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SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF ALAMEDA

AMANDA ARTENO, an individual, **PATRICIA MARTINEZ,** an individual, **JAMES TALBOT,** an individual, and **KEVIN TAM,** an individual.

Plaintiffs,

v.

CALIFORNIA FAIR PLAN ASSOCIATION, an unincorporated association, and **DOES 1-10**,

Defendants.

Case No. 24CV084506

CLASS ACTION COMPLAINT

PARTIES/VENUE/JURISDICTION[1]

1. The CALIFORNIA FAIR PLAN ASSOCIATION (CFP) is a California unincorporated association licensed to conduct business in California. CFP issues property insurance covering risks of loss in homes in all California counties, including Alameda County.

2. Plaintiff Amanda Arteno owns property at 40605 Auberry Road, Auberry, California, which is presently insured by CFP pursuant to its standard homeowners' policy.

3. Plaintiff Patricia Martinez owns property at 31096 Yosemite Springs Road, Coarsegold, California, which is presently insured by CFP pursuant to its standard homeowners' policy.

4. Plaintiff James Talbot owns property at 4538 Cielo Circle, Calabasas, California, which is presently insured by CFP pursuant to its standard homeowners' policy.

5. Kevin Tam owns property at 5745 Balboa Drive, Oakland, California, which his presently insured by CFP pursuant to its standard homeowners' policy.

6. Plaintiffs seeks to represent the following Class:

All persons or entities presently insured under a CFP policy which includes either of the following provisions or functionally equivalent language:

- "we insure for 'direct physical loss' which is defined as any actual loss or physical damage, evidence by permanent physical changes, to the covered property …", and/or
- "Perils Insured Against … Smoke Damage. a. When used in this policy, 'smoke damage' means sudden and accidental direct physical loss from smoke (including airborne, windborne, or wind-driven combustion by-products or particulates such as carbon/soot/ash/char/debris) that is visible

[1] Allegations are on information and belief except as relates to allegations regarding to Plaintiffs individually.

to the unaided human eye, or odor from smoke or ash that is detected by the unaided human nose of an average person, and not by the subjective senses of you or by laboratory testing."

7. The true names and capacities of defendants DOES 1 through 10 are unknown and they are therefore sued by fictitious names. Each of the DOE defendants is, in some manner, responsible for the damages alleged. All allegations in this complaint are asserted equally against DOES 1 to 10.

8. Venue is proper in the Superior Court of California for the County of Alameda. The allegations and claims for relief set forth herein arise out of conduct by CFP in all California counties, including Alameda County. Plaintiffs and the Class reside in all California counties, including Alameda County, and have purchased property insurance from CFP insuring homes in all California counties.

CALIFORNIA FAIR PLAN ASSOCIATION

9. In 1968, the California Legislature enacted the FAIR Plan Chapter, Insurance Code §§10090, et seq., creating CFP.

10. CFP's expenses and benefits liabilities are funded by all insurers licensed to write property insurance in California in proportion to their share of the California property insurance marketplace. Insurance Code §10095(c).

11. CFP is administered by a Governing Committee made up of senior executives from the state's largest property insurance carriers.

12. Because of increasing wildfire activity across California, and the reluctance of the largest retail carriers to insure in high-risk regions, consumers have increasingly turned to CFP for coverage.

13. CFP's market share of homeowners in areas which have experienced wildfire activity, or who are at risk for wildfires, has therefore increased dramatically in the past decade.

14. At present CFP insures hundreds of thousands of homeowners and other property

owners in this state.

15. The CFP enabling statute requires CFP to afford "Basic Property Insurance" to those consumers unable to obtain such insurance in the normal marketplace.

16. "Basic Property Insurance" is defined by the statute to include "perils insured under the standard fire policy" (Insurance Code §10091(c)(1), which standard policy appears in Insurance Code §2071. The standard policy provides for insurance "against all LOSS BY FIRE …."[2]

17. The enabling statute requires CFP to issue and operate pursuant to a Plan of Operation (PO) which must be approved by the Commissioner. (Insurance Code §10095(a).)

18. As required by the enabling statute, the operative PO provides that CFP will issue "Basic Property Insurance," defined as "insurance against direct loss to real or tangible personal property at a fixed location in those geographic or urban areas designated by the Commissioner, *from perils insured under the standard fire policy*…,"[3] which includes coverage against "all LOSS BY FIRE" to insured properties, as set forth in in Insurance Code §2071.

CFP'S STANDARD POLICY IS UNLAWFUL AS IT FAILS TO PROVIDE THE MANDATORY MINIMUM COVERAGE FOR LOSSES CAUSE BY FIRE[4]

19. Insurance Code §2070 provides that every fire policy in California must provide "coverage with respect to the peril of fire, when viewed in its entirety, . . . substantially equivalent to or more favorable to the insured than that contained in the Standard Form Fire Insurance Policy that appears at Insurance Code §2071.

20. Insurance Code §2083 provides that it "is a misdemeanor for any insurer . . . to . . . issue a fire policy covering in whole or in part property in California and varying from the

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[2] The capitalization is in the statute.

[3] **Exhibit A,** page 6.

[4] CFP's standard policy, a form of which was issued to Plaintiffs and the Class, is attached as **Exhibit B.**

California standard form of policy otherwise than as provided by this article."

21. The Standard Form Fire Insurance Policy set forth in Insurance Code §2071 provides coverage for "all LOSS BY FIRE" to the insured property, without limitation or restriction on the scope of covered losses.

22. In the policies CFP sold to Plaintiffs and the Class, the policy provides for coverage for "'direct physical loss', which is defined as any actual loss or physical damage, evidenced by permanent physical changes, to the covered property caused by" a series of named perils, including "fire" and "smoke damage," which are separately defined.

23. CFP's property policies sold to Plaintiff and the Class conflict with and provide less coverage than the Standard Fire Policy, in violation of Insurance Code §§2070, 2083, and 10090 et seq., because they unlawfully restrict mandatory coverage for losses caused by fire by reliance on

- the policy's definition of "direct physical loss," which limits coverage to loss or damage to the covered property evidenced by permanent physical changes; and
- the policy's "smoke damage" provision, which supplies restricted coverage for "direct physical loss from smoke (including airborne, windborne, or wind-driven combustion by-products or particulates such as carbon/soot /ash/char/debris) that is visible to the unaided human eye, or odor from smoke or ash that is detected by the unaided human nose of an average person, and not by the subjective senses of you or by laboratory testing."

24. Because, by the means set forth, CFP's policies provide less coverage for loss or damage caused by the peril of fire than is provided in the Standard Form Policy (Insurance Code §2071), they are unlawful pursuant to Insurance Code §§2070, 2083, and 10090 et seq.,

25. Each of the provisions at issue is likewise unlawful.

26. Because the policies issued to Plaintiffs and the Class are contrary to California

law, by operation of law the policy incorporates the language in the Standard Fire Policy, which provides coverage for "all LOSS BY FIRE" to the property.

