REPORT OF MARKET CONDUCT EXAMINATION

Travelers Insurance Group
NAIC Group #3548

The following companies within the group were included in the exam:

THE AUTOMOBILE INSURANCE CO. OF HARTFORD, CT	**NAIC #**	**19062**
THE STANDARD FIRE INSURANCE CO.	**NAIC #**	**19070**
THE CHARTER OAK FIRE INSURANCE CO.	**NAIC #**	**25615**
THE PHOENIX INSURANCE CO.	**NAIC #**	**25623**
THE TRAVELERS INDEMNITY CO.	**NAIC #**	**25658**
THE TRAVELERS INDEMNITY CO. OF AMERICA	**NAIC #**	**25666**
THE TRAVELERS HOME & MARINE INSURANCE CO.	**NAIC #**	**27998**
TRAVCO INSURANCE CO.	**NAIC #**	**28188**
TRAVELERS COMMERCIAL INS CO.	**NAIC #**	**36137**
TRAVELERS PROPERTY CASUALTY INSURANCE CO.	**NAIC #**	**36161**

Travelers Group
One Tower Square
Hartford, CT 06183-1100

AS OF

July 31, 2008

BY

KANSAS INSURANCE DEPARTMENT
ETS# KS023-M33

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Honorable Sandy Praeger
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612-1603

Dear Commissioner Praeger:

In accordance with your respective authorization, and pursuant to K.S.A. 40-222, a market conduct examination has been conducted on the business affairs of:

THE AUTOMOBILE INSURANCE CO. OF HARTFORD, CT
THE STANDARD FIRE INSURANCE CO.
THE CHARTER OAK FIRE INSURANCE CO.
THE PHOENIX INSURANCE CO.
THE TRAVELERS INDEMNITY CO.
THE TRAVELERS INDEMNITY CO. OF AMERICA
THE TRAVELERS HOME & MARINE INSURANCE CO.
TRAVCO INSURANCE CO.
TRAVELERS COMMERCIAL INS CO.
TRAVELERS PROPERTY CASUALTY INSURANCE CO.

Travelers Group
One Tower Square
Hartford, CT 06183-1100

hereafter referred to as "Travelers" or "the Company", and the following report of such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, FLMI, ARM, ARe
Market Conduct Supervisor
Examiner in Charge

PURPOSE AND SCOPE OF REVIEW

A targeted market conduct examination of selected companies of the Travelers Insurance Group was conducted pursuant to K.S.A. 40-222. The exam team reviewed personal lines underwriting, claim files and complaints to determine if the Company was in compliance with applicable statutes, regulations and bulletins of the State of Kansas.

The audit was conducted according to the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2008 (Handbook). The exam team utilized the standards and tests recommended in the Handbook. An acceptable tolerance standard of a 7% maximum error rate was used for claim procedures and a 10% maximum error rate was used for all other categories. The examination report is a report written by test rather than a report written by exception. This means all standard tests that were used are described and results indicated.

The exam team reviewed personal lines claim and complaint files in Overland Park, KS. Personal lines underwriting and additional complaint files were reviewed in the Company's administrative office in Hartford, CT. The exam period under review was January 1, 2007 through July 31, 2008.

The examination included, but was **not limited to the following:**

COMPANY OVERVIEW
History and Profile
Prior Market Conduct Examination Reports
Fines and/or Penalties

COMPLAINT HANDLING
Record Keeping
Timely Response

UNDERWRITING & RATING
Proper Rating
Underwriting Acceptance/Termination
Use of Appropriate Forms
Promptness of Policy Issuance
Proper Maintenance of Underwriting Files

CLAIMS
Claim Processing
Timeliness and Accuracy of Claim Payment
Proper Maintenance of Claim Files

EXECUTIVE SUMMARY

The Kansas Insurance Department (KID) performed a market conduct examination of Travelers. The period of examination was January 1, 2007 through July 31, 2008. The exam focused on private passenger auto and homeowners lines of business. The Travelers companies also write numerous other lines, including workers compensation, commercial multiple peril, fire, inland marine, and allied lines among others.

The examiners reviewed the Company personal lines underwriting, rating manuals, claims, and complaints. A series of meetings were held with the Travelers staff that focused on their current operations. To supplement and verify the understanding of how the Company does business, a series of samples were selected for review to verify their procedures and practices in claims, underwriting and rating. There was an error discovered in rating homeowner policies, as well as a three cancellation notices were found to be in violation. There were no major issues noted with complaint or claim handling.

The Company passed most tests; and in terms of delivering good service to its insureds, the examiners were impressed with the overall positive and professional performance by the Travelers staff and management to their policyholders. However, the exam team has made recommendations on several policy and procedure issues.

LIST OF RECOMMENDATIONS

Underwriting and Rating

1. On the homeowners line of business, the rates charged for policy coverage were not in accordance with filed rates. The formula programmed into the Quantum homeowners system was slightly different than the formula filed with KID and resulted in either an overcharge or undercharge to the consumer. This affected 94 % of their homeowners book of business. There were a total of 8,995 policies that were overcharged an amount totaling $36,369, and 8,471 policies that were undercharged an amount totaling $41,107. This is a violation of K.S.A. 40-955(a)&(g).

Travelers needs to re-file their Quantum homeowners rule to reflect the correct way the age of the insured is to be calculated. Travelers needs to refund the excess premium to their 8,995 customers that were overcharged in their Quantum Homeowners program for the incorrect calculation of age of insured factor.

Examiner Notes:
The Company filed and received KID approval effective July 26, 2009 to amend the Quantum HO Rule 420—Age of Insured—to align the description of the rule with the actual system calculation of the insured's age. Refund checks were sent to overcharged policyholders on 10/19/10.

2. With regard to auto nonrenewals, the Company exceeded the 10% error tolerance level for Standard 16, which deals with whether nonrenewals comply with policy provisions and state laws. While there was no one specific issue with their nonrenewal procedures, there were three

areas that collectively caused them to fail this portion of the standard. Travelers needs to review their nonrenewal procedures to ensure they are handled appropriately.

Examiner Note:
Travelers indicated they will conduct additional staff training and reinforce existing training as appropriate.

3. The wording on Travelers auto cancellation notices, PL2900 and PL2901, did not have the complete wording on the notice as outlined in K.S.A. 40-3118(b) and must be updated.

Examiner Note:
The company has re-filed auto cancellation notices PL-2900 and PL-2901 effective August 1, 2009 to comply with K.S.A. 40-3118(b).

4. Travelers homeowners cancellation notice, PL-4201A, states, "Any excess of paid premium (if not tendered) will be refunded on demand". Kansas Statute K.S.A. 40-2,112(d) requires that the unearned premium collected has to be returned with the notice except in certain situations. Travelers indicated that, "Refunds are included with cancellations as a matter of course in Kansas. The message mentioned is part of our countrywide template and does not apply to insureds in the state of Kansas." However the exam team feels that this could be confusing to Kansas policyholders. Travelers should revise their homeowners termination notice and remove the reference to excess premium "refunded on demand."

Examiner Note:
Travelers indicated they will amend PL-4201A to remove the language referencing premium "refunded on demand". Confirmation of this change should be provided to KID within 30 days of the date of this report.

CLAIM HANDLING

1. For first party claims, Travelers was not in the practice of sending a denial letter to an insured when the amount of damage to an individual's automobile is below the deductible. It is the exam team's recommendation that the Company start sending letters to their insureds confirming the claim is closed for no pay because the amount of damage is below the policy deductible.
2. For third party claims, Travelers needs to review their claim handling procedures to ensure on all denied claims that the third party claimant is notified when claims are denied, and that the notification is documented in the claim file.

Examiner Note:
Based on this recommendation, Travelers has agreed to send letters to insureds who do not receive payment due to the application of the deductible. These letters will confirm that the claim is being closed with no payment.

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

History and Profile

History - Travelers

The Automobile Insurance Company of Hartford, Connecticut was incorporated on June 25, 1965 and commenced business on August 9, 1968 under the laws of Connecticut. The company is wholly owned by The Standard Fire Insurance Company (TSFIC), which is a wholly-owned subsidiary of Travelers Insurance Group Holdings Inc. (TIGHI). TIGHI is a wholly-owned subsidiary of Travelers Property Casualty Corp (TPCC).

The Charter Oak Fire Insurance Company was incorporated on April 29, 1931 and commenced business on October 14, 1935 under the laws of Connecticut. The company is wholly owned by The Travelers Indemnity Company (TTIC), which is a wholly-owned subsidiary of TIGHI. TIGHI is a wholly-owned subsidiary of TPCC.

The Phoenix Insurance Company (TPIC) was incorporated in June, 1850 and commenced business in July, 1850 under the laws of Connecticut. The company is wholly owned by The Travelers Indemnity Company (TTIC), which is a wholly-owned subsidiary of TIGHI. TIGHI is a wholly-owned subsidiary of TPCC.

The Standard Fire Insurance Company (TSFIC) was incorporated on July 6, 1905 and commenced business on March 26, 1910 under the laws of Connecticut. The company is wholly owned by TIGHI which is a wholly-owned subsidiary of TPCC.

The Travelers Home and Marine Insurance Company was incorporated on July 24, 1991 and commenced business on June 2, 1992 under the laws of Indiana. The company re-domesticated to the State of Connecticut effective January 1, 1999. The company is wholly owned by The Travelers Indemnity Company (TTIC), which is a wholly-owned subsidiary of TIGHI. TIGHI is a wholly-owned subsidiary of TPCC.

The Travelers Indemnity Company of America was incorporated on January 2, 1946 and commenced business on May 1, 1946 under the laws of Georgia. The company re-domesticated to the State of Connecticut effective July 1, 1997. The company is wholly owned by TPIC.

TTIC was incorporated on March 25, 1903 and commenced business on May 12, 1906 under the laws of Connecticut. The company is wholly owned by TIGHI.

TravCo Insurance Company was incorporated on July 24, 1991 and commenced business on June 2, 1992 under the laws of Indiana. The company re-domesticated to the State of Connecticut effective January 1, 1999. The company is wholly owned by TTIC.

