fraud warning on insurance forms.	25
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.	24
CCR §2695.9(f) *[CIC §790.03(h)(5)]	The Company applied betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property.	21
CIC §§2051 and 2051.5/CCR §2695.9(f) *[CIC §790.03(h)(3)]	The Company failed to document in the claim file all justification for the adjustment of the amount claimed because of betterment, depreciation, or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property.	3
CCR §2695.7(g) *[CIC §790.03(h)(5)]	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	20

Citation	Description of Allegation	SFGIC Number of Alleged Violations
CCR §2695.7(b) *[CIC §790.03(h)(4)]	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	18
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	18
CIC §14047(a) *[CIC §790.03(h)(3)]	The Company failed, after assigning three or more adjusters within a six-month period to a claim under a policy of residential insurance arising as a result of a declared state of emergency, to in a timely manner assign a real or personal property claims adjuster to be primarily responsible for a claim, provide the insured with a written status report, establish a primary point of contact for the insured, and provide the insured with one or more direct means of communication with the primary point of contact.	15
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to include a statement in its claim denial that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	11
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	7
CIC §14046(b)(1) *[CIC §790.03(h)(3)]	The Company failed to provide the claimant with a copy of the most recent notice describing the most significant California laws pertaining to property insurance policies, including those related to a declared state of emergency, as defined in Section 8558 of the Government Code, or other emergency declared by a public official no later than 15 calendar days from the date on which the insurer received notice of the claim.	5
CCR §2695.5(e)(2) *[CIC §790.03(h)(3)]	The Company failed, upon receiving notice of claim, to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.	4
CIC §790.03(h)(15)	The Company misled a claimant as to the applicable statute of limitations.	3
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.	3

Citation	Description of Allegation	SFGIC Number of Alleged Violations
CCR §2695.5(e)(3) *[CIC §790.03(h)(3)]	The Company failed, upon receiving notice of claim, to begin any necessary investigation within 15 calendar days.	3
CCR §2695.3(a) *[CIC §790.03(h)(3)]	The Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.	3
CIC §395 *[CIC §790.03(h)(2)]	In two instances, the Company failed to provide, free of charge, a complete copy of the insured's current insurance policy or certificate within 30 calendar days of receipt of a request from the insured after a covered loss.	2
CIC §2695.9(d)(3) *[CIC §790.03(h)(3)]	The Company failed to supply the claimant with a copy of the insurer adjusted estimate from the repair individual or entity of the insured's choice.	2
CCR §2695.9(d) *[CIC§790.03(h)(3)]	The Company settled the claim on the basis of a written scope and/or estimate without supplying the insured with a copy of each document upon which the settlement was based. The Company failed to prepare the estimate in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction.	1 1
CCR §2695.4(a) *[CIC §790.03(h)(1)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	2
CIC §790.034(b)(1) *[CIC §790.03(h)(3)]	The Company failed, upon receiving notice of claim, to provide the insured with a copy of §790.03 of the California Insurance Code within 15 calendar days.	1
CCR §2695.7(f) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim.	1
CIC §10103.7(b)(1) *[CIC §790.03(h)(5)]	The Company failed to offer a payment under the contents (personal property) coverage in an amount no less than 30 percent of the policy limit applicable to the covered dwelling structure, up to a maximum of two hundred fifty thousand dollars ($250,000), without requiring the insured to file an itemized claim if the residence was furnished at the time of the loss.	1

Citation	Description of Allegation	SFGIC Number of Alleged Violations
CIC §790.03(h)(5) General Finding	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	1
CIC §790.03(h)(1) General Finding	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	1
Total Number of Alleged Violations		**398**

***DESCRIPTIONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES**

CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
CIC §790.03(h)(2)	The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
CIC §790.03(h)(4)	The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.
CIC §790.03(h)(13)	The Company failed to provide promptly a reasonable explanation of the bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company should address corrective action for other jurisdictions when applicable.

Money recovered within the scope of this report was $41,914.90 as described in section numbers 7, 9, 10, 11, and 15 below.

1. In 79 instances, the Company failed to provide written notice of the need for additional time every 30 calendar days until a determination is made. The Company failed to transmit status letters in 44 instances. In the 35 remaining instances, the status letters were sent late. The Department alleges these acts are in violation of CCR §2695.7(c)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings of non-compliance with CCR §2695.7(c)(1). The Company states these were unintentional oversights by claim handlers and were file-specific errors. The Company conducted team meetings in the 4th Quarter of 2025 and reminded claim handlers of the need to send timely status letters, and the importance of following established processes and procedures in compliance with California regulations. The Company states it does not believe these instances rise to the level of a violation of CIC §790.03(h)(3).

2. In 41 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Company did not name the correct payees on indemnity checks as follows:

- In 19 instances, not all the named insureds were listed as payees.
- In 10 instances, the Company erroneously named non-insureds as payees.

- In 7 instances, the "Trust" account was not named as a payee
- In 5 instances, the mortgagee and/or an additional mortgagee was not named as a payee

The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees to the findings that indemnity payments were not accurately paid to all correct payees, and/or that the Company was not properly paying all pertinent legal homeowners with financial interest. The Company held team meetings to remind the California claim handlers that all legal payees should be included in indemnity settlements.

3. In 29 instances, the Company failed to properly advise the insured that the time limit to bring suit under the policy is extended to 24 months after inception of the loss related to a declared state of emergency. The Department alleges these acts are in violation of CIC §2071 and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges that in a state of emergency, the statute of limitation is extended to 24 months. In these instances, the Company agrees that no required written notice was sent in 18 instances; in 11 instances, the notice provided incorrectly stated the time period to be one year. The Company discussed this non-compliance issue in team meetings conducted in the 4th Quarter of 2025. The Company does not believe that these instances rise to the level of a violation of CIC §790.03(h)(3).

4. In 27 instances, the Company failed, upon acceptance of the claim, to tender payment within 30 calendar days. The Company issued payments on accepted claims beyond the regulatory timeline. The Department alleges these acts are in violation of CCR §2695.7(h) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: In 22 instances, the Company agrees with the findings. The Company states these were file-specific errors and does not believe they rise to the level of a violation of CIC §790.03(h)(5). These were unintentional oversights on the part of the claim handlers. As a result of these findings, the Company conducted team meetings with California claim handlers for compliance reinforcement in the 4th quarter of 2025.

In five (5) instances, the Company believes it did not violate CCR §2695.7(h) which requires the payment of an accepted claim within 30 days. The Company states status letters were sent requesting additional time to review estimates in these instances.

Summary of the Department's Evaluation of the Company's Response: There were undisputed portions of these claims that the Company had accepted. Therefore, the undisputed amounts should have been paid within 30 days of the acceptance. Instead, the Company made repeated extensions to review estimates after accepting the claim for periods extending up to four months before issuing payment. This is an unresolved issue.

5. In 26 instances, the Company failed to comply with the requirements of §2695.5(b) as described below:

a) **In 22 instances, the Company failed, upon receiving a communication from a claimant, to furnish the claimant with a response within 15 calendar days.**
In these instances, the Company received communications and failed to respond within the regulatory timeline.

b) **In 4 instances, the Company failed, in responding to a communication from a claimant, to furnish the claimant with a complete response based on the facts as then known.**
In two instances, the Company failed to furnish timely a copy of the policy to an insured's attorney in one case, and to an insured's Public Adjuster in the other. In the third instance, the Company failed to furnish supporting documents requested on a claim denied to an insured's Public Adjuster. In the fourth instance, the Company failed to respond to a request for deductible information.