CDI'S RECENT INVESTIGATION AND FINDINGS REGARDING CFP'S UNLAWFUL POLICY

27. In or about October 2016 (State Tracking No. 16-6646) CFP sought approval for the form property policy which sought to limit coverage, reduce claims investigation expenses, and reduce indemnity payments to policyholders by inclusion in the form of, among other changes:

(a) a newly defined definition of "direct physical loss"; and

(b) separate coverage for "smoke damage".

28. CFP intended by the changes set forth above to limit coverage provided by its property policies, to reduce claims investigation expenses, and to reduce indemnity payments for covered fire losses.

29. At the time it sought approval of its new property policy in or about October 2016 and thereafter, in fact, knowing that CDI would consider reductions in coverage, savings in claims expenses, and savings in indemnity payments, in making its decision whether to approve the proposed changes, CFP intentionally misrepresented and concealed the true impact of the proposed modifications to its policy form and withheld the true facts from CDI, for the purpose of maximizing the profits of its contributing companies, and for an anti-competitive purpose, in violation of Insurance Code §§2070, 2071, 2083, and 10090 et seq.

30. Specifically, in or about October 2016, as part of its form filing, CFP told the CDI in its form application filed under penalty of perjury that "The changes in the policy will either provide no change in coverage or will provide some broadening of coverage."

31. In the same filing, CFP expressly adopted each of the assertions in the form filing, including the assertions in the preceding paragraphs.

32. Contrary to its sworn statements to the CDI in the approval application, in communications to sales agents and insureds in California in or about April 2017, in which it introduced the revised property policy—the policy issued to Plaintiffs and the Class—CFP

informed the sales agents and insureds that the changes to its new form policy set forth above, including but not limited to the new definition of "Direct physical loss," amounted to a reduction of coverage and would result in denials of claims that would have been paid under the prior policy.

33. The Commissioner approved CFP's approval application on January 25, 2017, which order permitted CFP to sell the policy, including the policies sold to Plaintiffs and the Class.

34. After July 2017, having obtained approval for its new policy form by means of concealment and misrepresentation, CFP issued the policy to Plaintiffs and the Class.

35. From July 2017 to the present, consistent with its warning to its customers and sales agents, CFP has denied or partially denied hundreds of covered fire claims in reliance on the changes to the insuring language of its policy for which it obtained approval in or about 2017.

36. In correspondence on January 4, 2021,[5] CDI alerted CFP of its conclusion that the policy sold to Plaintiffs and the Class is unlawful because it fails to afford the mandatory minimum coverage required by California law, in the manner described above.

37. In that correspondence, CDI likewise alerted CFP to its conclusion that that CDI's 2017 approval for the Policy was obtained by CFP in reliance on misrepresentations to CDI regarding coverage implications of the form submitted for approval and concealments of material facts.

38. In its January 4, 2021, correspondence to CFP, based on its conclusions regarding the invalidity of the CFP policy and the illegal means by which CFP had obtained approval of the policy from the CDI, the CDI demanded the following:

- CFP was directed to review all fire and/or smoke damage claims it has denied, in whole or in part, since the violative policy language took effect in January 2017, and

[5] **Exhibit C,** Letter of CDI General Counsel Kenneth Schnoll to CDI General Counsel Kenneth Schnoll to CFP President Anneliese Jivan.

adjust these claims without applying that violative policy language;

- CFP was directed to submit a revised policy form that omits the violative language discussed below and take such additional steps as described below;
- Until such as time as CFP submitted a revised policy form and that form is approved by CDI, CDI directed CFP to read and interpret its policy in a manner that complies with applicable law;
- CFP was directed to cease any application or interpretation of the violative language contained in its Dwelling Fire Policy to deny, in whole or in part, the payment of claims;
- CFP was directed to make an immediate form filing to revise its Dwelling Fire Policy so as to comport with California law;
- CFP was directed to provide CDI with the following information within thirty (30) days from January 4, 2021: (1) a list of any and all fire and/or smoke damage claims that CFP has denied, in whole or in part, since January 1, 2017, including claimed amounts, names of policyholders, and all documentation of the reasons for denying the claims, in whole or in part; and (2) a list of all pending litigation, including captioning information, involving CFP claim denials, in whole or in part, under the Dwelling Fire Policy currently in use or that was approved by the Department in form filing no. 16-6646.

39. After receiving the CDI's correspondence and directives, CFP did not comply with any of the CDI's directives, and continued to sell the unlawful policy in California, including to Plaintiffs and the Class.

40. Following a year-long investigation of CFP's handling of wildfire claims, in a Report of the Targeted Market Conduct Examination of California Fair Plan Association adopted May 25, 2022,[6] CDI confirmed the allegations in its January 2021 letter, concluding:

- The Policy fails to provide coverage for fire that is "substantially equivalent to or

[6] **Exhibit D,** Market Conduct Examination Report, adopted May 25, 2022.

more favorable to the insured than that contained in the California Standard Form Fire Insurance Policy as reflected in CIC §2071";

- CFP "failed to provide coverage for all loss by fire as set forth in the California Standard Form Fire Insurance Policy";
- In the application for approval of the Policy, CFP "omitted relevant facts and misrepresented revised language as providing broad or broader coverage than the policy provided previously. In [Fair Plan's] Filing Memorandum in support of its form filing to CDI, [Fair Plan] specifically represented to CDI that its proposed revisions, including its new definition of "direct physical loss," would not reduce or eliminate existing coverages, might even broaden coverage, and would have no rate impact. Specifically, [Fair Plan] stated: 'The changes in the policy will either provide no change in coverage or will provide some broadening of coverage. The Fair Plan will not revise rates for the additional coverage.'

Despite its representations to CDI, [Fair Plan] handled claims for smoke damage based on its policy's definition of 'direct physical damage' as requiring permanent physical changes to covered property. However, loss caused by fire does not require 'permanent physical changes' for there to be coverage. Further, a loss from smoke stemming from fire should be adjusted as would a loss caused only by fire. Smoke damage is not a separate occurrence from fire. [Fair Plan's] definition of smoke and/or smoke damage is not at least equivalent to that required under the Standard Form Fire Insurance Policy and is therefore a violation of law."

41. Notwithstanding the CDI's findings and directives to CFP that it reform its unlawful policy, since the Market Conduct Examination CFP has continued to sell and adjust claims under the unlawful policy in California, including to Plaintiffs and the Class.

CLASS ACTION ALLEGATIONS

42. Plaintiffs bring this action as a class action pursuant to California Code of Civil Procedure §382.

43. *Numerosity*. Plaintiffs are informed and believe, and thereupon allege, that the Class contains hundreds of thousands of members and is therefore sufficiently numerous to justify class treatment.