Travelers Commercial Insurance Company was incorporated on January 3, 1990 and commenced business on January 12, 1990 under the laws of Connecticut. The company was formerly known as Aetna Commercial Insurance Company. The company is wholly owned by Travelers Casualty and Surety Company, which is a wholly-owned subsidiary of TIGHI.

Travelers Property Casualty Insurance Company was incorporated on January 3, 1990 and commenced business on January 12, 1990 under the laws of Connecticut. The company was formerly known as Aetna Insurance Company. The company is wholly owned by TSFIC.

TPCC is a direct, wholly-owned subsidiary of The Travelers Companies, Inc., which is a property-casualty insurance holding company engaged, through its subsidiaries, in two business segments: Commercial Lines and Personal Lines.

On April 2, 1996, Travelers Property Casualty Corp. purchased the property and casualty business of The Aetna Casualty and Surety Company and its property-casualty affiliates.

On April 1, 2004 Travelers Property Casualty Corp. merged with The St. Paul Companies and became known as The St. Paul Travelers Companies, Inc.

On February 26, 2007 The St. Paul Travelers Companies, Inc. changed its name to The Travelers Companies, Inc.

2007 Written Premium in Kansas

		Private Passenger Auto	Homeowners
Naic #19062	**Automobile Ins. Co. of Hartford**	$3,337,751	$1,374,966
Naic #19070	**Standard Fire Ins. Co.**	$1,353,006	$7,338,418
Naic #25623	**Phoenix Ins**	$3,124,563	$1,453,297
Naic #25658	**Travelers Indemnity Co.**	$519,480	$314,210
Naic #25666	**Travelers Indemnity of America**	$167,688	$814,151
Naic #28188	**TRAVCO**	$754,956	$6,037,581
Naic #25615	**Charter Oak Fire**	$326,241	$0
Naic #27998	**Travelers Home & Marine**	$14,214,007	$7,302,337
Naic #36137	**Travelers Commercial**	$1,132,077	$0
Naic #36161	**Travelers Property Casualty Ins.**	$0	$427,094

Fines and/or Penalties

The NAIC I-Site database was reviewed. There was nothing noted that warranted follow-up by this exam team.

Tests for Company Operations/Management

Standard 7

Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. K.S.A. 40-222 (a)(b)(c)&(g)

> The Company provided the exam team with the necessary records and documents in a timely fashion.

The Company passed Standard 7.

Standard 9

The regulated entity cooperates on a timely basis with examiners performing the examinations. K.S.A. 40-222 (c)&(g)

> The Company was very cooperative and provided the exam team with the items requested within the time frames established for this exam.

The Company passed Standard 9.

COMPLAINT HANDLING

Policyholder Service and Complaints

Travelers defines a complaint as "any communication from a customer, agent, shareholder or state insurance department that expresses a grievance or dissatisfaction concerning the products, services, operations or policies of the Company."

Reports are produced monthly for complaints received in the previous month and distributed to Home Office and Field Office management. This report includes the total number of complaints received, the line of business, the nature and disposition of the complaint, and the dates received and final disposition.

Complaint Handling Procedures

Consumer Affairs is responsible for facilitating the resolution of written and telephone complaints to ensure the Company is in compliance with NAIC and state guidelines.

Written Complaints Received in Consumer Affairs

1. When Consumer Affairs receives a written complaint, it is date stamped, and the information entered into the Consumer Affairs Tracking System (CATS). Then, the complaint is faxed to the appropriate office or department for handling.

2. When the responding office or department receives the faxed complaint, it determines the appropriate person to handle responding to the grievance. This person researches the issue and prepares a response. The response and any supporting documentation are mailed to the complainant.

3. A copy of the response with any supporting documentation and the completed CATS form are faxed to Consumer Affairs so it may be reviewed and closed in CATS.

Corporate Guideline – Written complaints are responded to within 7 calendar days from the date Consumer Affairs date stamps the complaint letter.

Written Complaints Received Directly in a Field Office or Home Office Department

1. When a complaint is received, the office dates stamps it, researches the issue, and mails the response to the complainant.

2. The original complaint, response, and any supporting documentation are faxed to Consumer Affairs so the complaint information can be entered into the CATS database.

Telephone Complaints Received in Consumer Affairs

1. When Consumer Affairs receives a telephone complaint, the information is entered into CATS. Then, the complaint is faxed to the appropriate office or department for handling.

2. The responding person researches the problem and calls the complainant back no later than the next business day.

3. The completed CATS form with any supporting documentation is faxed to Consumer Affairs so it may be reviewed and closed in CATS.

Corporate Guideline – Telephone complaints are responded to within 24 hours from receipt of the call in Consumer Affairs.

Tests for Complaint Handling

(See Appendix I for the wording of the appropriate statute or regulation)

Standard 1

All complaints are recorded in the required format on the company complaint register. K.S.A. 40-2404 (10)

The Company provided the exam team with a copy of the complaint log. It was more detailed than the information required in K.S.A. 40-2404 (10).

The Company passed Standard 1.

Standard 2
The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. K.A.R. 40-1-34, Sections 5(a) & 6

The Company provided the exam team with a copy of Traveler's complaint handling procedures manual. This document spells out the procedures to follow in handling a number of different types of complaints.

The Company passed Standard 2.

Standard 3
The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. K.A.R. 40-1-34, 6

The Company passed Standard 3.

Standard 4
The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations. K.A.R. 40-1-34, Sections 6, & 8(a)&(c)

Type	Sample	Errors	%Pass
Claim Complaints	59	1	98%
Rating & Underwriting Complaints	39	0	100%

- One complaint file the Company did not respond to KID within fifteen working days as required by K.A.R. 40-1-34, 6(b).

The Company passed Standard 4.

UNDERWRITING AND RATING

New business for automobile policies is written through The Company's Quantum Automobile program, and for homeowners, through their Quantum homeowners program.

The Quantum Automobile and Homeowners programs use The Travelers Home and Marine Insurance Company to write individual new business risks and renewals produced by their independent agents. The Travelers Commercial Insurance Company is used to write Quantum Auto policies through their Affinity Group, and the Travelers Property and Casualty Insurance Company is used to write Quantum Home policies through their Affinity Group.

The Travelers Legacy Automobile Program is a renewal only program for policies that were written in The Travelers Indemnity Company of America, The Travelers Indemnity Company,

Travco Insurance Company, The Phoenix Insurance Company, and The Charter Oak Fire Insurance Company.

The Travelers Legacy Homeowners Program is a renewal only program for policies that were written in The Standard Fire Insurance Company, The Automobile Insurance Company of Hartford, The Phoenix Insurance Company, The Travelers Indemnity Company, The Travelers Indemnity Company of America and Travco Insurance Company.

The new business process begins when the agent obtains information from the customer and completes an application with the customer's information. Customer information is recorded on the Acord application form.

A small portion of automobile and homeowners policies is written through their direct channel.

After the application is completed and signed by the customer, the policy information is then input into the Travelers policy application system, ATLAS 3, where the accuracy of the information and the eligibility of the policy are verified through system support edits.

For Quantum Automobile policies, loss history is verified through the ordering of Comprehensive Loss Underwriting Evaluation (CLUE) reports, and driving record history is verified through the ordering of motor vehicle reports (MVR's). An Insurance score is also obtained.

For Quantum Homeowners policies, loss history is verified by ordering a loss history report from CLUE. Dwelling inspections are also ordered based on criteria to verify the estimated dwelling amount entered on the application. An Insurance score is also obtained.

On renewal, changes to an auto or homeowners policy are made based on information received from the customer or agent. Information from Travelers claim records is used to update the loss history. MVR's are ordered periodically on auto policies to update driving record information, and dwelling coverage amounts are periodically confirmed with homeowners customers.

Tests for Underwriting and Rating

(See Appendix I for the wording of the appropriate statute or regulation)

General Company Underwriting & Rating Standards

Standard 1: Rating Practices

The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan. K.S.A 40-955

Type	Sample	Errors	%Pass
Auto New Business	25	0	100%
Homeowners New Business	21	see below	

- Quantum Homeowners rule #420 defined the calculation used for determining the age of the insured. The formula was incorrectly filed with KID. The formula programmed into the Quantum homeowners system was slightly different than the filed formula and resulted in either an overcharge or undercharge to the consumer. This affected 94 % of their homeowners book of business. Travelers is in violation of K.S.A. 40-955 (a)&(g).

The Company failed the Homeowners portion of Standard 1.

Standard 2: Rating Practices
All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations. K.S.A. 40-955

Type	Sample	Errors	%Pass
Auto New Business	25	0	100%
Homeowners New Business	21	0	100%

The Company passed Standard 2.

Standard 3: Rating Practices
Regulated entity does not permit illegal rebating, commission cutting or inducements.

The exam team did not specifically test for this standard. In the normal review of the sample files, any indications of rebating, commission cutting or inducements would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 4: Underwriting Practices
The regulated entity underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulate entity guidelines in the selection of risks. K.S.A. 40-953; K.A.R. 40-3-44

Type	Sample	Errors	%Pass
Auto New Business	25	0	100%
Homeowners New Business	21	0	100%

The Company passed Standard 4.

Standard 5: Underwriting Practices
All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the department of insurance (if applicable). K.S.A. 40-216

See Standard #11 of "Specific Property & Casualty Underwriting & Rating Standards".

Standard 6: Underwriting Practices
Policies, riders and endorsements are issued or renewed accurately, timely and completely.

The exam team did not specifically test for this standard. In the normal review of the sample files, any policies, renewals or endorsements that were not processed timely and completely would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 7: Rejections/Declinations
Rejections and declinations are not unfairly discriminatory.

The Company does not reject or decline a new submission. Bound applications are issued and then cancelled if the client does not meet the new business criteria or accept an alternate rating plan.

Standard 8: Termination Practices
Cancellation/nonrenewal, discontinuances and declination notices comply with policy provisions and state laws and regulated entity guidelines.

See Standard 16 of "Specific Property & Casualty Underwriting & Rating Standards".

Standard 9: Terminations
Recessions are not made for non-material misrepresentation.