The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response to a): In 14 of 22 instances, the Company agrees that communications were not responded to within 15 calendar days. These were unintentional oversights on the part of the claim handlers. The Company conducted team meetings in the 4th Quarter of 2025 for compliance reinforcement. The Company further states it does not believe these instances rise to the level of a general business practice violation of CIC § 790.03(h)(2).

However, the Company does not agree to the following eight (8) of 22 instances:

- In three instances, the Company states it received communications from Public Adjusters referencing earlier correspondence to the Company. However, there is no record in the claim file documents of prior communication unanswered.

- In two instances, the Department alleges the Company received an email from the insured's attorney on April 22, 2025, stating that a phone message wasn't

responded to within 15 days; and on July 11, 2025, stating that another email was not responded to within 15 days. The Company disagrees that it was not engaged in continuous communication with the insured's attorney prior to, and after receiving the attorney's email that was referenced by the Department. The Company further states it did not receive any correspondence from the attorney as claimed in the email. The Company states it responded within 15 days to correspondence that is documented in the file.

- In one instance, the Department alleges the Company responded six months after receiving a lease agreement for temporary location. The Company disagrees. The Company requested documentation within the regulatory timeframe. To date, the Company has not received documentation. The Company has offered and remains available to address the reasonably necessary increase in costs incurred by the insured to maintain their normal standard of living.

- In one instance, the Department alleges the Company did not respond to the insured's request to obtain liability/Renter's policy as part of the lease agreement. The Company disagrees and states it has requested documentation of the incurred fee. To date, the Company has not received documentation. The Company has offered and remains available to address the reasonable and necessary increase in costs incurred by the insured to maintain their normal standard of living.

- In one instance, the Department states the insured requested a certified copy of her policy and was instead given an uncertified copy 28 days later. The Company does not believe it is required to provide the insured with a certified copy of the policy and cites CIC §2071 which states in part, "an insurer shall provide to the insured, free of charge, a complete, current copy of their policy within 30 calendar days of receipts of a request from the insured. The policy must include the full insurance policy, any endorsements, and the declarations page."

Summary of the Company's Response to b): In three instances, the Company agrees that it failed to respond to a communication with a complete response based on the facts as then known. These were unintentional oversights on the part of the claim handlers. The Company conducted team meetings in the 4th Quarter of 2025 for compliance reinforcement.

The Company, however, does not agree in one instance pertaining to an insured attorney's request for confirmation of the insured's deductible. The Company states the Claim Specialist left a message for the insured attorney within the regulatory timeframe. Further, the Company states it does not believe this instance is a violation of CIC § 790.03(h)(2).

Summary of the Department's Evaluation of the Company's Response: In the eight (8) disputed alleged violations under (a), the files reflect that the Company did not respond to communications. In the one (1) disputed allegation under (b), the file reflects the Company did not respond to the communication. These are unresolved issues.

6. In 25 instances, the Company failed to include the California fraud warning on insurance forms. In 18 instances on the Attestation in Support of Personal Property Total Loss Advance form and in one (1) instance on the Designation Authorization form the Company failed to include fraud warning language. In six (6) instances Company claim forms included fraud warning language, however the language used did not align with the requirements of California law. The Department alleges these acts are in violation of CIC §1871.2(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings and states that the six (6) that contained incorrect language were unintentional oversights on the part of the claim handlers. The Company held team meetings to reiterate the importance of sending correct form letters with correct California fraud language in all written communications to the insureds.

The Company further states that it believes the Attestation in Support of Personal Property Total Loss Advance and the Designation Authorization forms do not fall within the requirements of CIC §1871.2(a); however, the Company will add the fraud language to these forms.

Department's Evaluation of the Company's Response: The Department believes the claim forms require fraud language per CIC § 1871.2(a).

7. In 24 instances, the Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given. These instances pertained to the Company's failure to provide written denials in whole or in part, on claims for Additional Living Expenses (ALE) and other items such as damage to contents, medical expenses, claim for wage loss, air purifiers, valet parking, spa treatments, resort fees, haircuts, reimbursement for additional mileage incurred, a privacy screen, a request for a neighborhood security guard with cost split among neighbors, cost for a storage unit, and the cost of hygienist and safety testing for contaminants.

The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company responds to the findings as follows:

The Company agrees with the findings in 20 of the instances that it failed to provide written denials in whole or in part and/or made verbal denials of claims. The Company states these were unintentional oversights on the part of the claim handlers. The Company further stated that each claim is investigated based on the facts, circumstances, location, environmental history and evidence presented. The Company reopened claims as applicable and has continued to review claims presented. In one case involving the claim for the cost of hygienist testing, the Company has determined this to be covered and has issued payment of $1,260 to the insured.

The Company conducted training in the 4th Quarter of 2025 for its claim handlers for compliance reinforcement with the requirements of the regulation. The Company stated that it does not believe these instances rise to the level of a violation of CIC §790.03(h)(13).

In the remaining four instances, the Company does not agree with the findings. The Company stated these four instances pertained to wear and tear damage to vehicles, a claim for increased coverage, spa services and haircuts, and a status letter was sent instead of a denial letter. The Company does not agree that it violated this regulation because it was in the process of determining what claims were part of the ALE claim. The Company has since followed up with the insureds to determine what will be paid, and what will be denied in writing.

Summary of the Department's Evaluation of the Company's Response: The regulation requires where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing. The Company failed to do so in the disputed instances. This is an unresolved issue.

8. In 21 instances, the Company applied betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property. These instances pertain to the depreciation of the dwelling/structural components. In each instance, the Company applied depreciation to one or more structural components not normally subject to repair and replacement during the useful life of the property and/or during the items' lifespan. The Department alleges these acts are in violation of CCR §2695.9(f) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company disagrees with the findings. The Company states all physical property has a useful life expectancy. In these cases of partial loss to the structure, a deduction for physical depreciation applied only to components of a structure that are normally subject to repair and replacement during the useful life of that structure. Depreciation was taken based on the average life expectancy, age and condition of the items needing to be replaced in accordance with the insureds' Rental Dwelling Policy.

Summary of the Department's Evaluation of the Company's Response: The Company depreciated components such as insulation, foundations, concrete piers, steel rebar, sheathing, framing, lumber, baseboards, molding, sub-flooring, lath & plaster, wiring, masonry and stone, a meter mast for overhead power, a meter conduit extension for underground power, a grounding rod, sheathing, weatherproofing, siding, drywall, paneling, wood floors, marble/granite countertop, shower pan, toilet, etc. Although the Regulations do not delineate what types of specific structural components are normally subject to repair and replacement or property that is excluded from depreciation, these examples have a useful life/life expectancy of decades or more years and will not depreciate during the items' lifespan absent some known reason such as damage sustained in a prior loss. This is an unresolved issue.