44. *Common questions*. There exist questions of law and fact common to each member of the Class. Common legal and factual questions include, but are not limited to the following:

- In violation of Insurance Code §2070, 2071, 2083, and 10090 et seq. does CFP fail to afford Plaintiffs and the Class the mandatory coverage for fire losses by reliance on the policies' definition of "direct physical loss"?
- In violation of Insurance Code §§2070, 2071, 2083, and 10090 et seq. does CFP fail to afford it insureds with the mandatory coverage for fire losses by reliance on the policies' smoke damage" provision?

45. *Typicality*. Plaintiffs' claims are typical of the claims of the Class in that they are insured under CFP property policies which, in the manner and by the means set forth above, fail to provide the mandatory minimum coverage for fire losses.

46. *Adequacy of Representation*. Plaintiffs will fairly and adequately protect the interests of the Class. Plaintiffs have no interest which conflicts with the Class and have retained lawyers who are experienced plaintiff-side insurance litigators with extensive class action experience.

47. *Community of Interest*: Questions of law or fact common to the Class predominate over any question affecting only individual members. The issues raised in this action involve: (a) identical insurance policies; and (b) uniform statutes governing the contents of insurance policies and payment of claims under property insurance policies.

48. *Superiority of the Class Action Procedure*. Class treatment of the claims asserted by Plaintiffs is superior to other methods of adjudicating the claims of the Class in that:

(a) The prosecution of separate actions by individual members of the Class would create a foreseeable risk of inconsistent or varying adjudications which would

establish incompatible results and standards of conduct for CFP and the Commissioner.

(b) Class action treatment avoids the waste and duplication inherent in potentially thousands of individual actions and conserves the resources of the courts.

(c) The cost of litigating individual claims relating to property is so great that, in the absence of a class action, members of the Class have no effective remedy. Because of the narrow relief sought, the absence of any request for money damages, and the high cost of litigation, in the absence of a class action it is likely that few members of the Class would seek legal redress for the particular claims as to which Plaintiffs seek class treatment herein.

(d) Class members are unlikely to be interested in the control of their individual claims because of the cost and complexity of the allegations, and the relatively small size of the claims, and, if a particular member of the Class has a compelling reason to control his or her claim, he or she may opt out of the Class.

(e) There are no difficulties which arise from the concentration of the claims asserted herein in a single forum and there are considerable economies in such concentration.

(f) There are no difficulties in managing this action because of the virtual identicality of legal and factual issues required to be resolved for Plaintiffs and the Class as to the issues for which Plaintiffs seek class treatment. Accordingly, this case should be maintained as a class action.

(g) CFP's law violations apply generally to the Class and therefore final injunctive relief and/or declaratory relief sought is appropriate as applied to the Class as a whole.

RELIEF SOUGHT

49. Plaintiffs are CFP customers who are insured under the post-2017 standard CFP homeowners' policy which contains the policy language found by the Commissioner to be

unlawful in California because it fails to provide the mandatory minimum coverage for fire losses, in violation of Insurance Code §§2070, 2071, 2083, and 10090 et seq.

50. Plaintiffs seek by way of this suit to obtain from CFP the mandatory minimum coverage required by California law.

51. On behalf of themselves and the Class, Plaintiffs seek the following, among other relief set forth below:

- the Court's declaration, consistent with the findings of the CDI, that the policies sold to Plaintiffs and the Class fail to afford the required mandatory minimum coverage for losses caused by fire; and
- the Court's declaration, consistent with the findings of the CDI, that the policies sold to Plaintiffs and the Class violate Insurance Code §§2070, 2071, 2083, and §10090 et seq.;
- a temporary and permanent injunction requiring CFP to cease applying the two policy provisions the CDI found render CFP's standard homeowners' policy unlawful;
- a temporary and permanent injunction requiring CFP to provide insurance to Plaintiffs and the Class for the mandatory minimum coverage required by California law, namely, coverage for "all LOSS BY FIRE" to insured properties policies sold to Plaintiffs and the Class to comply with California law;
- notification to the Class regarding the Court's declaration and injunctive relief.

52. The effect of relief sought will be to ensure enforcement of the Commissioner's findings in his Market Conduct Examination, compliance by CFP with California law, and insurance for Plaintiffs and the Class that provides the mandatory minimum coverage for fire losses.

FIRST CAUSE OF ACTION
DECLARATORY AND INJUNCTIVE RELIEF

(AGAINST FAIR PLAN AND DOES 1-10)

53. Plaintiffs and the Class incorporate by reference the preceding paragraphs as though fully set forth in this First Cause of Action against CFP and DOES 1-10.

54. An actual controversy has arisen and now exists between the parties concerning whether CFP violates California law (Insurance Code §2070, 2071, 2083, and 10090 et seq.) by:

- failing to afford Plaintiffs and the Class the mandatory coverage for fire losses by reliance on the policies' definition of "direct physical loss"; and
- failing to afford Plaintiffs and the Class the mandatory coverage for fire losses by reliance on the policies' "smoke damage" provision?

55. CFP and DOES 1-10 dispute that they are violating the foregoing statutes in the manner alleged.

56. Pursuant to California Code of Civil Procedure §1060, Plaintiffs and the Class seek a judicial determination of the rights and obligations of the parties pursuant to California Insurance Code §§ 2070, 2071, 2083, 10090 et seq.

57. Accordingly, a judicial declaration is necessary and appropriate, and no other adequate remedy is available to Plaintiffs and the Class.

58. Plaintiffs and the Class seek an order of the Court that CFP is barred:

- from failing to afford Plaintiffs and the Class the mandatory coverage for fire losses by reliance on the policies' definition of "direct physical loss," in violation of Insurance Code §2070, 2071, 2083, and 10090 et seq.;
- from failing to afford Plaintiffs and the Class the mandatory coverage for fire losses by reliance on the policies' smoke damage" provision in violation of Insurance Code §2070, 2071, 2083, and 10090 et seq.?

59. Plaintiffs and the Class seek the Court's declarations and temporary and permanent injunctions against CFP as set forth above.

PRAYER FOR RELIEF

Plaintiffs and the Class pray for judgment against CFP and DOES 1-10 as follows:

1. for declaratory relief as set forth;

2. for injunctive relief as set forth;

3. for attorneys' fees pursuant to CCP §1021.5 and/or any other applicable provision of California law;

4. for costs of suit;

5. for such other relief the Court finds just and proper.