Not Applicable

Specific Property & Casualty Underwriting & Rating Standards

Standard 1: Rating Practices
Credits and deviations are consistently applied on a non-discriminatory basis. K.S.A. 40-953; K.S.A. 40-954

Type	Sample	Errors	%Pass
Auto New Business	25	0	100%
Homeowners New Business	21	0	100%

The Company passed Standard 1.

Standard 8: Underwriting Practices
Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim.

Type	Sample	Errors	%Pass
Auto New Business	25	0	100%
Homeowners New Business	21	0	100%

The Company passed Standard 8.

Standard 10: Underwriting Practices
The regulated entity underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulate entity guidelines in the selection of risks. K.S.A. 40-953; K.S.A. 40-954; K.S.A. 40-955; K.A.R. 40-3-44

There was no indication of any type of discriminatory activity in the files the exam team reviewed.

Standard 11: Underwriting Practices
All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the department of insurance (if applicable). K.S.A. 40-216

Type	Sample	Errors	%Pass
Auto New Business	25	0	100%
Homeowners New Business	21	0	100%

The Company passed Standard 11.

Standard 12: Underwriting Practices
Regulated entity verifies that VIN number submitted with application is valid and that the correct symbol is utilized. K.S.A. 40-953; K.S.A. 40-954

The Company uses a software package purchased from an outside vendor to automatically assign VIN numbers as the car information is entered into their system.

Standard 13
The regulated entity does not engage in collusive or anti-competitive underwriting practices. K.S.A. 40-2404

There was no indication of any type of this activity in the files the exam team reviewed.

Standard 16: Termination Practices
Cancellation/nonrenewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract. K.S.A. 40-276(a), K.S.A. 40-277, K.S.A. 40-278, K.S.A. 40-2,111, K.S.A. 40-2,112, K.S.A. 40-2,120, K.S.A. 40-2,121, K.S.A. 40-2,122, K.A.R. 40-3-15, K.A.R. 40-3-23, K.A.R. 40-3-28 & K.A.R. 40-3-31.

Type	Sample	Errors	%Pass
HO Cancellations - Underwriting	51	0	100%
Auto Cancellations - Underwriting	59	3	95%
HO Nonrenewal - Underwriting	25	0	100%
Auto Nonrenewal - Underwriting	31	5	84%

Cancellation Other	25	0	100%

- One auto nonrenewal was inconsistent with the statutory requirement that a substantial change in exposure must have occurred since the last renewal before nonrenewal action can be taken. This action is a violation of K.S.A. 40-276a(a)(4).

- One Auto nonrenewal had an incorrect date of expiration on the notice. This is a violation of K.S.A. 40-276a.

- Three auto non renewals had no nonrenewal notice or proof of mailing in the file to document that the policies were nonrenewed. This is a violation of K.S.A. 40-276a and K.S.A. 40-3118.

- Two auto cancellations did not allow enough time to meet the requirements of K.A.R 40-3-15 (a)&(b) and K.S.A. 60-206(d).

- One auto cancellation did not have a copy of the cancellation notice sent to the insured. This is a violation of K.S.A. 40-3118(b) and K.A.R. 40-3-15(b).

General comments regarding Travelers' processing of cancellation and nonrenewal notices:

The wording on Travelers auto cancellation notices, PL2900 and PL2901, did not have the complete wording on the notice as outlined in K.S.A. 40-3118(b). These have since been re-filed with KID.

Travelers homeowners cancellation notice, PL-4201A, states "Any excess of paid premium (if not tendered) will be refunded on demand". Kansas Statute K.S.A. 40-2,112(d) requires that the unearned premium collected has to be returned with the notice except in certain situations. Travelers indicated that "Refunds are included with cancellations as a matter of course in Kansas. The message mentioned is part of our countrywide template and does not apply to insureds in the state of Kansas." However the exam team feels that this could be confusing to Kansas policyholders.

Twenty-three policies that were cancelled for underwriting reason were reviewed to determine if the refund check was sent in compliance with K.S.A. 40-2,112(d). Three policies did not meet the requirements of K.S.A. 40-2,112 for having and the money dispersed at the time the notice was sent. This is a violation of K.S.A. 40-2,112(d). Travelers indicated that a correction to their process was implemented prior to the start of the market conduct exam.

The Company failed certain portions of Standard 16.

Standard 17
All policies are correctly coded.

Type	Sample	Errors	%Pass
Auto New Business	25	0	100%
Homeowners New Business	21	0	100%

The Company passed Standard 17.

Underwriting and Rating Recommendations

General Company Underwriting & Rating Standards

1. On the homeowners line of business, the rates charged for policy coverage were not in accordance with filed rates. The formula programmed into the Quantum homeowners system was slightly different than the formula filed with KID and resulted in either an overcharge or undercharge to the consumer. This affected 94 % of their homeowners book of business. There were a total of 8,995 policies that were overcharged an amount totaling $36,369, and 8,471 policies that were undercharged an amount totaling $41,107. This is a violation of K.S.A. 40-955(a)(g).

Travelers needs to re-file their Quantum homeowners rule to reflect the correct way the age of the insured is to be calculated. Travelers needs to refund the excess premium to their 8,995 customers that were overcharged in their Quantum Homeowners program for the incorrect calculation of age of insured factor.

Examiner Notes:
The Company filed and received KID approval effective July 26, 2009 to amend the Quantum HO Rule 420—Age of Insured—to align the description of the rule with the actual system calculation of the insured's age. Refund checks were sent to overcharged policyholders on 10/19/10.

Specific Property & Casualty Underwriting & Rating Standards

1. Travelers needs to review their nonrenewal procedures. The Company failed the auto nonrenewal portion of Standard 16. While there was no one specific issue with their nonrenewal procedures, there were three areas that collectively caused them to fail this portion of the standard.

Examiner Note:
Travelers indicated they will conduct additional staff training and reinforce existing training as appropriate.

2. The wording on Travelers auto cancellation notices, PL2900 and PL2901, did not have the complete wording on the notice as outlined in K.S.A. 40-3118(b). Travelers has indicated that they will correct this item. Within 30 days Travelers should confirm that they have re-filed their auto termination notice with KID to conform with K.S.A. 40-2,112.

Examiner Note:
The company has re-filed auto cancellation notices PL-2900 and PL-2901 effective August 1, 2009to comply with K.S.A. 40-3118(b).

3. Travelers homeowners cancellation notice, PL-4201A, states "Any excess of paid premium (if not tendered) will be refunded on demand". Kansas Statute K.S.A. 40-2,112(d) requires that the unearned premium collected has to be returned with the notice except in certain situations. Travelers indicated that "Refunds are included with cancellations as a matter of course in Kansas. The message mentioned is part of our countrywide template and does not apply to insureds in the state of Kansas." However the exam team feels that this could be confusing to Kansas policyholders. Within 30 days Travelers' should confirm that they have revised their homeowners termination notice and remove the reference to excess premium "refunded on demand."

Examiner Note:
Travelers indicated they will amend PL-4201A to add the desired language. Within 30 days Travelers should confirm that they have re-filed their auto termination notice with KID.

CLAIM HANDLING

A loss is reported to Travelers Call Reporting Center. The claim is then assigned to a claim professional. The insured, claimant and other relevant parties are contacted and interviewed regarding the loss. The investigation, determination of coverage, evaluation of liability and damages are completed. Reserves are established and adjusted based upon the complexity and value of the claim. Depending on the circumstances, other resources are utilized such as Special Investigations Unit, Subrogation, Major Case and Medical Professionals assist in handling the claim. The claim is then concluded based on the available coverage, legal responsibility and the amount of covered damage or benefits.

The claim professional communicates with the insured and provides a description and explanation of the applicable coverage and benefits. When appropriate, a written estimate of the damages is also provided to the insured. This information is usually communicated to the insured verbally, but may also be communicated in writing.

Tests for Claim Handling

(See Appendix I for the wording of the appropriate statute or regulation)

General Company Claim Standards

Standard 1
The initial contact by the regulated entity with the claimant is within the required time frame. K.A.R. 40-1-34, 6(a)&(d)

Type	Sample	Errors	%Pass
Paid Auto Claims	58	0	100%
Paid Homeowners Claims	52	0	100%
No Pay Claims	50	0	100%

The Company passed Standard #1.

Standard 2
Timely investigations are conducted. K.A.R. 40-1-34, Sections 7 & 8(c)

Type	Sample	Errors	%Pass
Paid Auto Claims	58	0	100%
Paid Homeowners Claims	52	1	98%
No Pay Claims	50	2	94%

- Two no pay claims took over 30 days to settle. This is a violation of K.A.R. 40-1-34, 7.
- One paid homeowners claim was not settled within 30 days. This is a violation of K.A.R. 40-1-34, 7. No notice was sent to the insured advising him that additional time was needed to complete the investigation. This is a violation of K.A.R. 40-1-34, 8(c).

The Company passed Standard 2.

Standard 3
Claims are resolved in a timely manner. K.A.R. 40-1-34, 8(a)&(c)

Type	Sample	Errors	%Pass
Paid Auto Claims	58	2	97%
Paid Homeowners Claims	52	1	98%
No Pay Claims	50	0	100%

- One paid auto claim had PIP benefits that were not paid in a timely fashion. This is a violation of K.S.A. 40-3110 (a)&(b).

- One paid auto claim was not paid in a timely fashion. This is a violation of K.S.A. 40-2404 (9)(c)&(e).

- One paid homeowners claim was not paid in a timely fashion. This is a violation of K.S.A. 40-1-34, 8(a).

The Company passed Standard 3.

Standard 4

The regulated entity responds to claim correspondence in a timely manner. K.A.R. 40-1-34, 6(a)&(d)

Type	Sample	Errors	%Pass
Paid Auto Claims	58	0	100%
Paid Homeowners Claims	52	0	100%
No Pay Claims	50	0	100%

The Company passed Standard 4.

Standard 5
Claim files are adequately documented. K.A.R. 40-1-34, Sections 4, 6(a) & 8(b)

Type	Sample	Errors	%Pass
Paid Auto Claims	58	1	98%
Paid Homeowners Claims	52	1	98%
No Pay Claims	50	0	100%

- One paid homeowners claim did not have an inventory of items date stamped or documented in the notes. This is a violation of K.A.R. 40-1-34, Section 4.