9. In three instances, the Company failed to document in the claim file all justification for the adjustment of the amount claimed because of betterment, depreciation, or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property. These instances are described below:

a) In one instance, the Company applied "average" condition on all items of the insured's personal property inventory when there was higher than average condition for some items.
b) In one instance, the Company erroneously deducted depreciation to its settlement amount and refunded it back upon discovery of its mistake. However, there is no documentation on the claim file to justify the original amount paid.
c) In one instance, the Company applied depreciation across the board at 0.15 (15%) in the amount of $16,792.78 from Coverage B (Personal Property). The claim file notes were void of any specific documentation regarding each item's age, life expectancy, and condition.

The Department alleges these acts are in violation of CIC §§2051 and 2051.5, and CCR §2695.9(f), and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings as described below:

a) The Company reopened the claim and issued $169.53 as the Payment Tracker Worksheet has been updated to reflect the condition of all personal property items as provided by the insured.
b) The Company indicates depreciation was inadvertently withheld and this error has now been corrected with the insured notified in writing.
c) The Company has reopened the claim and reached out to the insured on February 12, 2026, to review the depreciated items in question. The insured expressed no interest in pursuing the matter and claim has been closed.

The Company states these were file-specific errors by its claims handler and do not reflect a general business practice. The Company does not believe these instances are indicative of the pattern and practices of the Company's overall claim handling and therefore do not rise to the level of a violation of CIC §790.03(h)(3).

10. In 20 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. These instances are described as follows:

a) Home supplies and furniture rental invoices were not paid.
b) The contents claim was considered business use and not paid.
c) An estimate for dwelling damage was underpaid.
d) A line-item estimate for HEPA Vacuuming (PER SF) is missing square footage resulting in $0.00 payment.
e) Mileage claim for 1,100 miles was not paid.
f) Miscalculation of mileage reimbursement rate resulted in underpayment.
g) Loss of Rent calculation resulted in a 21.55% reduction in benefits.
h) Perishable food in the refrigerator due to power outage was not considered.
i) Damage to the sprinkler system was not paid.
j) The dwelling extension smoke damage cleaning of the garage was not paid.
k) The hygienist report of the insured's Public Adjuster was not considered by the Company for an independent assessment of damage.
l) A $500.00 single limit of liability was incorrectly applied to the Company's estimate on Trees/ Shrubs/ Other Plants
m) An "Internal Use Only" document reflects an additional $2,500.00 was available but not paid to the insured under Coverage B, Contents.
n) A privacy screen was not paid.
o) The Company did not confirm damage to a washer and dryer
p) The insured's estimate from his restoration vendor was $159,287.50 which was reduced by the Company by $128,783.32. The Company advised the insured that it would not pay for applying odor counteractants, seal stud for odor control, cleaning cabinetry, hydroxyl odor counteractant, vapor odor counteractant. The Company downgraded the smoke damage assessment from "heavy" to "light" damage and informed the insured that it would only pay for contents cleaning and only content manipulation from one room to another.
q) Regarding reimbursement of meals while eating out, the Company verbally advised the insured multiple months into the claim that meals out would not be covered under Additional Living Expense (ALE) because the insured had access to a kitchen.
r) The Company's estimate paid on April 22, 2025 did not account for overage and the insured's deductible of $3,000.00 was applied. Additionally, the estimate for Code upgrades of only $18,334.16 appeared low for the age of the home (78 years old). Finally, the policy coverage shows an additional $2,500.00 available for jewelry under contents, although the Company did not pay it.

s) The estimate did not include reasonable and necessary replacement of non-salvageable items observed during inspection such porous material items like bedding, pillows, and mattress' given the severity of the loss and the insured's health issues.
t) The insured's policy limit for Coverage A of $575,295.00 was reduced by the estimated damages for landscaping in the amount of $13,377.69 which on a 1,300 square foot house the Company has only allowed about $432.00/square foot.

The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees to 15 of the findings and issued payments as described below:

a) Home and furniture rental invoices for $1,237.30 have now been paid.
b) The contents claim for purchases from Best Buy has now been reimbursed $156.45.
c) An additional payment of $2,922.16 was issued for the difference in dwelling damage.
d) The Company reached out to the named insured to confirm the square footage of the attic. Upon determination of the appropriate measurements, the Company will update the estimate and issue payment for the supplement.
e) The Company has now paid $491.40 to reimburse for the 1,100 miles.
f) The appropriate form was not used to calculate mileage. However, the Coverage C policy limits had already been exhausted.
g) The adjuster improperly deducted from the Loss of Rent (LOR) settlement and the claim was reopened to issue a supplemental LOR payment of $96,039.53 including a letter explaining the LOR revision and payment. The Company issued this supplemental payment on August 29, 2025 prior to the Department's inquiry.
h) The policyholders were contacted regarding their food loss and payment for $500.00 was issued.
i) The Company contacted the insured to obtain status on the sprinkler system on October 29, 2025. The insured responded that they did not wish to pursue additional funds for the sprinkler system.
j) The Company issued payment of $2,098.76 for the dwelling extension smoke damage cleaning of the garage.
k) The hygienist report submitted by the insured's Public Adjuster was not reviewed and this was a file-specific error by the adjuster. The Company reopened the claim for further evaluation of coverage, and any additional reports will be provided to the insureds and their Public Adjuster as they become available.
l) The Company's estimate has been updated to reflect the correct application of the single limit of liability per tree. An additional payment of $2,242.09 was issued.
m) The Company inadvertently overlooked payment for the Option limit of $2,500.00. The Company reopened the claim to issue payment to the insured for $2,500.00.

n) The privacy screen is necessary and reasonable to maintain their standard of living. This was a file-specific error by the claim handle, and the Company has now paid the insured $254.00.
o) The washer and dryer were rented with the condominium. ServPro provided the list for the named insured's appliances that need to be discarded due to lead. Payment for the replacement of appliances to include the washer and dryer was issued in the amount of $1,756.00.

The Company does not agree to the findings in the remaining five instances as described below:

p) The Company wrote an estimate for light cleaning of all three levels. The scope of damages contained in "Level 3" was an error by the claim handlers who mistakenly copied the contractor's scope for "Heavy" damage which resulted in overpaying the insured.

q) It was not until June 17, 2025, that the claim handler had access to review ALE documentation provided by the Public Adjuster. Once this information was reviewed, the Company communicated settlement under the ALE portion of the claim.

r) The Company's estimate dated April 22, 2025, did account for the amounts over limit on coverage lines. The estimate provided to the insured will show the policy deductible regardless of how much over the limit a particular coverage line is. Also, Payment of Coverage B – Option Jewelry/Furs (Option JF) is currently premature. The Company included all necessary lines for the new "build" based on what the Company knows at this time and current codes. However, as a result of the Department's inquiry, the Company paid the insured $1,338.61 for additional living expenses.

s) The status letter of June 27, 2025, includes the Company's request for an estimate to clean the insured's personal property and an inventory of non-salvageable items. The status letter of August 8, 2025 outlines the pending personal property inventory and offers our assistance.

t) The Company continues to be available to discuss this estimate with the insureds if they have additional information to present. The Company believes the estimate accurately reflects the information available when written. The Company estimate was only a draft copy at that time prior to review on February 10, 2025, wherein the labor efficiency used was determined to be incorrect. The Company has since changed the labor efficiency from restoration/remodel/service to "New" so that the revised estimate becomes accurate.

