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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.

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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).

<u>Summary of the Company's Response:</u> 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.