- One paid auto claim had conflicting information in the diary notes. This is a violation of K.A.R. 40-1-34, Section 4.

The Company passed Standard 5.

Standard 6
Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations. K.A.R. 40-1-34, Sections 5(a), 8, & 9; K.S.A. 40-3110; K.S.A. 40-2-126

Type	Sample	Errors	%Pass
Paid Auto Claims	58	3	95%
Paid Homeowners Claims	52	0	100%
No Pay Claims	50	0	100%

- One paid auto claim had the wrong amount paid. This is a violation of K.A.R. 40-1-34, 9 (a)(2).

- Two paid auto claims had delays in sending PIP forms & payment. This is a violation of K.A.R. 40-1-34, 6d; K.S.A. 40-3110 (a)&(b).

The Company passed Standard 6.

Standard 7

Regulated entity claim forms are appropriate for the type of product.

Type	Sample	Errors	%Pass
Paid Auto Claims	58	0	100%
Paid Homeowners Claims	52	0	100%
No Pay Claims	50	0	100%

The Company passed Standard 7.

Standard 8
Claim files are reserved in accordance with the company's established procedures.

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any reserving abnormalities would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 9
Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. K.A.R. 40-1-34, 8(a)(b)&(c)

Type	Sample	Errors	%Pass
No Pay Claims	50	2	96%

- One no pay claim was denied and no denial letter was sent to the insured. This is a violation of K.A.R. 40-1-34, 8(a).

- One no pay claim was closed with no notification to the third party of acceptance or denial of the claim, in violation of K.S.A. 40-2404 (9)(n).

The Company passed Standard 9.

Standard 10
Canceled benefit checks and drafts reflect appropriate claim handling practices. K.A.R. 40-1-34, Sections 5(f), 8(a)&(c) & K.S.A. 40-3110

The exam team did not specifically test for this standard

Standard 11
Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy. K.S.A. 40-2404, (9) (f)&(g)

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any attempts to not settle a claim fair and promptly would have been

reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Specific Property & Casualty Claim Standards

Standard 1
Regulated entity uses the reservation of rights and excess of loss letters, when appropriate.

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any claims where a reservation of rights or excess of loss letter would have been appropriate would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 2
Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner. K.A.R. 40-1-34, 9(d)

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any subrogated claims would have been reviewed, and the examiner would have noted a deductible reimbursement. There were no issues with the files that were reviewed.

Standard 3
Loss statistical coding is complete and accurate

The exam team did not specifically test for this standard

Claim Handling Recommendations

1. For first party claims, Travelers was not in the practice of sending a denial letter to an insured when the amount of damage to an individual's automobile is below the deductible. It is the exam team's recommendation that the Company start sending letters to their insured's confirming the claim is closed for no pay because the amount of damage is below the policy deductible.
2. For third party claims, Travelers needs to ensure on all denied claims that the third party claimant is notified when claims are denied, and that notification should be in the claim file.

Examiner Note:
Based on this recommendation, Travelers has agreed to send letters to insureds who do not receive payment due to the application of the deductible. These letters will confirm that the claim is being closed with no payment.

SUMMARIZATION
Tests for Underwriting and Rating
General Company Underwriting & Rating Standards

1. On the homeowners line of business, the rates charged for policy coverage were not in accordance with filed rates. The formula programmed into the Quantum homeowners system was slightly different than the formula filed with KID and resulted in either an overcharge or undercharge to the consumer. This affected 94 % of their homeowners book of business. There were a total of 8,995 policies that were overcharged an amount totaling $36,369, and 8,471 policies that were undercharged an amount totaling $41,107. This is a violation of K.S.A. 40-955(a)(g).

Travelers needs to re-file their Quantum homeowners rule to reflect the correct way the age of the insured is to be calculated. Travelers needs to refund the excess premium to their 8,995 customers that were overcharged in their Quantum Homeowners program for the incorrect calculation of age of insured factor.

Examiner Notes:
The Company filed and received KID approval effective July 26, 2009 to amend the Quantum HO Rule 420—Age of Insured—to align the description of the rule with the actual system calculation of the insured's age. Refund checks were sent to overcharged policyholders on 10/19/10.

Specific Property & Casualty Underwriting & Rating Standards

1. Travelers needs to review their nonrenewal procedures. The Company failed the auto nonrenewal portion of Standard 16. While there was no one specific issue with their nonrenewal procedures, there were three areas that collectively caused them to fail this portion of the standard.

Examiner Note:
Travelers indicated they will conduct additional staff training and reinforce existing training as appropriate.

2. The wording on Travelers auto cancellation notices, PL2900 and PL2901, did not have the complete wording on the notice as outlined in K.S.A. 40-3118(b). Travelers has indicated that they will correct this item. Within 30 days Travelers should confirm that they have re-filed their auto termination notice with KID to conform with K.S.A. 40-2,112.

Examiner Note:
The company has re-filed auto cancellation notices PL-2900 and PL-2901 effective August 1, 2009 to comply with K.S.A. 40-3118(b).

3. Travelers homeowners cancellation notice, PL-4201A, states "Any excess of paid premium (if not tendered) will be refunded on demand". Kansas Statute K.S.A. 40-2,112(d) requires that the unearned premium collected has to be returned with the notice except in certain situations. Travelers indicated that "Refunds are included with cancellations as a matter of course in Kansas. The message mentioned is part of our countrywide template and does not apply to insureds in the state of Kansas." However the exam team feels that this could be confusing to Kansas policyholders. Within 30 days Travelers should confirm that they have revised their homeowners termination notice and remove the reference to excess premium "refunded on demand."

Examiner Note:
Travelers indicated they will amend PL-4201A to add the desired language. Within 30 days Travelers' should confirm that they have re-filed their auto termination notice with KID.

CLAIM HANDLING

1. For first party claims, Travelers was not in the practice of sending a denial letter to an insured when the amount of damage to an individual's automobile is below the deductible. It is the exam team's recommendation that the Company start sending letters to their insured's confirming the claim is closed for no pay because the amount of damage is below the policy deductible.
2. For third party claims, Travelers needs to ensure on all denied claims that the third party claimant is notified when claims are denied, and that notification should be in the claim file.

Examiner Note:
Based on this recommendation, Travelers has agreed to send letters to insureds who do not receive payment due to the application of the deductible. These letters will confirm that the claim is being closed with no payment.

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by Joe Wiest and the staff of the Travelers Insurance Group. The following examiners of the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

Market Conduct Division

Lyle Behrens	Mary Lou Maritt	Tate Flott
Supervisor	Market Conduct Examiner	Market Conduct Examiner

Respectfully submitted,

Lyle Behrens

Lyle Behrens, CPCU, CIE, FLMI, ARM, Are

APPENDIX I

K.A.R. 40-1-34 - UNFAIR CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

Table of Contents

Section 1. Authority

Section 1 is not adopted.

Section 2. Scope

This regulation applies to all persons and to all insurance policies and insurance contracts except policies of Workers' Compensation insurance. This regulation is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of K.S.A. 40-2404, and amendments thereto.

Section 3. Definitions

The definitions of "person" and of "insurance policy or insurance contract" contained in K.S.A. 40-2404, and amendments thereto shall apply to this regulation and, in addition, where used in this regulation:

(a) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;
(b) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;
(c) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;

(d) "Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract in this State;

(e) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

(f) "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(g) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer; and

(h) "Workers' Compensation" includes, but is not limited to, Longshoremen's and Harbor Workers' Compensation.

Section 4. File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

Section 5. Misrepresentation of Policy Provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(c) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(d) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(e) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

Section 6. Failure to Acknowledge Pertinent Communications

(a) Every insurer, upon receiving notification of a claim shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.
(b) Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.
(c) An appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.
(d) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within ten working days of notification of a claim shall constitute compliance with subsection (a) of this section.

Section 7. Standards for Prompt Investigation of Claim

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time.

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

(a) Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.
(b) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of this subsection. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.
(c) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.
(d) Section 8(d) is not adopted.
(e) An insurer shall not attempt to settle a loss with a first party claimant on the basis of a cash settlement which is less than the amount the insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

(f) If a claim is denied for reasons other than those described in section 8(a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(g) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(h) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or a contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.

(i) No insurer shall make statements which indicate the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

(a) When the insurance policy provides, for the adjustment and settlement of automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:

(1) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the claimant, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect to pay a cash settlement, based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost shall be determined by any source or method for determining statistically valid fair market value that meets both of the following criteria:

(A) The source or method's database, including nationally recognized automobile evaluation publications, shall provide values for at least eighty-five percent (85%) of all makes and models of private passenger vehicles for the last fifteen (15) model years taking into account the values for all major options for such vehicles; and

(B) The source, method, or publication shall provide fair market values for a comparable automobile based on current data available for the local market area as defined in subsection (j)(2).

(3) When an automobile total loss is settled on a basis which deviates from the methods and criteria described in subsection (a)(1) and (a)(2)(A) and (B) of

this section, the deviation must be supported by documentation giving the particulars of the automobile condition and the basis for the deviation. Any deviations from such cost, including deductions for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the claimant.

(b) Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's insurance policy or insurance contract.

(c) Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(e) If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.

(f) When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

(g) When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(h) Insurers shall include consideration of applicable taxes, license fees, and other fees incident to transfer of evidence of ownership in third party automobile total losses and shall have sufficient documentation relative to how the settlement was obtained in the claim file. A measure of damages shall be applied which will compensate third party claimants for the reasonable loss sustained as the proximate result of the insured's negligence.

(i) A claimant has the right of recourse if the claimant notifies the insurer, within thirty (30) days after the receipt of the claim draft, that claimant is unable to purchase a comparable automobile for the amount of the claim draft. Upon receipt of this notice, the insurer shall reopen its claim file within five (5) business days, and one of the following actions shall apply.

(1) the Insurer shall either pay the claimant the difference between the market value as determined by the insurer and the cost of the comparable vehicle of like kind and quality which the claimant has located, or negotiate and effect the purchase price of this vehicle for the claimant; or

(2) the insurer may elect to offer a replacement in accordance with provisions of subsection 9(a)(1).