Summary of the Department's Evaluation of the Company's Response:

p) The Company acknowledges that the claim handler mistakenly copied the contractor's scope for heavy damage which it claimed resulted in overpaying the insured. However, the Company failed to explain to the insured its assessment of damage as light cleaning versus the contractor's assessment of heavy damage.

q) The claim file does not reflect that the Company disclosed the insured's applicable coverages, specifically advising the insured under Coverage C that increased meal expenses for eating out would not be covered when a kitchen is available to the insured at their temporary displacement location during the contact call on January 14, 2025. The file documentation reflects that this coverage limitation was not communicated to the insured until June 18, 2025, at which time the Company explained that meal expenses would not be reimbursed. By then the insured had already relied to their detriment that these "incurred expenses" would be covered. The insured had been incurring meal costs for eating out and submitting receipts from the onset of the loss; however, the Company did not tell them these additional living expenses would not be covered over 5 months at which time it appears the Company was estopped from asserting this policy language.

r) The deductible taken from the exhausted limit from Coverage A should have been absorbed using other available coverages on the policy.

s) The Company inspected the property on January 22, 2025 and the inspection notes state there was heavy smoke odor with ash and soot present. The parking garage, and the buildings behind and to the side of the insured's property were 100% total fire losses. The Company did not assign a vendor to at least assess the insured property damage, and the supplement did not use the current labor rate for when it was written.

t) The Company acknowledges that it incorrectly used a labor efficiency rate of restoration/remodel/service instead of new, however it did not explain this error to the insured. While the Company continues to be available to discuss this estimate with the insureds if they have additional information to present and believes that the estimate accurately reflects the information available when written, its estimate to rebuild is not consistent with the likely cost to rebuild give the demands for labor and materials in the Palisades area.

These issues are unresolved.

11. <u>In 18 instances, the Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.</u> The Company received proof of claim for Additional Living Expenses (ALE), damage to personal property, cleaning estimates, repair estimates, lost jewelry, a signed lease agreement, smoke radiation, personal property pack, environmental testing expenses, landscaping repairs, and debris removal. The Company did not accept or deny these claims in whole or in part within 40 calendar

days of receipt. The Department alleges these acts are in violation of CCR §2695.7(b) and are unfair practices under CIC §790.03(h)(4).

Summary of the Company's Response: The Company acknowledges the findings described below:

In 11 instances, the Company agrees that the Company failed to accept or deny the claims within regulatory timelines. The Company states that these were file-specific errors of the claim handlers that are not indicative of the pattern and practices of the Company's overall claim handling. As a result of Department inquiries, the Company reopened one claim and paid $12,923.98 for debris removal fees and $1,316,37 for landscaping fees that were listed in the contractor's estimate, and reopened another claim and paid $1,019.25 for personal property and additional living expenses.

The Company conducted team meetings in the 4th Quarter of 2025 to reinforce the need for compliance with California claims handlers. The Company states it does not believe these instances rise to the level of a violation of CIC §790.03(h)(4).

In seven instances, the Company does not agree with the findings because the claims have since been accepted and paid; the limits were already paid, and no additional funds are available; and/or the Company continues with the process of reviewing the claims.

Summary of the Department's Evaluation of the Company's Response: Regardless of whether the claims have ultimately been accepted or paid or remain to be paid in the disputed seven instances, the Company is required by regulation to accept or deny them within the regulatory timeline of 40 days. In these instances, the Company did not accept or deny the claims until well beyond 40 days. Examples among these instances include: pool and driveway damages were accepted 94 days late; the pool bid, balcony bid, and window bid accepted 85 days late; the roof area inspection accepted 86 days late; and interior and exterior testing accepted 87 days late.

The Company has not stated how it intends to ensure that future claims will be accepted or denied within the 40-day regulatory timeframe. Any ongoing discussions with the insureds or their representatives do not excuse non-compliance, unless they are clearly documented as to the basis of additional time needed. This is an unresolved issue.

12. In 18 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. These instances are described as follows:

a) The Company delayed assigning a hygienist for 88 days after receiving a repair estimate.
b) There was no active investigation documented in the file for 88 days.

c) The Company handled the claim inconsistently which resulted in overpayment for displacement, the use of varying rates to calculate mileage, and unclear settlement letters to the insured.
d) The claim file lacked clear documentation of the insured's displacement locations, dates, and whether they included a kitchen. It is unclear if the insured incurred additional ALE expenses beyond the advance, and if additional payments were owed.
e) The Company did not review the insured's Covenants, Conditions and Restrictions (CC&Rs) claim file to evaluate the responsibility of the insured versus the Homeowners Association. (HOA).
f) The adjuster failed to explain the breakdown of the Loss of Rent (LOR) despite multiple email requests from the insured. The Team Manager also instructed the adjuster to contact the insured which was not done.
g) There was a delay of over two months (April 16, 2025 to June 24, 2025) in inspecting a property after the First Notice of Loss (FNOL), despite multiple follow-ups from the insured's attorney.
h) The Company failed to set reserves for a Loss of Rent (LOR) claim following a tenant evacuation.
i) The Company did not actively pursue necessary documentation for a Loss of Rent (LOR) claim, and the file was noted as "No LOR noted". This resulted in the claim file being prematurely closed before investigation was complete.
j) The insured's home was a total burn, and he was incurring Additional Living Expenses (ALE) for lodging as of January 7, 2025. He provided the Company with a signed lease agreement in April 2025. The Company sent multiple notices advising it needed additional time and did not validate the ALE claim for $18,000.00 per month until July 2025.
k) The Company inspected the insured's property on February 14, 2025. The insured's attorney provided proof of claim for pack-out expenses, demolition and repairs on March 26, 2025. Following this date, the attorney sent multiple emails inquiring about delays, while the Company sent numerous letters stating a need for additional investigation time.
l) There was no adjuster activity in the file for the period of 30 days between May 5, 2025 and June 4, 2025.
m) The Company did not follow its process for the insured's LOR claim which caused delays and confusion, an incorrect settlement amount, a referral to the wrong team, and telling the insured a check was ready to be picked up at the Catastrophe tent when it was not approved. The Company did not advise the insured that a Schedule E tax form was needed to calculate the settlement.
n) The insured informed the Company that he replaced his garage door due to wind damage; however, the Company closed the file without following up on documentation to pay the claim. The Company has an affirmative duty to investigate and a duty to follow up on missing information rather than closing the claim.

o) The Company did not explain the LOR breakdown to the insured, despite the insured's multiple emails requesting clarity. There was also a manager's direction to call the insured which the adjuster failed to do.
p) The insured's attorney sent multiple emails to set up an inspection and asserted the Company did not communicate back for two months.
q) The insured obtained an estimate from Servpro to inspect the property on January 13, 2025. Servpro wrote an estimate for smoke damage remediation in the amount of $72,488.30 that included asbestos mitigation in the amount of $18,250. The Company assigned Servpro in April to write an estimate on its behalf on April 16, 2025. Servpro wrote an estimate for the same damages in the amount of $44,373.18. Six months elapsed to resolve the claim.
r) The Company assigned the claim to Servpro to inspect the property on January 20, 2025, however it did not follow up until March 1, 2025, only after a management review (40 days). Further, the Company did not prepare an itemized estimate after receiving Servpro's bulk cleaning estimate which delayed reconciliation of estimates. The Company also delayed inspection of personal property items. This inaction contributed to additional issues when the Company later discovered that Servpro had bagged and disposed of said items while not clearly documenting the items discarded. As of August 19, 2025, the personal property portion was not settled, and the Company advised the public adjuster that it could not agree to all items being claimed at that time.