Dated: July 24, 2024 KERLEY SCHAFFER LLP

BY: Dylan L. Schaffer
Attorneys for Plaintiffs

EXHIBIT A

EXHIBIT A

BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of THE CALIFORNIA FAIR PLAN ASSOCIATION, Respondent.	STIPULATION AND ORDER NO. 2023- 1 REGARDING THE CALIFORNIA FAIR PLAN ASSOCIATION'S REVISED PLAN OF OPERATION (INSURANCE CODE § 10095)

RECITALS

WHEREAS, RICARDO LARA is the California Insurance Commissioner ("Commissioner");

WHEREAS, the California FAIR Plan Association ("FAIR Plan") is an involuntary association of all admitted insurers licensed to write and engaged in writing Basic Property Insurance in California, governed by Chapter 9 of Part 1, Division 2 of the California Insurance Code[1], sections 10090 *et seq.*, ("Chapter 9");

WHEREAS, pursuant to section 10090, the FAIR Plan's purposes are:

(a) to assure stability in the property insurance market for property located in the State of California;

(b) to assure the availability of basic property insurance as defined by [Chapter 9];

(c) to encourage maximum use, in obtaining basic property insurance, of the normal insurance market provided by admitted insurers and licensed surplus line brokers; and

(d) to provide for the equitable distribution among admitted insurers of the responsibility for insuring qualified property for which basic property insurance cannot be obtained through the normal insurance market by the establishment of a FAIR Plan…;

WHEREAS, pursuant to section 10095, subdivision (g), administration of the FAIR Plan is subject to the Commissioner's supervision;

WHEREAS, pursuant to Insurance Code section 10095, subdivision (f), the Commissioner may, at any time, revoke approval of the FAIR Plan's Plan of Operation if the Commissioner feels it is necessary to carry out the purposes of Chapter 9;

[1] Unless otherwise noted, all statutory citations are to Chapter 9 of Part 1, Division 2 of the California Insurance Code, sections 10090 *et seq.*

WHEREAS, pursuant to Insurance Code section 10095, subdivision (f), the FAIR Plan is required to amend its Plan of Operation at the direction of the Commissioner;

WHEREAS, pursuant to Insurance Code section 10095, subdivision (g), the FAIR Plan may, on its own initiative or at the request of the Commissioner, amend the Plan of Operation subject to approval by the Commissioner;

WHEREAS, the FAIR Plan's current Plan of Operation (Ed. 11/19/21) requires the FAIR Plan to offer, under its Division I Commercial Property Program ("CPP"), combined coverage limits of $8.4 million, consisting of $5.6 million for building coverage and $2.8 million for business personal property coverage at one location;

WHEREAS, the FAIR Plan's current Plan of Operation (Ed. 11/19/21) requires the FAIR Plan to offer, under its Division II Commercial Multiperil Businessowners Insurance Policies ("BOP"), combined coverage limits of $7.2 million, consisting of $4 million for building coverage and $2 million for business personal property coverage at one location, and $600 thousand per occurrence and $1.2 million in the aggregate for liability coverage per policy;

WHEREAS, the Commissioner and the FAIR Plan have jointly drafted and agreed upon a revised Plan of Operation (Ed. 03/29/23) ("New Plan"), attached hereto as Exhibit A; and

WHEREAS, the Commissioner feels the New Plan, attached hereto as Exhibit A, is necessary to carry out the purposes of Chapter 9.

STIPULATION

Based on the foregoing Recitals, which are part of this agreement, the Department and the FAIR Plan stipulate as follows:

A. The Commissioner and the FAIR Plan agree that, as set forth in the New Plan attached hereto as Exhibit A, it is necessary to amend the Plan of Operation to increase the available coverage limits that the FAIR Plan offers under its Division I CPP and under its Division II BOP, and that doing so will fulfill the FAIR Plan's purposes by assuring the availability and stability of the commercial property insurance market in California and adequately protecting property located in California from the risk of loss due to peril(s) covered by the FAIR Plan's policies.

B. The Commissioner and the FAIR Plan agree that the FAIR Plan shall offer combined Division I CPP coverage limits of $20 million for building coverage, business personal property coverage, and other associated coverages at one insured location.

C. The Commissioner and the FAIR Plan agree that the FAIR Plan shall offer combined Division II BOP coverage limits of $20 million for building coverage, business personal property coverage, and other associated coverages at one insured location, plus additional limits of $1 million per occurrence and additional limits of $3 million in the aggregate for liability coverage per policy, for total combined limits of up to $23 million for Division II BOP coverage.

Dated: March 29, 2023

KENNETH B. SCHNOLL
Deputy Commissioner and General Counsel
California Department of Insurance

Dated: March 29, 2023

VICTORIA ROACH
President, The California FAIR Plan Association

ORDER

Based on the foregoing stipulation, the Commissioner orders as follows:

1. The Commissioner hereby revokes the FAIR Plan's current Plan of Operation (Ed. 11/19/21) to the extent that such Plan of Operation does not specify that the FAIR Plan shall offer Division I CPP policies with combined coverage limits of up to $20 million, for building coverage, business personal property coverage, and other associated coverages at one insured location;

2. The Commissioner hereby revokes the FAIR Plan's current Plan of Operation (Ed. 11/19/21) to the extent that such Plan of Operation does not specify that the FAIR Plan shall offer Division II BOP policies with combined coverage limits of up to $20 million for building coverage, business personal property coverage, and other associated coverages at one insured location, plus additional limits of $1 million per occurrence and $3 million in the aggregate for liability coverage per policy, for total combined limits of up to $23 million for Division II BOP coverage;

3. The New Plan is hereby promulgated pursuant to Insurance Code section 10095, subdivisions (f) and (g), and shall become effective on the date of this Order, without further action by the Commissioner;

4. Not later than sixty (60) days after the date of this Order, the FAIR Plan shall submit a separate rule filing to reflect the increased limit of liability for its Division I CPP policies that may be purchased through the FAIR Plan. Thereafter, the FAIR Plan shall implement the increase in the limit of liability for Division I CPP policies no later than ninety (90) days after the rule change necessary to implement the increased limit of liability for its Division I CPP policies is approved by the Commissioner;

5. Not later than sixty (60) days after the date of this Order, the FAIR Plan shall submit a separate rule filing to reflect the increased limit of liability for its Division II BOP policies that may be purchased through the FAIR Plan. Thereafter, the FAIR Plan shall implement the increase in the limit of liability for its Division II BOP policies no later than ninety (90) days after the rule change necessary to implement the increased limit of liability for its Division II BOP policies is approved by the Commissioner.

6. This order shall be effective immediately.

IT IS SO ORDERED this 29 day of March, 2023.

RICARDO LARA
California Insurance Commissioner

EXHIBIT A

PLAN OF OPERATION (Ed. 3/29/23)

Ed. 3/29/23

CALIFORNIA FAIR PLAN ASSOCIATION

This is the Plan of Operations of the California FAIR Plan as required by Section 10095 of the California Insurance Code.

The California FAIR Plan (hereinafter referred to as the FAIR Plan) has been formulated by the insurance industry for the purpose of making certain Property Insurance available to responsible applicants who have been unable to secure such insurance in the normal insurance market.