(j) As used in this regulation the following terms shall have the following meanings:

(1) comparable automobile means a vehicle of the same make, model, year, style and condition, including all major options of the claimant vehicle;

(2) local market area means the fifty (50) mile area surrounding the place where the claimant vehicle was principally garaged.

K.A.R. 40-3-15. Fire and casualty insurance contracts; cancellation at option of insurer; notice required.

(a) Each policy or contract, that is issued by fire or casualty insurers within the state of Kansas, and that provides for cancellation at the option of the insurer, shall contain a provision within the policy, or at the discretion of the commissioner, within an amending rider, that the insured will be notified in writing at least 30 days in advance of the effective date of cancellation.

(b) Each fire or casualty insurer that cancels a policy or insurance contract in the state of Kansas, shall provide written notice of cancellation to the insured. Each cancellation notice shall specify the cancellation date and shall state in clear language that the policy is being cancelled. The following statement or one that is substantially the same shall be used: ``You are hereby notified that your policy number _____ is cancelled effective _____.''

This regulation shall not apply to:

(1) Health, accident or hospitalization policies issued by casualty companies;

(2) crop-hail policies or contracts; or

(3) policies or contracts cancelled as a result of non-payment of premium.

(Authorized by K.S.A. 40-103; implementing K.S.A. 40-216, 40-1603(c); effective Jan. 1, 1966; amended Jan. 1, 1968; amended May 1, 1979; amended May 1, 1986.)

K.S.A. 40-216 Business prohibited until certain filings made; contracts effective on filing; filing of contracts on behalf of insurer by rating organization or another insurer; contracts written in foreign language; suspension or modification of filing requirements by commissioner; hearing, order.

(a) (1) No insurance company shall hereafter transact business in this state until certified copies of its charter and amendments thereto shall have been filed with and approved by the commissioner of insurance. A copy of the bylaws and amendments thereto of insurance companies organized under the laws of this state shall also be filed with and approved by the commissioner of insurance. The commissioner may also require the filing of such other documents and papers as are necessary to determine compliance with the laws of this state.

(2) (A) Except as provided in subparagraph (B), each contract of insurance or indemnity issued or delivered in this state shall be effective on filing, or any subsequent date selected by the insurer, unless the commissioner disapproves such contract of insurance within 30 days after filing because the rates are determined to be inadequate, excessive, unfairly discriminatory or otherwise fail to meet the requirements of this act.

(B) The following contracts of insurance or indemnity shall not be subject to the provisions of subsection (A):

(i) Contracts pertaining to large risks as defined in subsection (i) of K.S.A. 40-955, and amendments thereto, which are exempt from the filing requirements of this section;

(ii) personal lines contracts filed in accordance with paragraph (3) of this section;

(iii) any form filing for the basic coverage required by K.S.A. 40-3401 et seq., and amendments thereto; and

(iv) form filing for workers compensation.

No form filing listed in clauses (iii) and (iv) of this subparagraph shall be used in this state by any insurer until such form filing has been approved by the commissioner.

(3) Each personal lines contract of insurance or indemnity issued or delivered in this state shall be on file for a period of 30 days before becoming effective unless the commissioner disapproves such personal lines contract if the rates are determined by the commissioner to be inadequate, excessive, unfairly discriminatory or otherwise fail to meet the requirements of this act. For the purposes of this paragraph, the term "personal lines" shall mean insurance for noncommercial automobile, homeowners, dwelling, fire and renters insurance policies as defined by the commissioner by rules and regulations.

(4) Under such rules and regulations as the commissioner of insurance shall adopt, the commissioner may, by written order, suspend or modify the requirement of filing forms of contracts of insurance or indemnity, which cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The commissioner may make an examination to ascertain whether any forms affected by such order meet the standards of this code.

(5) The failure of any insurance company to comply with this section shall not constitute a defense to any action brought on its contracts. An insurer may satisfy its obligation to file its contracts of insurance or indemnity either individually or by authorizing the commissioner to accept on its behalf the filings made by a licensed rating organization or another insurer.

(b) The commissioner of insurance shall allow any insurance company authorized to transact business in this state to deliver to any person in this state any contract of insurance or indemnity, including any explanatory materials, written in any language other than the English language under the following conditions:

(1) The insured or applicant for insurance who is given a copy of the same contract of insurance or indemnity or explanatory materials written in the English language;

(2) the English language version of the contract for insurance or indemnity or explanatory materials delivered shall be the controlling version; and

(3) any contract of insurance or indemnity or explanatory materials written in any language other than English shall contain a disclosure statement in 10 point boldface type, printed in both the English language and the other language used, stating the English version of the contract of insurance or indemnity is the official or controlling version and that the version is written in any language other than English is furnished for informational purposes only.

(c) All contracts of insurance or indemnity that are required to be filed with the commissioner of insurance shall be accompanied by any version of such contract of insurance or indemnity written in any language other than the English language.

(d) Any insurance company or insurer, including any agent or employee thereof, who knowingly misrepresents the content of a contract of insurance or indemnity or explanatory

materials written in a language other than the English language shall be deemed to have violated the unfair trade practice law.

(e) For the purposes of this section, the term "contract of insurance or indemnity" shall include any rider, endorsement or application pertaining to such contract of insurance or indemnity.

(f) (1) If at any time after a filing becomes effective, the commissioner finds that such filing does not comply with this act, after the commissioner shall send written notice to every insurer and rating organization making such filing that a hearing concerning such filing will be held in not less than 10 days.

(2) After the hearing, the commissioner shall issue an order stating:

(A) The reasons why such filing failed to comply with the act; and

(B) the date, within a reasonable time after the date the order is issued, upon which such filing shall no longer be effective.

(3) A copy of the commissioner's order shall be sent to every insurer and rating organization that made such filing.

(4) No order issued pursuant to this subsection shall affect any contract or policy made or issued under such filing prior to the date specified upon which such filing shall no longer be effective.

History: L. 1927, ch. 231, 40-216; L. 1967, ch. 248, § 2; L. 1979, ch. 134, § 1; L. 1999, ch. 63, § 1; L. 2004, ch. 159, § 5; L. 2006, ch. 130, § 1; L. 2007, ch. 150, § 1; July 1

K.S.A. 40-276. Cancellation of automobile liability insurance; definitions.

As used in this act: "Policy of automobile liability insurance" means a policy insuring against the liability of the insured for the death, disability or damages of another and against loss or damage to the property of another, arising from the use of an automobile that is issued to cover the following types of automobiles owned by an individual or by husband and wife, including automobiles hired under a long term contract and written on a specified car basis:

(a) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others;

(b) Any other four-wheel motor vehicle with a load capacity of one thousand five hundred (1,500) pounds or less which is not used in the occupation, profession or business of the named insured, other than farming: *Provided,* That the term "policy of automobile liability insurance" shall not include policies of automobile liability insurance (1) issued through the Kansas automobile assigned risk plan, (2) insuring more than four automobiles, nor (3) insuring the automobile hazard of garages, automobile sales agencies, repair shops, service stations or public parking places.

History: L. 1967, ch. 271, § 1; Jan. 1, 1968.

K.S.A. 40-276a. Automobile liability insurance policies; denial of renewal; notice; conditions; exceptions.

(a) Any insurance company that denies renewal of an automobile liability insurance policy in this state shall give at least 30 days written notice to the named insured, at his last known address, or cause such notice to be given by a licensed agent of its intention not to renew such policy. No insurance company shall deny the renewal of an automobile liability insurance policy except in one or more of the following circumstances or as permitted in subsection (b):

(1) When such insurance company is required or has been permitted by the commissioner of insurance, in writing, to reduce its premium volume in order to preserve the financial integrity of such insurer;

(2) when such insurance company ceases to transact such business in this state;

(3) when such insurance company is able to show competent medical evidence that the insured has a physical or mental disablement that impairs his ability to drive in a safe and reasonable manner;

(4) when unfavorable underwriting factors, pertinent to the risk, are existent, and of a substantial nature, which could not have reasonably been ascertained by the company at the initial issuance of the policy or the last renewal thereof;

(5) when the policy has been continuously in effect for a period of five years. Such five-year period shall begin at the first policy anniversary date following the effective date of the policy, except that if such policy is renewed or continued in force after the expiration of such period or any subsequent five-year period, the provisions of this subsection shall apply in any such subsequent period; or

(6) when any of the reasons specified as reasons for cancellation in K.S.A. 40-277 are existent, except that (A) when failure to renew is based upon termination of agency contract, obligation to renew will be satisfied if the insurer has manifested its willingness to renew, and (B) obligation to renew is terminated on the effective date of any other automobile liability insurance procured by the named insured with respect to any automobile designated in both policies.

Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal. Nothing in this section shall require an insurance company to renew an automobile liability insurance policy if such renewal would be contrary to restrictions of membership in the company which are contained in the articles of incorporation or the bylaws of such company.

(b) (1) No insurance company shall refuse to renew a policy until after June 30, 2002, based on an insured's failure to maintain membership in a bona fide association, until both the insurance company and bona fide association have complied with the requirements of this subsection. No insurance company shall refuse to renew any coverage continuously in effect before July 1, 2002, unless:

(A) The application for insurance and the insurance policy shall clearly disclose that both the payment of dues and current membership in the bona fide association are prerequisites to obtaining or renewing the insurance;

(B) the bona fide association has filed a certification with the commissioner of insurance verifying the eligibility of the insurance company to refuse to renew an insurance policy based on the membership in the bona fide association; and

(C) any money paid to the bona fide association as a membership fee:

(i) Shall not be used by the insurance company directly or indirectly to defray any costs or expenses in connection with the sale or purchase of the insurance; and

(ii) shall be set independently of any factor used by the insurance company to make any judgment or determination about the eligibility of any individual to purchase or renew such insurance. For the purposes of this provision, the individual may be a member of the bona fide organization or an employee or dependent of such a member.

(2) (A) Upon request the bona fide association shall file a statement with the commissioner of insurance verifying that the bona fide association meets the requirements of this paragraph.