The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees to the findings that it failed to conduct a diligent, thorough, and fair investigation in the 16 instances labeled (a) through (p) above. The Company stated that these were file-specific errors, and conducted team meetings during the 4th quarter of 2025 to reiterate requirements and the need for compliance with California claim handlers. Where applicable the Company has now reopened claims and otherwise followed up with insureds to complete appropriate investigation and in one of these instances, as result of the Department's inquiry, paid the insured $5,500.00 for lost rent.

In the last two instances, the Company does not believe it failed to conduct a diligent, thorough and fair investigation as described below:

q) The Company does not agree with the finding and states the first Servpro provider assigned did not conduct an inspection, and his identity is not known. The Servpro estimate conducted for the Company was received on April 11, 2025. The Company, upon settlement discussions with the insured settled the smoke damage remediation on May 16, 2025. The Company further states it is a normal process to have reconciliation with the contractor for differences in opinion. The claim for asbestos remediation was reconciled and settled on December 1, 2025.

r) The Company does not agree with the finding. The Company created an estimate-only assignment on January 25, 2025, and informed the insured the same day. Follow-up contact occurred on February 28, during which the insured did not disclose they were using a new vendor. The Company first received the new vendor information on March 5 and the estimate on March 7. The bid was reconciled and accepted on March 21, however it remained within the previously issued advance payment. All other issues were resolved within 14 days of receiving the contractor's estimate. The file shows multiple offers to help the insureds complete their personal property inventory, including offers for in-person assistance.

Summary of the Department's Evaluation of the Company's Response: With respect to item q), a standard reconciliation process where the insurer and the Public Adjuster (PA) collaborated to refine the claim scope should not take several months particularly on the issue of asbestos abatement, which was evident from the onset of the claim. It took almost a year to get settled and the Company's use of a preferred vendor Servpro may present a conflict of interest. The Company has not proposed corrective action.

With respect to item r), the lack of contact with Servpro and the Company's failure to prepare an itemized estimate after receiving Servpro's bulk cleaning estimate delayed reconciliation of estimates. The Company has not proposed corrective action.

These issues are unresolved.

13. In 15 instances, the Company, after assigning three or more adjusters within a six-month period to a claim under a policy of residential insurance arising as a result of a declared state of emergency, failed to in a timely manner assign a real or personal property claims adjuster to be primarily responsible for a claim, provide the insured with a written status report, establish a primary point of contact for the insured, and provide the insured with one or more direct means of communication with the primary point of contact. The Department alleges these acts are in violation of CIC §14047(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings and responds as follows:

In 11 instances, the Company agrees it did not provide the insureds with a primary point of contact following the assignment of a third or subsequent claims adjuster. The Company indicates these were file-specific errors on the part of the claim adjusters and are not indicative of the pattern and practices of the Company's overall claim handling. The Company conducted refresher training in team meetings held in the 4th Quarter of 2025.

In four instances, the Company does not agree it failed to comply with CIC §14047(a). The Company admits there were 4 to 5 adjusters assigned to three of these claims, and a team consisting of seven members assigned to the fourth. "Other performers" were also assigned to aid in claim handling for these teams. The Company stated it considers the entire team to be the claim owner, and is therefore the primary point of contact regardless of which team member is communicating with the insured. The Company further stated that reassignment and/or status letters were sent when claims were given to a new claim owner.

Summary of the Department's Evaluation of the Company's Response: The Company's process in these cases failed to provide the insureds with a written status report and/or to establish a primary point of contact with one or more direct means of communication, and instead created confusion for the insureds who were left feeling like they were given the "run around" by the Company. The Company has not proposed any change in process to ensure compliance. This is an unresolved issue.

14. In 11 instances, the Company failed to include a statement in its claim denial that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that the right to review by the California Department of Insurance was not referenced in its denial letter. In nine instances, the Company provided the referral language in revised letters to the insureds. In two instances, the claims were reopened and paid.

The Company held team meetings in the 4th Quarter of 2025 with California claim handlers to reiterate the need to include this required communication in its denial letters. The Company does not believe these instances rise to the level of a violation of a CIC §790.03(h)(3).

15. In seven instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. These instances are described below:

a) In two instances on one claim, the Company sent denial letters for hygienist testing stating that the testing was not payable because it would be considered a safety inspection. The initial invoice for $4,125.00 was denied on March 6, 2025 and the supplemental invoice for $5,985.00 was denied on June 10, 2025.
b) In one instance, the Company misrepresented to the insured's son that payments under Coverage C – Loss of Rents would be issued only as incurred.

c) In one instance, the Company issued a $100,000.00 advance payment, coded under personal property (COV B). The Company, however, misrepresented that it had to withhold $10,000.00 to account for the insured's deductible.
d) In one instance, the Company misrepresented that the policy does not pay for temporary housing outside the country.
e) In one instance, the Company misrepresented that air testing may be approved if completed before mitigation, although not afterward due to the "contamination exclusion."
f) In one instance, the Company advised the insured that he would not be entitled to the Loss of Rent benefit if the tenant decided to cancel the lease.

The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges the findings as follows:

a) The Company revised the State Farm estimate and had already issued payment on November 26, 2025 for the initial invoice. As the result of the Department's inquiry, an additional payment was issued on December 20, 2025 for $5,985.00.
b) The Company agrees with the findings and states that this was a file-specific error and is not indicative of the pattern and practices of its overall claim handling. State Farm has provided payment for our insured's entire claim under Coverage C – Loss of Rents during an in-person meeting on April 29, 2025, in accordance with the applicable policy language.
c) The Company agrees that the withholding of $10,000.00 was an error which was then corrected on February 5, 2025, with an additional payment of $10,000.00.
d) The Company agrees with the finding and is currently working with the insured on their incurred additional living expenses, including but not limited to housing costs, which may have been incurred while they resided outside the United States.
e) The Company agrees with the finding regarding this inquiry of post-cleaning testing and states it was an unintentional oversight on the part of the claim handler.
f) The Company agrees with the finding about the incorrect information provided regarding the Loss of Rents policy provision. The claim was re-opened, and the correct Loss of Rents policy provision information was provided to the insureds in a letter dated August 29, 2025.

The Company states that team meetings were held in the 4th quarter of 2025 with all California claim handlers for compliance reinforcement. The Company states it does not believe the above instances are indicative of the pattern and practices of the Company's overall claim handling and therefore do not rise to the level of a CIC 790.03(h)(1) violation.

16. In five instances, the Company failed to provide the claimant with a copy of the most recent notice describing the most significant California laws pertaining to property insurance policies, including those related to a declared state of

emergency, as defined in Section 8558 of the Government Code, or other emergency declared by a public official no later than 15 calendar days from the date on which the insurer received notice of the claim. Specifically, the Declared Disaster Forms were not sent in four (4) instances and were sent beyond the statutory timeline in one (1) instance. The Department alleges these acts are in violation of CIC §14046(b)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings and states that team meetings were held in the 4th quarter of 2025 with all California claim handlers to reiterate the need to send required documentation timely. The Company however does not believe these instances rise to the level of a CIC §790.03(h)(3) violation as these were file-specific errors by the claim handlers.