DIVISION I – Property Insurance Plan

Provisions Applicable to Division I

Section I – Purposes of Plan

The purposes of the Plan are:

A. to make available, subject to the conditions hereinafter stated, Basic Property Insurance;

B. to establish a FAIR Plan (Fair Access to Insurance Requirements), and to provide for the equitable distribution and placement of risks among Insurers in the manner and subject to the conditions hereinafter stated;

C. to conform with the applicable provisions of the Urban Property Protection and Reinsurance Act of 1968 and California Insurance Code, Chapter 9, Part 1, Division 2; and

D to encourage maximum use of the normal insurance market by admitted insurers and licensed surplus brokers.

Section II – Effective Date

The Plan shall become effective as of July 24, 1968.

Section III – Definitions

A. "Insurer" means any insurance company or other organization which is licensed to write and is engaged in writing, Basic Property Insurance and other coverages with respect to such Basic Property Insurance, on a direct basis, in this State.

B. "Basic Property Insurance" means insurance against direct loss to real or tangible personal property at a fixed location in those geographic or urban areas designated by the Commissioner, from perils insured under the standard fire policy and extended coverage

endorsement, vandalism and malicious mischief and such other insurance coverages as may be added with respect to such property by the Placement Facility with the approval of the Commissioner or by the Commissioner, but shall not include insurance on automobile or farm risks. (Insurance Code section 10091, subd. (c).) For purposes of this Plan, Basic Property Insurance shall also include the Businessowners policy as set out in Division II of this Plan.

C. "Association," "Industry Placement Facility" (herein referred to as the Placement Facility) or "FAIR Plan" means the joint reinsurance association (the California FAIR Plan Association) formed for the following purposes:

1. to formulate and administer the Plan;

2. upon request by or on behalf of any property owner requesting an inspection under the Plan, to distribute the risks involved equitably among the Insurers with which it is doing business; and

3. to place Basic Property Insurance, as defined in Paragraph B of this Section, up to the full insurable value of the risk to be insured subject to the limits of liability stated in Section VI, Paragraph C, with one or more Insurers with which it is doing business, except to the extent that deductibles, percentage participation clauses, and other underwriting devices are employed to meet special problems of insurability.

D. "Inspection Bureau" means the organization designated by the Placement Facility with the approval of the Commissioner to make inspections to determine the condition of the properties for which Basic Property Insurance is sought and to perform such other duties as may be authorized by the Placement Facility.

E. "Urban Area" includes any municipality or other political subdivision of this State, subject to population or other limitations defined in rules and regulations of the Secretary of the United States Department of Housing and Urban Development, and such additional areas as may be designated by the Commissioner.

F. "Geographical Area" means any area designated by the Commissioner or by the Committee with the approval of the Commissioner.

G. "Premiums Written" means gross direct premiums charged with respect to property in this State on all policies of Basic Property Insurance and the Basic Property Insurance premium components of all multiperil policies, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits.

H. "Commissioner" means the Insurance Commissioner of the State of California.

I. "Plan" means this Plan of Operation and the insurance program it establishes

J. "Profits" for purposes of Insurance Code section 10095, subdivision (c) means Operating Income minus the sum of Operating Expense, incurred losses, and incurred loss adjustment expenses.

K. "Operating Income" means earned premiums plus investment income.

L. "Operating Expense" means income taxes and all other expenses of the Plan.

Section IV – FAIR Plan – Inspections and Reports

A. Any person having an insurable interest in real or tangible personal property in the State of California within the area covered under the Plan shall be entitled upon written or oral request therefor to the Placement Facility, to a prompt inspection of the property by the Inspection Bureau without cost.

B. The manner and scope of the inspections of FAIR Plan business shall be prescribed by the Placement Facility with the approval of the Commissioner.

C. An inspection report shall be made for each property inspected. The report shall cover pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. A representative photograph of the property may be taken during the inspection.

D. The inspector shall have no authority to advise whether any Insurer or the FAIR Plan will provide the coverage.

E. After the inspection a copy of the completed inspection report, and any photograph indicating the pertinent features of building, construction, maintenance, occupancy and surrounding property shall be sent to the designated insurer or to the Placement Facility promptly and in any event within five days after the report is completed. The report shall include a description of any conditions for which charges or surcharges may be imposed. A copy of the inspection report shall be sent to the applicant or his agent upon request.

Section V – Procedure After Inspection

A. The Placement Facility shall, within three business days after receipt of the inspection report and request, complete an action report, advising that:

1. the risk is acceptable and if surcharged, the improvements necessary before it will provide coverage at an unsurcharged rate;

2. the risk will be acceptable if the improvements noted in the action report are made by the applicant and confirmed by reinspection; or

3. the risk is not acceptable for the reasons stated in the action report.

B. If the risk is accepted, the Placement Facility shall deliver the policy or binder to the applicant upon payment to the Placement Facility of the premium. As soon as practicable but no later than February 1, 2024, or such later date approved by the Commissioner, premiums for Division I may be paid by applicants or existing policyholders in full or in monthly installments by personal check, cashier's check, money order, credit card or electronic funds transfer.

C. In the event a risk is declined because it fails to meet reasonable underwriting standards, the Placement Facility shall notify the applicant and shall include a copy of the inspection report and the action report. Reasonable underwriting standards shall include, but not be limited to, the following:

1. physical condition of the property, such as its construction, heating, wiring, evidence of previous fires or general deterioration;

2. its present use or housekeeping, such as vacancy, overcrowding, storage of rubbish or flammable materials; or

3. other specific characteristics of ownership, condition, occupancy, or maintenance which are violative of public policy and result in unreasonable exposures to loss.

Neighborhood or area location or any hazard beyond the control of the property owner shall not be deemed to be acceptable criteria for declining a risk.

D. In the event the risk is conditionally declined because the property does not meet reasonable underwriting standards but can be improved to meet such standards, the Placement Facility shall promptly advise the applicant what improvements noted in the action report should be made to the property, and the notification and advices to the applicant shall include a copy of the inspection report and the action report. Upon completion of the improvements by the applicant or property owner, the Placement Facility, when so notified, will have the property promptly reinspected.

E. If the inspection of the property reveals that there are one or more substandard conditions, surcharges may be imposed in conformity with any applicable substandard rating plan.

Section VI – California FAIR Plan Association – Placement Distribution

A. The California FAIR Plan Association (herein referred to as the Association or the FAIR Plan) is hereby created consisting of all Insurers.

B. The Association shall be authorized:

1. to write and issue policies of insurance as provided in this Plan on behalf of its Insurers; the respective liabilities of the Insurers shall be several and not joint, except as stated in Provisions Applicable to Division I and Division II, Section IX of this Plan, and each such Insurer shall be considered to be a direct insurer for its share in such writings, such share to be determined for each Insurer pursuant to the provisions of Paragraphs D and E of Division I, Section VI and other pertinent provisions of the Plan;

2. to assume and cede reinsurance pursuant to Insurance Code section 10095, subdivision (b).