(B) For the purposes of this subsection, "bona fide association" means an association which:

(i) Has been in active existence for at least five consecutive years immediately preceding the date the statement is filed;

(ii) has been formed and maintained in good faith for purposes other than obtaining or providing insurance and does not condition membership in the association on the purchase of insurance;

(iii) has articles of incorporation and bylaws or other similar governing documents;

(iv) has a relationship with one or more specific insurance companies and identifies each such insurance company; and

(v) and does not condition membership in the association or set membership fees on the eligibility of any individual to purchase or renew the insurance or on any factor that the insurance company could not lawfully consider when setting rates. For the purposes of this provision, the individual may be a member of the bona fide organization or an employee or dependent of such a member.

(3) Membership fees collected by the bona fide association shall not be deemed to be premiums of the insurance company that issued the coverage unless the bona fide association:

(A) Uses any portion of such membership fees directly or indirectly to defray any costs or expenses in connection with the sale or purchase of the insurance; or

(B) sets or adjusts membership fees for any member of the bona fide association based on any factor used by the insurance company that issues the insurance to make any judgment or determination about the eligibility of any individual to purchase or renew the insurance. For the purposes of this provision, the individual may be a member of the bona fide organization or an employee or dependent of such a member.

(4) If the membership fees are determined to constitute premiums pursuant to paragraph (3) of this subsection, the insurance company shall not refuse to renew a policy as otherwise permitted by this subsection.

History: L. 1972, ch. 176, § 1; L. 2002, ch. 58, § 1; July 1.

K.S.A. 40-277. Automobile liability insurance policies; limitations on policy conditions for cancellation.

No insurance company shall issue a policy of automobile liability insurance in this state unless the cancellation condition of the policy or endorsement thereon includes the following limitations pertaining to cancellation by the insurance company:

After this policy has been in effect for 60 days, or if the policy is a renewal, effective immediately, the company shall not exercise its right to cancel the insurance afforded under (here insert the appropriate coverage references) solely because of age or unless

1. The named insured fails to discharge when due any obligations in connection with the payment of premium for this policy or any installment thereof whether payable directly or under any premium finance plan; or

2. the insurance was obtained through fraudulent misrepresentation; or

3. the insured violates any of the terms and conditions of the policy; or

4. the named insured or any other operator, either resident in the same household, or who customarily operates an automobile insured under the policy,

(a) has had such person's driver's license suspended or revoked during the policy period, or

(b) is or becomes subject to epilepsy or heart attacks, and such individual cannot produce a certificate from a physician testifying to such person's ability to operate a motor vehicle, or

(c) is or has been convicted during the 36 months immediately preceding the effective date of the policy or during the policy period, for:

(1) Any felony, or

(2) criminal negligence, resulting in death, homicide or assault, arising out of the operation of a motor vehicle, or

(3) operating a motor vehicle while in an intoxicated condition or while under the influence of drugs, or

(4) leaving the scene of an accident without stopping to report, or

(5) theft of a motor vehicle, or

(6) making false statements in an application for a driver's license, or

(7) a third moving violation, committed within a period of 18 months, of (i) any regulation limiting the speed of motor vehicles, (ii) any of the provisions in the motor vehicle laws of any state, the violation of which constitutes a misdemeanor or traffic infraction, or (iii) any ordinance traffic infraction, or ordinance which prohibits the same acts as a misdemeanor statute of the uniform act regulating traffic on highways, whether or not the violations were repetitious of the same offense or were different offenses.

History: L. 1967, ch. 271, § 2; L. 1984, ch. 39, § 47; Jan. 1, 1985

K.S.A. 40-953. Same; excessive, inadequate or unfairly discriminatory rates or rates resulting in destruction of competition, standards.

Rates shall not be excessive, inadequate or unfairly discriminatory, nor shall an insurer charge any rate which if continued will have or tend to have the effect of destroying competition or creating a monopoly. Rates are presumed not to be excessive if a reasonable degree of market competition exists at the consumer level with respect to the class of business to which they apply. Rates in a noncompetitive market are excessive if they are producing or are likely to produce unreasonably high profits for the insurance provided or if expenses are unreasonably high in relation to services rendered. A competitive market in a type of insurance subject to this act is presumed to exist unless the commissioner after notice of hearing determines and orders that a reasonable degree of competition does not exist in the

market. Such order shall expire no later than one year after issuance unless the commissioner renews the rule after a hearing and a finding of the continued lack of a reasonable degree of competition. In determining whether a reasonable degree of market competition exists, the commissioner shall consider all relevant tests, including: (1) The number, market share, and concentration of insurers, as measured by the 1992 Horizontal Merger Guidelines published in the Federal Register September 10, 1992 (57 FR 41552), actively engaged in the class of business, (2) the existence of rate differentials in that class of business, (3) ease of entry into the market, and (4) whether long-run profitability for insurers in that class of business is unreasonably high in relation to its riskiness. If such competition does not exist, rates are excessive if they are likely to produce a long run profit that is unreasonably high in relation to the riskiness of the class of business, or if expenses are unreasonably high in relation to the services rendered.

Rates are inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

One rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors or like expense factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise, mass marketed plan or blanket policy.

History: L. 1997, ch. 154, § 3; July 1.

K.S.A. 40-954 Same; determining factors; expense provisions; classification of risks; modification for individual risks; contingencies and allowances for profit; exemptions; mandatory rating plan use.

In determining whether rates are not excessive or inadequate or not unfairly discriminatory:

(a) Due consideration shall be given to:

(1) Past and prospective loss and expense experience within and outside the state;

(2) catastrophe hazards and contingencies;

(3) trends within and outside this state;

(4) loadings for leveling premium rates over time;

(5) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers and the investment income of the insurer; and

(6) all other relevant factors within and outside the state, including the judgment of technical personnel.

(b) The expense provisions included in the rates to be used by an insurer may reflect the operating methods of the insurer, or group of insurers, and, so far as it is credible, its own expense experience.

(c) Risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classification may be based on race, color, creed or national origin and classifications in automobile insurance may not be based on physical

disability of an insured. Rates thus produced may be modified for individual risks in accordance with rating plans, schedules, except for workers compensation, individual risk premium modification plans and expense reduction plans that establish reasonable standards for measuring probable variations in experience, hazards, expenses or any combination of those factors.

Such standards shall permit recognition of expected differences in loss or expense characteristics, and shall be designed so that such plans are reasonable and equitable in their application, and are not unfairly discriminatory, violative of public policy or otherwise contrary to the best interests of the people of this state. This section shall not prevent the development of new or innovative rating methods which otherwise comply with this act.

(d) Rates may be modified for individual risks, upon written application of the insured, stating the insured's reasons therefore, filed with and not disapproved by the commissioner within 10 days after filings.

(e) The rates may contain provisions for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration shall be given to the investment income attributable to the line of insurance.

(f) The commissioner may by rule exempt any person or class of persons, line of insurance, or any market segment from any or all of the provisions of this chapter, if and to the extent that the commissioner finds their application unnecessary to achieve the purposes of this act.

(g) Once it has been filed, use of any rating plan shall be mandatory and such plan shall be applied uniformly for eligible risks in a manner that is not unfairly discriminatory.

History: L. 1997, ch. 154, § 4; July 1.

K.S.A. 40-955. Same; rate filings; review and approval of certain lines; effective dates; exemptions from filing.

(a) Every insurer shall file with the commissioner, except as to inland marine risks where general custom of the industry is not to use manual rates or rating plans, every manual of classifications, rules and rates, every rating plan, policy form and every modification of any of the foregoing which it proposes to use. Every such filing shall indicate the proposed effective date and the character and extent of the coverage contemplated and shall be accompanied by the information upon which the insurer supports the filings. A filing and any supporting information shall be open to public inspection after it is filed with the commissioner. An insurer may satisfy its obligations to make such filings by authorizing the commissioner to accept on its behalf the filings made by a licensed rating organization or another insurer. Nothing contained in this act shall be construed to require any insurer to become a member or subscriber of any rating organization.

(b) Certificate of insurance forms must be filed with the commissioner of insurance and approved prior to use. Notwithstanding the "large risk" filing exemption in subsection (j), a certificate of insurance cannot be used to modify, alter or amend the insurance policy it describes. The certificate of insurance shall contain the following or similar language: The certificate of insurance neither affirmatively nor negatively amends, extends or alters the coverage afforded by the policies listed thereon. An industry standard setting organization

may be authorized by the commissioner of insurance to file certificate of insurance forms on behalf of authorized insurers.

(c) Any rate filing for the basic coverage required by K.S.A. 40-3401 et seq. and amendments thereto, loss costs filings for workers compensation, and rates for assigned risk plans established by article 21 of chapter 40 of the Kansas Statutes Annotated or rules and regulations established by the commissioner shall require approval by the commissioner before its use by the insurer in this state. As soon as reasonably possible after such filing has been made, the commissioner shall in writing approve or disapprove the same, except that any filing shall be deemed approved unless disapproved within 30 days of receipt of the filing.

(d) Any other rate filing, except personal lines filings, shall become effective on filing or any prospective date selected by the insurer, subject to the commissioner disapproving the same if the rates are determined to be inadequate, excessive, unfairly discriminatory or otherwise fails to meet the requirements of this act. Personal lines rate filings shall be on file for a waiting period of 30 days before becoming effective, subject to the commissioner disapproving the same if the rates are determined to be inadequate, excessive, unfairly discriminatory or otherwise fail to meet requirements of this act. The term "personal lines" shall mean insurance for noncommercial automobile, homeowners, dwelling fire-and-renters insurance policies, as defined by the commissioner by rules and regulations. A filing complies with this act unless it is disapproved by the commissioner within the waiting period or pursuant to subsection (f).

(e) In reviewing any rate filing the commissioner may require the insurer or rating organization to provide, at the insurer's or rating organization's expense, all information necessary to evaluate the reasonableness of the filing, to include payment of the cost of an actuary selected by the commissioner to review any rate filing, if the department of insurance does not have a staff actuary in its employ.