17. In four instances, the Company failed, upon receiving notice of claim, to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. These instances are described below:

a) The Company failed to provide the insured within 15 calendar days the necessary instructions regarding Loss of Rent, such as what documentation is required and steps to receive payment.
b) The Company provided the insured the contents form 48 days after the claim was reported.
c) The Company did provide proper reasonable assistance upon notice of claim. The Company did not assign its preferred mitigation vendor, Servpro, to assess smoke damage, which is the Company's standard process for smoke and ash claims.
d) The Company did not give instructions on the process of food abatement within 15 calendar days which would impact on the insured's meal reimbursements. The claim was reported on January 10, 2025; however, the Company did not provide documentation on the food abatement process until March 21, 2025 via status letter – 70 days after the claim was reported

The Department alleges these acts are in violation of CCR §2695.5(e)(2) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings as follows:

a) The Company agrees the claims handler failed to address the Loss of Rent coverage and this was a file-specific error by the claim handler.
b) The Company agrees the Contents form was provided late and states this was an unintentional oversight by the claim handler.

The Company conducted team meetings in the 4th quarter of 2025 to remind its claim handlers of the importance of following required regulatory timelines.

c. As to item (c) above, the claim was reported late on May 19, 2025, 131 days after the date of loss, which presented a potential breach of contract by the insured. Thus, the loss was handled under a Reservation or Rights which on June 4, 2025 while the Company was investigating coverage issues.
d. As to item (d) above, the claim handler explained ALE coverage and how it applied on January 25, 2025. The Company's file note of March 5, 2025 reflects "NI (*insured*) to keep a list and receipts of expenses…."

Summary of the Department's Evaluation of the Company's Response: The Department's position on items (c) and (d) are as follows:

c) A Reservation of Rights for late notice of claim does not absolve the Company of its duty to perform and assist the insured as required by this regulation.

d) As to food abatement, the following notes on the file reflect there was no instruction or assistance within the 15-day regulatory timeline The claim was reported on January 10, 2025. The Company's file note from claim dated July 7, 2025, includes team manager's input when stating "CO discussed food not being abated by prior adjuster from 1/7/25-2/28/25. TM advised CO to only abate most recent food receipts since no one discussed abatement with PH's. CO has deleted individual line entries for food and moved the total cost of food pre-abatement to misc. CO will add food receipts from May to ALE WS for abatement".

These issues remain unresolved.

18. In three instances, the Company misled a claimant as to the applicable statute of limitations. The Company sent closing and denial letters to the insured advising of statute of limitation and stating that "the action must be started within one year after the date of loss or damage." The Department alleges these acts are in violation of CIC §790.03(h)(15).

Summary of the Company's Response: The Company agrees with the findings and states that these were file-specific errors by the claim handlers. The Company reopened the pertinent claims to send updated letters to the insureds regarding the statute of limitation. The Company reiterated this requirement to its California claim handlers through its team meetings conducted in the 4th quarter of 2025. The Company does not believe these instances rise to the level of a violation of a CIC §790.03(h)(15).

19. In three instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. These instances are described below in one instance each:

a) The Company sent communication and payment to the insured's uninhabitable address.
b) The Company prematurely closed the claim with significant items outstanding, including need for cleaning of the swimming pool and the need to remove and replace the attic insulation, instead of following up with the insured to obtain estimates.
c) The Company initially advised the insured that it was unable to issue any advance payment under ALE because the house was still "standing". Following receipt of a corporate complaint, however, the Company decided to approve six months of ALE without proof that there was a long-term lease, and/or that lodging expenses would be incurred.

The Department alleges these acts are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings as follows:

a) The Company agrees it mailed communication to the wrong address. The Company has reiterated the importance of accuracy in the mailing address selection in team meetings.
b) The Company states that the claim was closed on May 19, 2025. Since the claim was in a closed status for this time period, there was no active claim handling necessary. Claim handling continued when the claim was re-opened for new mail submitted into the claim on August 4, 2025.
c) The Company believes it followed its own practices and procedures wherein a Team Manager approved reasonable costs under this coverage based on verbal conversations with the insured and their son wherein the Company concluded that the insureds stayed in numerous Airbnb locations. The Company admits that despite repeated requests, the insureds have failed to submit copies of signed leases or Airbnb receipts to charge back against the ALE advances.

Summary of the Department's Evaluation of the Company's Response: With respect to item b), this claim was closed prematurely, when the Company knew that it had not resolved the smoke damage claims for pool cleaning and attic insulation. The Company should have been diligently working to resolve these claims instead of shifting that responsibility to its insured. The Company did not present a plan for corrective action.

With respect to item c), the Company did not follow its own established practices and procedures as documented in this file and many others that involved ALE claims for smoke damage only losses. The Company repeatedly told insureds, including this one, that it could not issue advanced payments for ALE if the house was still standing and that ALE is "an incurred coverage;" however, in this instance the Company deviated from that practice and issued 6 months of projected ALE with no documented evidence that a lodging expense for this amount had been or would be incurred. It appears the Company made an exception for this insured because they filed a corporate complaint.

These are unresolved issues.

20. <u>In three instances, the Company failed, upon receiving notice of claim, to begin any necessary investigation within 15 calendar days.</u> These instances were as follows:

a) The Company failed to assign and complete an inspection until 34 days after the notice of claim.
b) The Company received notice of claim on January 14, 2025 and closed the claim. The Company began its investigation 91 days after the claim was reopened.
c) The Company delayed the hygienist process from April 29, 2025, to June 4, 2025 – a total of 36 days.

The Department alleges these acts are in violation of CCR §2695.5(e)(3) and are unfair practices under CIC §790.03(h)(3).

<u>Summary of Company's Response:</u> The Company acknowledges the findings that these instances were all outside of the regulatory timelines to conduct necessary investigation: The Company further stated:

a) While the claim was reported by the policyholder on February 7, 2025, the inspection of the damage took place on March 13, 2025.
b) The Company agrees the claim was inadvertently closed by its claim handler on January 14, 2025 and was reopened for an inspection on April 21, 2025.
c) Given the size and nature of this large event, the timing and hiring of the hygienist seem reasonable.

The Company conducted team meetings in the 4th Quarter of 2025 to reinforce compliance with the need to timely initiate and conduct investigations. The Company does not believe these instances rise to the level of a CIC 790.03(h)(3) violation.

21. <u>In three instances, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.</u>

a) In the first instance, the Additional Living Expense (ALE) Worksheet was not provided with the initial Coverage C payment.
b) In the second instance, the insured reported to the reassigned adjuster that the prior adjuster had approved interior and exterior testing. There are no claim file notes or records on this agreement.
c) In the third instance, the insured requested withdrawal of his claim on January 14, 2025; however, there is no documentation in the file that the insured was sent a letter confirming this request.

The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the findings as follows:

a) In the first instance, the Company agrees that no ALE worksheet was provided with the initial Coverage C payment. This was an oversight on the part of the claim handler.
b) In the second instance, the Company acknowledges there were discrepancies in the file notes documented by the prior adjuster.
c) In the third instance, the Company agrees with the finding and sent a confirmation letter to the insured on January 7, 2026.

Further, for these 3 file-specific errors, coaching was provided regarding the requirements of CCR § 2695.3(a). The Company does not believe these instances rise to the level of a CIC § 790.03(h) violation.