3. to arrange for determination and collection of premium charges consistent with Section V, Paragraph B of this Plan of Operation and disbursement of return premiums, commissions and return commissions;

4. to direct and control the investigation, adjustment, defense, and payment of the losses and claims arising under the policies of insurance issued pursuant to this Plan.

C. The maximum limit of liability for Division I fire and allied lines policies which may be placed through this Plan is $3 million at one Location. As used in connection with Division I fire and allied lines policies, “Location” includes all buildings or structures which are located at one address or single assessor’s parcel, or at contiguous addresses or assessor’s parcels, owned by the same property owner(s). With respect to condominiums, a “location” also includes all units described on a recorded final map, parcel map or condominium plan, as set

forth in California Civil Code section 4125. Residences, other than condominiums, at contiguous addresses or assessor's parcels, shall be considered to be separate "locations." Adjacent houses on separate parcels occupied by family members or tenants of a common owner or landlord shall be considered separate "locations."

Upon approval by the Commissioner of the rule change to increase the limit of liability for Division I commercial property program, the maximum limit of liability for Division I commercial property policies which may be placed through this Plan is $20,000,000 for building coverage, business personal property coverage, and other associated coverages at one Insured Location. As used in connection with policies issued under Division I CPP, "Insured Location" includes all buildings or structures which are located at one address or single assessor's parcel, or at contiguous addresses or assessor's parcels, owned by the same property owner(s). With respect to condominiums, a "location" also includes all units described on a recorded final map, parcel map or condominium plan, as set forth in California Civil Code section 4125. Residences, other than condominiums, at contiguous addresses or assessor's parcels, shall be considered to be separate "locations." Adjacent houses on separate parcels occupied by family members or tenants of a common owner or landlord shall be considered separate "locations."

The maximum policy limits set forth herein are subject to periodic review and may be increased as deemed necessary by the Commissioner. Higher limits of liability also may be placed through the Plan under written guidelines adopted by a majority of the Governing Committee present and voting. The FAIR Plan may file any rate or rule application necessary to implement the maximum limits of liability required by this Paragraph.

D. Except as modified in Paragraph E. of Division I, Section VI and in Provisions Applicable to Division I and Division II, Section IX, each insurer shall participate in the writings, expenses, profits and losses of Division I of this Plan (including assessments for operating the Placement Facility) in the same proportion that its Premiums Written during the second preceding calendar year bear to the aggregate Premiums Written by all Insurers in the Plan, excluding that portion of the Premiums Written attributable to the operation of the Association.

E. Insurers that voluntarily write Basic Property Insurance on risks located in areas designated as brush hazard areas by the Insurance Services Office, inner city areas designated by the Commissioner, and high or very high fire hazard severity zones as determined and mapped by the Department of Forestry and Fire Protection, pursuant to Section 51178 of the Government Code, will to that extent, be proportionately relieved of the liability to participate in the Plan.

F. A group of Insurers under the same management, ownership or control shall have the option of designating an Insurer from within the group to assume all obligations on behalf of the entire group.

Section VII – Standard Policy Coverage

All policies issued for Basic Property Insurance, as defined in Section III, Paragraph B of Division I of this Plan of Operation, shall be on standard policy forms.

Section VIII – Cancellation

A. No policy or binder issued under this Plan shall be cancelled except:

1. for cause which would have been grounds for non-acceptance of the risk under the Plan had such cause been known to the Placement Facility at the time of acceptance;

2. for non-payment of premium; or

3. for other reasons described in Insurance Code sections 676 or 676.2 as applicable.

Notice of Cancellation, together with a statement of the reason therefor, shall be sent to the insured, accompanied by a statement that the insured has a right of appeal as hereinafter provided.

B. Notice of cancellation of policies on risks eligible for Plan inspection or coverage, sent by the Placement Facility or by any Insurer participating in the Plan shall be sent to the insured not less than thirty days in advance of the effective date of cancellation, together with information concerning Facility placement procedures; provided, however, that this Paragraph B shall be inapplicable in cases of non-payment of premiums, evidence of incendiarism, or evidence of material misrepresentation or concealment.

C. The provisions of Paragraph B immediately above shall also be applicable to notice of non-renewal of such policies.

Section IX – Rates

A. All rates charged by the FAIR Plan shall be subject to Commissioner's prior written approval. The FAIR Plan's rates shall not be excessive, inadequate, or unfairly discriminatory and shall be actuarially sound so that premiums are adequate to cover expected losses, expenses, and taxes, and shall reflect the FAIR Plan's investment income.

B. The FAIR Plan shall file a rate application for the dwelling line of business within 24 months after the effective date of any approved change to dwelling rates, unless otherwise directed by the Commissioner. The FAIR Plan shall file a rate application for the commercial line of business within 36 months after the effective date of any approved change to the commercial rates, unless otherwise directed by the Commissioner. The FAIR Plan shall provide all information and data required by the Commissioner to determine whether the rate proposed by the FAIR Plan complies with Insurance Code section 10100.2, subdivision (a).

C. Pursuant to Insurance Code section 10100.2, subdivision (c), all information considered by the FAIR Plan to establish rates shall be public records.

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Division II – Businessowners Policy

Provisions Applicable to Division II

Section I – Purposes of Plan

The purposes of the Plan are:

A. to make available, subject to conditions hereinafter stated, Basic Property Insurance and such other insurance coverages as are usual to Businessowners Insurance policies.

B. to provide for the equitable distribution and placement of such risks among Insurers in the manner and subject to the conditions stated herein.

Section II – Effective Date

The Plan shall become effective upon approval of the Commissioner.

Section III – Definitions

A. "Insurer" means any insurance company or other organization which is licensed to write and is engaged in writing Basic Property Insurance and other coverages with respect to such Basic Property Insurance on a direct basis in this state.

B. "Businessowners Policy" ("BOP") means Basic Property Insurance as defined in Division I Section IIIB of the Plan and shall include a combination of the Insurance Services Office's Standard Businessowners Property Coverage Form and Insurance Services Office's Standard Businessowners Liability Coverage Form for coverage on certain small business operations necessary and incidental to the occupancy of the property.

C. "Association," "Industry Placement Facility" (herein referred to as the Placement Facility) or "FAIR Plan" means the joint reinsurance association (the California FAIR Plan Association) formed for the following purposes:

1. to formulate and administer the Plan;

2. upon request by or on behalf of any qualified business owner requesting an inspection under the Plan, to distribute the risks involved equitably among the Insurers with which it is doing business; and

3. to place Commercial Multiperil Businessowners Insurance up to the full insurable value of the risk to be insured with one or more insurers with which it is doing business, except to the extent that deductibles, percentage participation clauses, and other underwriting devices are employed to meet special problems on insurability.