(f) (1) (A) If a filing is not accompanied by the information required by this act, the commissioner shall promptly inform the company or organization making the filing. The filing shall be deemed to be complete when the required information is received by the commissioner or the company or organization certifies to the commissioner the information requested is not maintained by the company or organization and cannot be obtained.

(B) If the commissioner finds a filing does not meet the requirements of this act, the commissioner shall send to the insurer or rating organization that made the filing, written notice of disapproval of the filing, specifying in what respects the filing fails to comply and stating the filing shall not become effective.

(C) If at any time after a filing becomes effective, the commissioner finds a filing does not comply with this act, the commissioner shall after a hearing held on not less than 10 days' written notice to every insurer and rating organization that made the filing issue an order specifying in what respects the filing failed to comply with the act, and stating when, within a reasonable period thereafter, the filing shall be no longer effective. Copies of the order shall be sent to such insurer or rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(2) (A) In the event an insurer or organization has no legally effective rate because of an order disapproving rates, the commissioner shall specify an interim rate at the time the order is issued. The interim rate may be modified by the commissioner on the commissioner's own motion or upon motion of an insurer or organization.

(B) The interim rate or any modification thereof shall take effect prospectively in contracts of insurance written or renewed 15 days after the commissioner's decision setting interim rates.

(C) When the rates are finally determined, the commissioner shall order any overcharge in the interim rates to be distributed appropriately, except refunds to policyholders the commissioner determines are de minimis may not be required.

(3) (A) Any person or organization aggrieved with respect to any filing that is in effect may make written application to the commissioner for a hearing thereon, except that the insurer or rating organization that made the filing may not proceed under this subsection. The application shall specify the grounds to be relied on by the applicant.

(B) If the commissioner finds the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds are established, and that such grounds otherwise justify holding such a hearing, the commissioner shall, within 30 days after receipt of the application, hold a hearing on not less than 10 days' written notice to the applicant and every insurer and rating organization that made such filing.

(C) Every rating organization receiving a notice of hearing or copy of an order under this section, shall promptly notify all its members or subscribers affected by the hearing or order. Notice to a rating organization of a hearing or order shall be deemed notice to its members or subscribers.

(g) No insurer shall make or issue a contract or policy except in accordance with filings which have been filed or approved for such insurer as provided in this act.

(1) On an application for personal motor vehicle insurance where the applicant has applied for collision or comprehensive coverage, the applicant shall be allowed to identify a lienholder listed on the certificate of title for the motor vehicle described in the application.

(2) On an application for property insurance on real property, the applicant shall be allowed to identify a mortgagee listed on a mortgage for the real property described in the application.

(h) The commissioner may adopt rules and regulations to allow suspension or modification of the requirement of filing and approval of rates as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used.

(i) Except for workers compensation and employer's liability line, the following categories of commercial lines risks are considered special risks which are exempt from the filing requirements in this section: (1) Risks that are written on an excess or umbrella basis; (2) commercial risks, or portions thereof, that are not rated according to manuals, rating plans, or schedules including "a" rates; (3) large risks; and (4) special risks designated by the commissioner, including but not limited to risks insured under highly protected risks rating plans, commercial aviation, credit insurance, boiler and machinery, inland marine, fidelity, surety and guarantee bond insurance risks.

(j) For the purposes of this subsection, "large risk" means: (1) An insured that has total insured property values of $5,000,000 or more; (2) an insured that has total annual gross revenues of $10,000,000 or more; or (3) an insured that has in the preceding calendar year a total paid premium of $50,000 or more for property insurance, $50,000 or more for general liability insurance, or $100,000 or more for multiple lines policies.

(k) The exemption for any large risk contained in subsection (h) shall not apply to workers compensation and employer's liability insurance, insurance purchasing groups, and the basic coverage required by K.S.A. 40-3401 et seq. and amendments thereto.

(l) Underwriting files, premium, loss and expense statistics, financial and other records pertaining to special risks written by any insurer shall be maintained by the insurer and shall be subject to examination by the commissioner.

History: L. 1997, ch. 154, § 5; L. 1999, ch. 63, § 2; L. 2006, ch. 124, § 1; L. 2007, ch. 150, § 2; July 1.

K.S.A. 40-2404. - Unfair methods of competition or unfair and deceptive acts or practices; disclosure of nonpublic personal information; rules and regulations

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) *failure to maintain complaint handling procedures.* Failure of any person, who is an insurer on an insurance policy, to maintain a complete record of all the complaints which it has received since the date of its last examination under K.S.A. 40-222, and amendments thereto; but no such records shall be required for complaints received prior to the effective date of this act. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, the date each complaint was originally received by the insurer and the date of final disposition of each complaint. For purposes of this subsection, "complaint" means any written communication primarily expressing a grievance related to the acts and practices set out in this section.

K.S.A. 40-3110 - Payment of PIP benefits

(a) Except for benefits payable under any workmen's compensation law, which shall be credited against the personal injury protection benefits provided by subsection (f) of K.S.A. 40-3107, personal injury protection benefits due from an insurer or self-insurer under this act shall be primary and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued in compliance with this act. An insurer or self-insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the insurer's policy of motor vehicle liability insurance affords the coverage required by this act. No claim for personal injury protection benefits may be made after two (2) years from the date of the injury.

(b) Personal injury protection benefits payable under this act shall be overdue if not paid within thirty (30) days after the insurer or self-insurer is furnished written notice of the fact of a covered loss and of the amount of same,

except that disability benefits payable under this act shall be paid not less than every two (2) weeks after such notice. If such written notice is not furnished as to the entire claim, any partial amounts supported by written notice is overdue if not paid within thirty (30) days after such written notice is furnished. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within thirty (30) days after such written notice is so furnished: Provided, That no such payment shall be deemed overdue where the insurer or self-insurer has reasonable proof to establish that it is not responsible for the payment, notwithstanding that written notice has been furnished. For the purpose of calculating the extent to which any personal injury protection benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of eighteen percent (18%) per annum.

K.S.A. 40-3118. Financial security as prerequisite to motor vehicle registration; certification of owner; documentation; termination of required insurance, notice; verification of certification; insurance company to maintain evidence on file with division, when; suspension of registration and driving privileges, hearing, reinstatement; prima facie evidence of operation of vehicle without financial security; unlawful acts; refund of unearned premium.

(a) No motor vehicle shall be registered or reregistered in this state unless the owner, at the time of registration, has in effect a policy of motor vehicle liability insurance covering such motor vehicle, as provided in this act, or is a self-insurer thereof, or the motor vehicle is used as a driver training motor vehicle, as defined in K.S.A. 72-5015, and amendments thereto, in an approved driver training course by a school district or an accredited nonpublic school under an agreement with a motor vehicle dealer, and such policy of motor vehicle liability insurance is provided by the school district or accredited nonpublic school. As used in this section, the term "financial security" means such policy or self-insurance. The director shall require that the owner certify and provide verification of financial security, in the manner prescribed by K.S.A. 8-173, and amendments thereto, that the owner has such financial security, and the owner of each motor vehicle registered in this state shall maintain financial security continuously throughout the period of registration. In addition, when an owner certifies that such financial security is a motor vehicle liability insurance policy meeting the requirements of this act, the director may require that the owner or owner's insurance company produce records to prove the fact that such insurance was in effect at the time the vehicle was registered and has been maintained continuously from that date. Failure to produce such records shall be prima facie evidence that no financial security exists with regard to the vehicle concerned. It shall be the duty of insurance companies, upon the request of the director, to notify the director within 30 calendar days of the date of the receipt of such request by the director of any insurance that was not in effect on the date of registration and maintained continuously from that date.

(b) Except as otherwise provided in K.S.A. 40-276, 40-276a and 40-277, and amendments thereto, and except for termination of insurance resulting from nonpayment of

premium or upon the request for cancellation by the insured, no motor vehicle liability insurance policy, or any renewal thereof, shall be terminated by cancellation or failure to renew by the insurer until at least 30 days after mailing a notice of termination, by certified or registered mail or United States post office certificate of mailing, to the named insured at the latest address filed with the insurer by or on behalf of the insured. Time of the effective date and hour of termination stated in the notice shall become the end of the policy period. Every such notice of termination sent to the insured for any cause whatsoever shall include on the face of the notice a statement that financial security for every motor vehicle covered by the policy is required to be maintained continuously throughout the registration period, that the operation of any such motor vehicle without maintaining continuous financial security therefor is a class B misdemeanor and shall be subject to a fine of not less than $300 and not more than $1,000 and that the registration for any such motor vehicle for which continuous financial security is not provided is subject to suspension and the driver's license of the owner thereof is subject to suspension.

(c) The director of vehicles shall verify a sufficient number of insurance certifications each calendar year as the director deems necessary to insure compliance with the provisions of this act. The owner or owner's insurance company shall verify the accuracy of any owner's certification upon request, as provided in subsection (a).

(d) In addition to any other requirements of this act, the director shall require a person to acquire insurance and for such person's insurance company to maintain on file with the division evidence of such insurance for a period of one year when a person has been convicted in this or another state of any of the violations enumerated in K.S.A. 8-285, and amendments thereto.

The director shall also require any driver whose driving privileges have been suspended pursuant to this section to maintain such evidence of insurance as required above.

The company of the insured shall immediately mail notice to the director whenever any policy required by this subsection to be on file with the division is terminated by the insured or the insurer for any reason. The receipt by the director of such termination shall be prima facie evidence that no financial security exists with regard to the person concerned.

No cancellation notice shall be sent to the director if the insured adds or deletes a vehicle, adds or deletes a driver, renews a policy or is issued a new policy by the same company. No cancellation notice shall be sent to the director prior to the date the policy is terminated if the company allows a grace period for payment until such grace period has expired and the policy is actually terminated.

For the purposes of this act, the term "conviction" includes pleading guilty or *nolo contendere*, being convicted or being found guilty of any violation enumerated in this subsection without regard to whether sentence was suspended or probation granted. A forfeiture of bail, bond or collateral deposited to secure a defendant's appearance in court, which forfeiture has not been vacated, shall be equivalent to a conviction.

The requirements of this subsection shall apply whether or not such person owns a motor vehicle.