22. In two instances, the Company failed to provide, free of charge, a complete copy of the insured's current insurance policy or certificate within 30 calendar days of receipt of a request from the insured after a covered loss. The Department alleges these acts are in violation of CIC §395 and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company acknowledges the findings and states that these were file-specific errors of the claims handler and are not indicative of the pattern and practices of the Company's overall claims handling. As a result of the examination, the Company sent a copy of the insurance policy to the insured's son on November 15, 2025 in the first instance, and to the Public Adjuster on February 23, 2026 in the second instance.

The Company has reiterated the need for compliance to California claim handlers during its team meetings held in the 4th Quarter of 2025. The Company believes these instances do not rise to the level of a violation of CIC §790.03(h)(2).

23. In two instances, the Company failed to comply with the requirements of CCR §2695.9(d) as described below:

a) In one instance, the Company failed to prepare the estimate in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction.

b) **In one instance, the Company settled the claim on the basis of a written scope and/or estimate without supplying the insured with a copy of each document upon which the settlement was based.**

The Department alleges these acts are in violation of CCR §2695.9(d) and are unfair practices under CIC §790.03(h)(3)

Summary of the Company's Response: The Company agrees with the findings and stated these were unintentional oversights by the claim handlers. The Company conducted team meetings in the 4th Quarter of 2025 to reinforce requirements for compliance with claims staff. In addition, for item (b) above, the Company reopened the claim to send a copy of the Payment Worksheet to the insured. The Company does not believe the above instances rise to the level of a violation of CIC §790.03(h)(3).

24. In two instances, the Company failed to supply the claimant with a copy of the insurer adjusted estimate from the repair individual or entity of the insured's choice. In one instance, the adjuster subtracted three line items from an estimate for hard goods cleaning, however the Company failed to provide the insured with a copy of the revised estimate. In the second instance, the Company failed to supply the insured with a copy of the adjusted estimate from the repair entity of the insured's choice. The Department alleges these acts are in violation of CCR §2695.9(d)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees to the findings and held team meetings with all California claim handlers in the 4th Quarter of 2025 to reiterate the need to send the required documentation. As a result of this examination, the Company sent the revised estimates to the insureds. The Company does not believe the above instances rise to the level of a violation of CIC § 790.03(h)(3).

25. In two instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. In the first instance, the Company failed to provide the insured with disclosure of the applicable coverage on the initial contact dates of January 13, 2025 and the following day when the insured requested the claim to be reopened. In the second instance, the Company provided the insured with an inaccurate time limit (deadline) for eligibility of recoverable depreciation within two years. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company agrees with the findings. In the first instance, the Company confirmed that it did not complete its Quality First Contact until April 15, 2025, or more than 3 months from initial contact. In the second instance, the Company agrees that an incorrect date (timeline) was provided in the initial letter to the insured. As a result of this finding, the Company has provided the insured

with the correct date (timeline) on October 16, 2025. The Company has also reinforced compliance with its California claim handlers in team meetings during the 4th Quarter of 2025. The Company does not believe these instances rise to the level of a violation of CIC §790.03(h)(1).

26. In one instance, the Company failed, upon receiving notice of claim, to provide the insured with a copy of §790.03 of the California Insurance Code within 15 calendar days. The insured was not provided with a copy of the required notice. The Department alleges this act is in violation of CIC §790.034(b)(1) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with this finding and states this was a file-specific error by the claim handler. The Company conducted team meetings in the 4th Quarter of 2025 and emphasized compliance to its California claim handlers.

27. In one instance, the Company failed to provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. The Company sent the insured a letter advising it is unable to pay the insured's claim however, it failed to provide written notice of a time period requirement or statute of limitation upon which the Company may rely to deny a claim. The Department alleges this act is in violation of CCR §2695.7(f) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states it did not deny the claim because at that time, the claim was below the insured's deductible. However, in response to the Department's inquiries the Company reopened the claim to send an updated letter to the insured with this statute of limitation (SOL) notice on December 19, 2025.

28. In one instance, the Company failed to offer a payment under the contents (personal property) coverage in an amount no less than 30 percent of the policy limit applicable to the covered dwelling structure, up to a maximum of two hundred fifty thousand dollars ($250,000), without requiring the insured to file an itemized claim if the residence was furnished at the time of the loss. The maximum amount of $250,000.00 was not met in this instance. However, the Company stated that "…no additional amounts for personal property will be paid without documentation consistent with policy requirements". The Department alleges this act is in violation of CIC §10103.7(b)(1) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges this finding and states that the initial advance was provided to the insured for immediate needs on January 15, 2025. An additional advance was paid on January 18, 2025 when the Company realized it did not comply with the requirement of CIC §10103.7(b)(1), Further,

the Company also erroneously applied the deductible amount against the advance payment thus this was refunded back to the insured on February 5, 2025. However, the Company does not believe this instance constitutes a violation of CIC §790.03(h)(5).

GENERAL FINDINGS

29. The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear, by charging the cost of hygienist and environmental testing in smoke damaged dwellings against the insured's policy limit of indemnity instead of treating it as a loss adjustment expense. Six cases where this occurred were observed in the examination sample. This practice reduces the amount of Coverage A available to the insured to rebuild or replace the dwelling and fails to properly classify costs associated with determining the scope of loss.

The Department alleges this is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company does not agree with this finding. The Company stated it did not request the testing in these cases, but rather the insureds hired the testing company on their own behalf. The Company did not rely upon the information provided within the reports for the adjustment of the claims. Since the Company did not rely upon the insureds' reports to write estimates or adjust claims, it did not consider these to be loss adjustment expenses.

Summary of the Department's Evaluation of the Company's Response: Charging the insured's testing costs against the limit of indemnity unfairly disadvantages the insured by reducing policy coverage. It should also be noted that the Company primarily uses Servpro vendors to perform assessments of smoke damage and prepare estimates for remediation. These vendors serve the Company's interests in managing claims for cost control and efficiency, which may conflict with additional information that speaks to the scope of the loss as obtained through hygienist or environmental testing, whether that testing is secured by the insured or by the Company. The Company has not taken steps to revise this practice. This issue is unresolved.

30. The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue by sending denial letters to insureds seeking reimbursement for hygienist and environmental testing that cite to the "Right to Inspect" provision of the policy as the basis for denial. This provision of the policy speaks to the Company's right to inspect a property to verify its insurability for underwriting purposes. The Company's use of this provision as grounds to deny a claim is a misrepresentation. At least 12 cases where this occurred were observed in the examination sample.

The Department alleges this is an unfair practice under CIC §790.03(h)(1).

Summary of the Company's Response: The Company agrees the section of the policy cited was not the appropriate section to justify claim denials and the section will not be used as such in future events. However, the Company maintains its position that these instances do not rise to the level of a general business practice and, thus, do not constitute a CIC § 790.03(h)(1) violation.