D. "Inspection Bureau" means the organization designated by the Placement Facility with the approval of the Commissioner to make inspections to determine the condition of the properties or businesses for which Basic Property Insurance and Commercial Multiperil

Businessowners Insurance is sought and to perform such other duties as may be authorized by the Placement Facility.

E. "Urban Area" includes any municipality or other political subdivision of this State, subject to population or other limitations defined in rules and regulations of the Secretary of the United States Department of Housing and Urban Development, and such additional areas as may be designated by the Commissioner.

F. "Geographical Area" means any area designated by the Commissioner or by the Governing Committee with the approval of the Commissioner.

G. "Premiums Written" means gross direct premiums charged with respect to property in this State on all policies of Basic Property Insurance and the premium components of Basic Property Insurance and of such other insurance coverages as are usual to Commercial Multiperil Businessowners Insurance policies, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits.

H. "Commissioner" means the Insurance Commissioner of the State of California.

I. "Plan" means this Plan of Operation and the insurance program it establishes.

J. "Profits" for purposes of Insurance Code section 10095, subdivision (c) means Operating Income minus the sum of Operating Expense, incurred losses, and incurred loss adjustment expenses.

K. "Operating Income" means earned premiums plus investment income.

L. "Operating Expense" means income taxes and all other expenses of the Plan.

Section IV – FAIR Plan – Inspections and Reports

A. Any person owning and operating a business who has an insurable interest in real or tangible personal property and who desires Basic Property Insurance and such other insurance coverages as are usual to Businessowners Insurance policies, in the State of California within the area covered under the Plan shall be entitled upon written or oral request therefor to the Placement Facility, to a prompt inspection of the property by the Inspection Bureau without cost.

B. The manner and scope of the inspections of FAIR Plan business shall be prescribed by the Placement Facility with the approval of the Commissioner.

C. An inspection report shall be made for each business inspected. The report shall cover pertinent structural, occupancy and business operations features as well as the general condition of the building, premises and surrounding structures. A representative photograph of the business property and premises may be taken during the inspection.

D. The inspector shall have no authority to advise whether any Insurer or the FAIR Plan will provide the coverage.

E. After the inspection a copy of the completed inspection report, and any photograph indicating the pertinent features of building, construction, maintenance, occupancy, business operations and surrounding property and premises shall be sent to the designated insurer or to

the Placement Facility promptly and in any event within five days after the report is completed. The report shall include a description of any conditions for which charges or surcharges may be imposed. A copy of the inspection report shall be sent to the applicant or his agent upon request.

Section V – Procedure After Inspection

A. The Placement Facility shall, within three business days after receipt of the inspection report and request, complete an action report, advising that:

1. the risk is acceptable and if surcharged, the improvements necessary before it will provide coverage at an unsurcharged rate;

2. the risk will be acceptable if the improvements noted in the action report are made by the applicant and confirmed by reinspection; or

3. the risk is not acceptable for the reasons stated in the action report.

B. If the risk is accepted, the Placement Facility shall deliver the policy or binder to the applicant upon payment to the Placement Facility of the premium.

C. In the event a risk is declined because it fails to meet reasonable underwriting standards, the Placement Facility shall notify the applicant and shall include a copy of the inspection report and the action report. Reasonable underwriting standards shall include, but not be limited to, the following:

1. physical condition of the property, such as its construction, heating, wiring, evidence of previous fires or general deterioration;

2. its present use or housekeeping, such as vacancy, overcrowding, storage of rubbish or flammable materials; or

3. other specific characteristics of ownership, condition, occupancy, business operations or maintenance which are violative of public policy and result in unreasonable exposures to loss.

Neighborhood or area location or any hazard beyond the control of the property or business owner shall not be deemed to be acceptable criteria for declining a risk.

D. In the event the risk is conditionally declined because the property does not meet reasonable underwriting standards but can be improved to meet such standards, the Placement Facility shall promptly advise the applicant what improvements noted in the action report should be made to the property, and the notification and advices to the applicant shall include a copy of the inspection report and action report. Upon completion of the improvements by the applicant or property owner, the Placement Facility, when so notified, will have the property promptly reinspected.

E. If the inspection of the property reveals that there are one or more substandard conditions, surcharges may be imposed in conformity with any applicable substandard rating plan.

Section VI- California FAIR Plan Association – Placement Distribution

A. The Association shall be authorized:

1. to write and issue policies of insurance as provided in this Plan on behalf of its Insurers; the respective liabilities of the Insurers shall be several and not joint, except as stated in Provisions Applicable to Division I and Division II, Section IX of this Plan, and each such Insurer shall be considered to be a direct insurer for its share in such writings, such share to be determined for each Insurer pursuant to the provisions of Paragraphs C and D of Division II, Section VI and other pertinent provisions of the Plan;

2. to assume and cede reinsurance pursuant to Insurance Code section 10095, subdivision(b);

3. to arrange for determination and collection of premium charges and disbursement of return premiums, commissions and return commissions; and

4. to direct and control the investigation, adjustment, defense, and payment of the losses and claims arising under the policies of insurance issued pursuant to Division II of this Plan.

B. Upon approval by the Commissioner of the rule change to increase the limit of liability for Division II Commercial Multiperil Businessowners Program (or "BOP") policies that may be purchased through the Plan, the maximum limit of liability for Commercial Multiperil Businessowners Program policies which may be placed through Division II of this Plan as part of a Businessowners Insurance policy is a combined limit of $20 million for building coverage, business personal property coverage, and other associated coverages at one Insured Location. The maximum applicable limit of business liability insurance which may be placed through Division II of this Plan with respect to such property as part of a Commercial Multiperil Businessowners Insurance policy is: $1 million per occurrence and $3 million in the aggregate per policy. As used in connection with policies issued under Division II BOP, "Insured Location" includes all buildings or structures which are located at one address or single assessor's parcel, or at contiguous addresses or assessor's parcels, owned by the same property owner(s). With respect to condominiums, a "location" also includes all units described on a recorded final map, parcel map or condominium plan, as set forth in California Civil Code section 4125. Residences, other than condominiums, at contiguous addresses or assessor's parcels, shall be considered to be separate "locations." Adjacent houses on separate parcels occupied by family members or tenants of a common owner or landlord shall be considered separate "locations."

The maximum policy limits set forth herein are subject to periodic review and may be increased as deemed necessary by the Commissioner. Higher limits of liability also may be placed through the FAIR Plan under written guidelines adopted by a majority of the Governing Committee present and voting. The FAIR Plan may file any rate or rule application necessary to implement the maximum limits of liability required by this Paragraph.