(e) Whenever the director shall receive prima facie evidence, as prescribed by this section, that continuous financial security covering any motor vehicle registered in this state is not in effect, the director shall notify the owner by registered or certified mail or United States post office certificate of mailing that, at the end of 30 days after the notice is mailed, the

registration for such motor vehicle and the driving privileges of the owner of the vehicle shall be suspended or revoked, pursuant to such rules and regulations as the secretary of revenue shall adopt, unless within 10 days after the notice is mailed: (1) Such owner shall demonstrate proof of continuous financial security covering such vehicle to the satisfaction of the director; or (2) such owner shall mail a written request which is postmarked within 10 days after the notice is mailed requesting a hearing with the director. Upon receipt of a timely request for a hearing, the director shall afford such person an opportunity for hearing within the time and in the manner provided in K.S.A. 8-255, and amendments thereto. If, within the ten-day period or at the hearing, such owner is unable to demonstrate proof of continuous financial security covering the motor vehicle in question, the director shall revoke the registration of such motor vehicle and suspend the driving privileges of the owner of the vehicle.

(f) Whenever the registration of a motor vehicle or the driving privileges of the owner of the vehicle are suspended or revoked for failure of the owner to maintain continuous financial security, such suspension or revocation shall remain in effect until satisfactory proof of insurance has been filed with the director as required by subsection (d) and a reinstatement fee in the amount herein prescribed is paid to the division of vehicles. Such reinstatement fee shall be in the amount of $100 except that if the registration of a motor vehicle of any owner is revoked within one year following a prior revocation of the registration of a motor vehicle of such owner under the provisions of this act such fee shall be in the amount of $300. The division of vehicles shall remit such fees to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the state highway fund.

(g) In no case shall any motor vehicle, the registration of which has been revoked for failure to have continuous financial security, be reregistered in the name of the owner thereof, the owner's spouse, parent or child or any member of the same household, until the owner complies with subsection (f). In the event the registration plate has expired, no new plate shall be issued until the motor vehicle owner complies with the reinstatement requirements as required by this act.

(h) Evidence that an owner of a motor vehicle, registered or required to be registered in this state, has operated or permitted such motor vehicle to be operated in this state without having in force and effect the financial security required by this act for such vehicle, together with proof of records of the division of vehicles indicating that the owner did not have such financial security, shall be prima facie evidence that the owner did at the time and place alleged, operate or permit such motor vehicle to be operated without having in full force and effect financial security required by the provisions of this act.

(i) Any owner of a motor vehicle registered or required to be registered in this state who shall make a false certification concerning financial security for the operation of such motor vehicle as required by this act, shall be guilty of a class A misdemeanor. Any person, firm or corporation giving false information to the director concerning another's financial security for the operation of a motor vehicle registered or required to be registered in this state, knowing or having reason to believe that such information is false, shall be guilty of a class A misdemeanor.

(j) The director shall administer and enforce the provisions of this act relating to the registration of motor vehicles, and the secretary of revenue shall adopt such rules and regulations as may be necessary for its administration.

(k) Whenever any person has made application for insurance coverage and such applicant has submitted payment or partial payment with such application, the insurance company, if payment accompanied the application and if insurance coverage is denied, shall refund the unearned portion of the payment to the applicant or agent with the notice of denial of coverage. If payment did not accompany the application to the insurance company but was made to the agent, the agent shall refund the unearned portion of the payment to the applicant upon receipt of the company's notice of denial.

(l) For the purpose of this act, "declination of insurance coverage" means a final denial, in whole or in part, by an insurance company or agent of requested insurance coverage.

History: L. 1974, ch. 193, § 18; L. 1974, ch. 194, § 1; L. 1975, ch. 247, § 1; L. 1976, ch. 221, § 1; L. 1977, ch. 164, § 3; L. 1979, ch. 149, § 2; L. 1981, ch. 198, § 1; L. 1982, ch. 206, § 1; L. 1984, ch. 174, § 3; L. 1985, ch. 48, § 18; L. 1987, ch. 174, § 2; L. 1996, ch. 51, § 3; L. 1999, ch. 162, § 12; L. 2001, ch. 5, § 123; July 1.

40-2,112. Adverse underwriting decisions; reasons required to be furnished; refunds of premiums; time for making decision.

(a) In the event of an adverse underwriting decision the insurance company, health maintenance organization or agent responsible for the decision shall either provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise such persons that upon written request they may receive the specific reason or reasons in writing.

(b) Upon receipt of a written request within 60 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance company, health maintenance organization or agent shall furnish to such person within 21 business days of the receipt of such written request:

(1) The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to subsection (a); or

(2) if specific items of medical-record information are supplied by a health care institution or health care provider it shall be disclosed either directly to the individual about whom the information relates or to a health care provider designated by the individual and licensed to provide health care with respect to the condition to which the information relates, whichever the insurance company, health maintenance organization or agent prefers; and

(3) the names and addresses of the institutional sources that supplied the specific items of information given pursuant to subsection (b)(2) if the identity of any health care provider or health care institution is disclosed either directly to the individual or to the designated health care provider, whichever the insurance company, health maintenance organization or agent prefers.

(c) The obligations imposed by this section upon an insurance company, health maintenance organization or agent may be satisfied by another insurance company, health maintenance organization or agent authorized to act on its behalf.

(d) The company, health maintenance organization or the agent, whichever is in possession of the money, shall refund to the applicant or individual proposed for coverage, the difference between the payment and the earned premium, if any, in the event of a declination of insurance coverage, termination of insurance coverage, or any other adverse underwriting decision.

(1) If coverage is in effect, such refund shall accompany the notice of the adverse underwriting decision, except such refund obligation shall not apply if:

(A) Material underwriting information requested by the application for coverage is clearly misstated or omitted and the company or health maintenance organization attempts to provide coverage based on the proper underwriting information; or

(B) the company or health maintenance organization includes with the notice of the adverse underwriting decision an offer of coverage to an applicant for life insurance under a different policy or at an increased premium. If such a counter-offer is made by the insurer, the insured or the insured's legal representative shall have 10 business days after receipt thereof in which to notify the company or health maintenance organization of acceptance of the counter-offer, during which time coverage will be deemed to be in effect under the terms of the policy for which application has been made, but such coverage shall not extend beyond 30 calendar days following the date of issuance of the counter-offer by the insurance company or health maintenance organization. The insurance company or health maintenance organization shall promptly refund the premium upon notice of the insured's refusal to accept the counter-offer or upon expiration of such 30 calendar day period, whichever occurs first.

(2) If coverage is not in effect and payment therefor is in the possession of the company, health maintenance organization or the agent, the underwriting decision shall be made within 20 business days from receipt of the application by the agent unless the underwriting decision is dependent upon substantive information available only from an independent source. In such cases, the underwriting decision shall be made within 10 business days from receipt of the external information by the party that makes the decision. The refund shall accompany the notice of an adverse underwriting decision.

History: L. 1981, ch. 190, § 2; L. 1989, ch. 140, § 1; L. 1990, ch. 163, § 1; L. 1994, ch. 355, § 1; May 19.

K.S.A. 40-2,126. - Interest Due On Insurance Settlements,

Except as otherwise provided by K.S.A. 40-447, 40-3110 and 44-512a, and amendments thereto, each insurance company, fraternal benefit society and any reciprocal or interinsurance exchange licensed to transact the business of insurance in this state which fails or refuses to pay any amount due under any contract of insurance within the time prescribed herein shall pay interest on the amount due. If payment is to be made to the claimant and the same is not paid within 30 calendar days after the amount of the payment is agreed to between the claimant and the insurer, interest at the rate of 18% per annum shall be payable from the date of such agreement. If payment is to be made to any other person for providing repair or other services to the claimant and the same is not paid within 30 calendar days following the date of completion of such services and receipt of the billing statement, interest at the rate of 18% per annum shall be payable on the amount agreed to between the claimant and the insurer from the date of receipt of the billing statement.

K.S.A. 60-206. Time, computation and extension. The following provisions shall govern the computation and extension of time:

(a) *Computation; legal holiday defined.* In computing any period of time prescribed or allowed by this chapter, by the local rules of any district court, by order of court, or by any applicable statute, the day of the act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period so computed is to be included, unless it is a Saturday, Sunday or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday or a legal holiday. When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. A half holiday shall be considered as other days and not as a holiday. "Legal holiday" includes any day designated as a holiday by the congress of the United States, or by the legislature of this state, or observed as a holiday by order of the supreme court. When an act is to be performed within any prescribed time under any law of this state, or any rule or regulation lawfully promulgated thereunder, and the method for computing such time is not otherwise specifically provided, the method prescribed herein shall apply.

(b) *Enlargement.* When by this chapter or by a notice given thereunder or by order of court an act is required or allowed to be done at or within a specified time, the judge for cause shown may at any time in the judge's discretion (1) with or without motion or notice order the period enlarged if request therefor is made before the expiration of the period originally prescribed or as extended by a previous order or (2) upon motion made after the expiration of the specified period permit the act to be done where the failure to act was the result of excusable neglect; but it may not extend the time for taking any action under subsection (b) of K.S.A. 60-250, subsection (b) of K.S.A. 60-252, subsections (b), (e) and (f) of K.S.A. 60-259 and subsection (b) of K.S.A. 60-260, and amendments thereto, except to the extent and under the conditions stated in them.

(c) *For motions--affidavits.* A written motion, other than one which may be heard *ex parte,* and notice of the hearing thereof shall be served not later than five days before the time specified for the hearing, unless a different period is fixed by these rules or by order of the judge. Such an order may for cause shown be made on *ex parte* application. When a motion is supported by affidavit, the affidavit shall be served with the motion; and except as otherwise provided in subsection (d) of K.S.A. 60-259, and amendments thereto, opposing affidavits may be served not later than one day before the hearing, unless the court permits them to be served at the time of hearing.

(d) *Additional time after service by mail.* Whenever a party has the right or is required to do some act or take some proceedings within a prescribed period after the service of a notice or other paper upon such party and the notice or paper is served upon such party by mail, three days shall be added to the prescribed period.