EXHIBIT C

State Farm General Insurance Company
1 State Farm Plaza
Bloomington, IL 61710-0001

June 2, 2026

Towanda David, MCM
California Department of Insurance
Chief, Field Claims Bureau
300 South Spring Street, 10th Floor
Los Angeles, California 90013
Towanda.David@insurance.ca.gov

Re: State Farm General Insurance Company; NAIC # 25151
Targeted Market Conduct Examination – Palisades and Eaton Fires

Dear Ms. David:

State Farm General Insurance Company ("State Farm" or the "Company") acknowledges receipt of the Adopted Report (the "Report") of the California Department of Insurance's ("Department" or "CDI") Market Conduct Exam following the Palisades and Eaton wildfires of January 2025. The Report was adopted by the Commissioner on May 1, 2026, and transmitted to State Farm via email on May 4, 2026. State Farm submits its comments to the Report pursuant to Section 12938(b) of the Insurance Code and requests that the Department publish our comments together with the posting of the Report.

Importantly, these comments follow the process laid out by the CDI and should serve as public record of State Farm's response to the Report. Unfortunately, the Commissioner chose to publicly release the entirety of the Report weeks ago without State Farm's response, politicizing a tragic event and threatening to suspend State Farm's ability to serve customers over primarily administrative and procedural errors. We reject any suggestion that State Farm engaged in a general practice of mishandling or intentionally underpaying wildfire claims.

To the contrary, ***State Farm has been laser-focused on helping customers*** since the devastating wildfires in January 2025 that killed at least 28 people and destroyed more than 18,000 structures. State Farm received over 11,000 claims, corresponded with its insureds over 2 million times and has issued over $5.9 billion in payments.

This Market Conduct Examination is unprecedented both in terms of timing (noticed only 5 months after the catastrophe) and in its inclusion of open claims in the review. At only 5 months after the event, the Company was in the very early stages of handling claims and engaged in ongoing fact gathering and investigation.

While State Farm and CDI may agree on some facts related to, and the timing of steps taken as to, certain files, there are significant differences in terms of interpretation of those facts. Several findings in the Report are not supported by statute, regulation, or insurance contract provisions. The Report includes arbitrary interpretations of the Insurance Code. And it highlights a small scope of minor and/or technical alleged violations. In 12 of the 30 Report findings, the Department identified no more than three instances of the activity described.

With respect to the Report findings, State Farm maintains its position that ***none of the Report's allegations rise to the level of a "general practice" by the Company in violation of Section 790.03(h) of the Insurance Code, nor were they knowingly performed.*** State Farm's disagreement with CDI's conclusions and statements about the scope and content of the law is discussed below in detail.

State Farm is proud of its response to the Palisades and Eaton wildfires. We recognize that in an event of this scale, a perfect process is impossible but extraordinary progress has been made toward helping people recover. And State Farm is committed to addressing remaining customer concerns. In instances where State Farm acknowledged file-specific errors, we identified remedial or corrective action where appropriate, including refresher training, and noted whether that action has been completed or is still being implemented.

To address concerns raised by CDI throughout the Report, and further build on the work State Farm has already done to help its insureds recover after the fires, we recently announced additional customer commitments, including refining our existing processes to assign a single point of contact for each customer with an open wildfire claim, providing direct contact information, offering weekly proactive updates unless the customer prefers otherwise, and using a transparent handoff if reassignment is needed. Those steps are designed to give customers clear, consistent support throughout recovery.

State Farm submits the following comments specific to several Report findings.

Finding 1—Status Letters

State Farm sent 2,033 status letters in the 220 reviewed claim files. Of the status letters identified as late in the Report, approximately 20% were mailed within 7 days of the required date. And approximately 50% came from just 11 of the total 220 claim files reviewed. Notwithstanding these relatively few instances, and even as to the affected files, State Farm's insureds were continuously kept informed throughout the claim process with verbal and other types of communications. The Company maintains its position that these isolated instances do not rise to the level of general business practice and, thus, do not constitute a CIC 790.03(h)(3) violation.

Finding 3—Statute of Limitations Notifications

Prior to the Commissioner's adoption of the Report, State Farm advised CDI that full corrective action had been taken to address this finding, but CDI chose to omit the details of that action from the Adopted Report. State Farm sent supplementary correspondence with the correct time-to-file-suit provision on or before April 1, 2026, to all policyholders for which notification was required in connection with the Palisades/Eaton fires. State Farm also has gone one step further: Although CDI has not included this law in its annual notice of Significant California Laws Pertaining to Residential Property Insurance Policies, State Farm has added this section to the letter it sends to insureds making them aware of these important laws.

The Company maintains its position that these instances do not rise to the level of a general business practice and, thus, do not constitute a CIC 790.03(h)(1) violation.

Finding 6—Fraud Warnings

State Farm respectfully disagrees with the Department's conclusion that State Farm "failed to include the California fraud warning on insurance forms." The Company maintains its position that Section 1871.2(a) of the Insurance Code does not set forth a legal requirement that the fraud language be included on forms that do not constitute "notice" as contemplated in the statute. Although CDI asserts that the referenced forms require the fraud language, it provides no legal basis for that assertion. Absent such a legal requirement, it also follows that there is no violation of Section 790.03(h)(3).

Finding 8—Application of Depreciation or Betterment

State Farm respectfully disagrees with the Department's conclusion that State Farm incorrectly applied betterment or depreciation to specific types of property under a non-homeowners policy, including a Rental Dwelling policy. As the Department acknowledges, under the California Code of Regulations, Title 10, Chapter 5, subchapter 7.5, section 2695.9(f), there is no delineation of the types of specific structural components that should or should not be excluded from depreciation. Rather, the Department has expressed its opinion as to the useful life/life expectancy of specific items without any support as the underlying basis for such opinion. Basing a finding and alleged violation of a regulation on a previously unstated and unsupported interpretation of that regulation by the regulating entity is arbitrary. Absent a violation of the referenced regulation, it also follows that there is no violation of Section 790.03(h)(5).

Finding 13—Primary Points of Contact

As defined under California Code section 14047(d)(2), a primary point of contact is "a first-party real or personal property claims adjuster *or team* employed as a member or members of the insurer's staff who are knowledgeable about the claim and its current status." (Emphasis added.)

These files were consistently handled utilizing a team of adjusters and therefore were compliant with the statutory requirement. For the noted instances of noncompliance, the Company disagrees that this issue remains unresolved as State Farm has provided the Department with message points addressing the issues that were discussed in internal meetings in the 4th Quarter of 2025, as acknowledged in the Commissioner's Adopted Report. As noted above, despite State Farm's position that a team can be a primary point of contact, State Farm has announced further customer commitments to provide consistent support for policyholders throughout recovery, including assigning a single point of contact. The Company maintains its position that these instances were not violations of California Code section 14047(d)(2) and do not rise to the level of a general business practice and, thus, do not constitute a CIC 790.03(h)(3) violation.

Finding 29—Environmental Testing

State Farm respectfully disagrees with the Department's conclusion that State Farm violated Section 790.03(h)(5) of the Insurance Code as the cited section of the code does not support such a finding. The Department provides no basis for the conclusion that the costs of tests requested and procured by the insured should be paid as a loss adjustment expense. The Company previously explained that it did not request testing in these cases, but rather the insureds hired the testing company on their own behalf. For the adjustment of these claims, the Company did not rely upon the information provided within the reports obtained by the insureds; therefore, while State Farm paid for the cost of testing, it did not consider these costs to be loss adjustment expenses.

State Farm is unaware of any statute, regulation, or contract provision that supports the Department's conclusion or the finding on which the conclusion is based.

Sincerely,

Paula J Lutes

Paula Lutes
Counsel