C. Except as modified in Paragraph D. of Division II, Section VI and in Provisions Applicable to Division I and Division II, Section IX, each Insurer shall participate in the writings, expenses, profits and losses of the business written pursuant to Division II of this Plan (including assessments for operating the Placement Facility) in the same proportion as its Commercial Multiperil premiums written during the second preceding calendar year bear to the aggregate

Commercial Multiperil premiums written by all Insurers in the Plan, excluding that portion of the premiums written attributable to the operation of the Association pursuant to Division II of this Plan.

D. Insurers which voluntarily write Commercial Multiperil Insurance on risks located in specific areas designated by the Governing Committee or by the Commissioner will, to that extent, be proportionately relieved of the liability to participate in Division II of this Plan.

E. A group of Insurers under the same management or ownership shall have the option of designating an Insurer from within the group to assume all obligations on behalf of the entire group.

Section VII – Standard Policy Coverage

All Businessowners Insurance policies ("BOP") issued pursuant to Division II of this Plan shall be on standard policy forms, except as modified with permission of the Commissioner, and shall be issued for a term of one year.

Section VIII – Cancellation

A. No policy or binder issued under Division II of this Plan shall be canceled except:

1. for cause which would have been grounds for non-acceptance of the risk under the Plan had such cause been known to the Placement Facility at the time of acceptance;

2. for nonpayment of premium; or

3. for other reasons described in Insurance Code section 676.2.

Notice of Cancellation, together with a statement of the reason therefor, shall be sent to the insured, accompanied by a statement that the insured has a right of appeal as hereinafter provided.

B. Notice of cancellation of policies on risks eligible pursuant to Division II for Plan inspection or coverage, sent by the Placement Facility or by any Insurer participating in the Plan shall be sent to the insured not less than thirty days in advance of the effective date of cancellation, together with information concerning Facility placement procedures; provided, however, that this Paragraph B shall be inapplicable in cases of nonpayment of premiums, evidence of incendiarism, or evidence of material misrepresentation or concealment.

C. The provisions of Paragraph B immediately above shall also be applicable to notice of non-renewal of such policies.

Section IX – Rates

A, All rates charged by the FAIR Plan shall be subject to Commissioner's prior written approval. The FAIR Plan's rates shall not be excessive, inadequate, or unfairly discriminatory and

shall be actuarially sound so that premiums are adequate to cover expected losses, expenses, and taxes, and shall reflect the FAIR Plan's investment income.

B. The FAIR Plan shall file a rate analysis on or before July 1, 2024 for Division II. After such rate analysis is reviewed by the Commissioner, the FAIR Plan shall not be required to file a subsequent rate analysis or application, unless otherwise directed by the Commissioner, except that the FAIR Plan shall be required to file a rate application promptly if Division II reaches 1,000 policies, and so long as Division II retains 1,000 policies, the FAIR Plan shall file a rate application within 36 months after the effective date of the new BOP rates, unless otherwise directed by the Commissioner. The FAIR Plan shall provide all information and data required by the Commissioner to determine whether the rate proposed by the FAIR Plan complies with Insurance Code section 10100.2, subdivision (a).

C. Pursuant to Insurance Code section 10100.2, subdivision (c), all information considered by the FAIR Plan to establish rates shall be public records

Provisions Applicable to Division I and Division II

Section I – Right of Appeal

Any Applicant or Insurer shall have the right of appeal to the Governing Committee. A decision of the Governing Committee may be appealed to the Commissioner within thirty days from the action or decision of the Governing Committee. Each denial of insurance shall be accompanied by a statement that the applicant has the right of appeal to the Governing Committee and the Commissioner and setting forth the procedures to be followed for such appeal.

Section II – Commission

Commission, under the Plan shall be determined by the Governing Committee, and shall be paid to the licensed producer designated by the applicant.

Section III – Administration

A. This Plan shall be administered by a Governing Committee (herein referred to as the Committee) of the Placement Facility, subject to the supervision of the Commissioner, and operated by a Manager appointed by the Committee.

B. The Committee shall consist of nine voting Insurers, which shall be elected as follows:

two members from the American Property Casualty Insurance Association

one member from all other stock insurers

one member from all other non-stock insurers

six members from at-large insurers

Not less than four of the members of the Committee shall be California domiciled companies.

The Committee shall, in addition, have as non-voting members one representative of insurance agents, one representative of insurance brokers, one representative of the public, one representative of surplus line brokers and each to be appointed by the Governor of the State of California.

Not more than one participating Insurer in a group under the same management or ownership shall serve on the Committee at the same time. Representatives on the Committee shall serve for a period of one year or until successors are elected.

All members of the Governing Committee shall execute a Non-Disclosure Agreement, subject to the approval of the Commissioner, agreeing to maintain the confidentiality of (1) any pending or anticipated litigation, and any matters falling within the attorney-client privilege, to the extent that confidentiality is required for the attorney to exercise his/her ethical duties as a lawyer; and (2) any matter involving employment, termination, terms and conditions of employment, evaluation, promotion or disciplining of any prospective or current FAIR Plan employee or contractor, and which shall include a provision that the defense and indemnification obligations contained in Section VI of this Plan will not apply with respect to a breach of the Non-Disclosure Agreement.

C. The Chairman of the Committee shall appoint a Nominating Committee consisting of not less than three voting members who shall place in nomination the voting Insurers for election at the annual meeting. If nominations are made at the annual meeting for voting Insurers other than those nominations made by the Nominating Committee, such nominations shall designate the category of voting Insurers as indicated in Paragraph B of this Section.

D. Voting for election to the Committee at the annual meeting will be on a weighted basis in accordance with Premiums Written (as defined in Division I, Section III, Paragraph G, and in Division II, Section III, Paragraph G.) during the second preceding calendar year as disclosed in the reports filed by the Insurers with the Commissioner.

E. The Governing Committee may establish subcommittees that may convene to deliberate with respect to only those matters specified in the respective charter for each such subcommittee and to make recommendations to the Governing Committee regarding such specified matters. The charters shall be approved by the Governing Committee annually, at a meeting of the Governing Committee at which the Commissioner and/or his or her representatives are present, and such charters shall be provided to the Commissioner in advance of such meeting as part of the Governing Committee packet, at the same time or before the Governing Committee packet is provided to the Governing Committee members. The subcommittees authorized by this Plan of Operation are as follows: Underwriting Subcommittee; Claims Subcommittee; Accounting Subcommittee; Investment Subcommittee; Nominating Subcommittee, Reinsurance Subcommittee, and an Executive Subcommittee. Each subcommittee shall include at least one nonvoting member of the Governing Committee.

F. Only the Executive subcommittee may exercise delegated authority from the Governing Committee. The Executive subcommittee shall include the nonvoting member of the Governing Committee described in Insurance Code section 10094 as the “representative of the public.”

Section IV - Meetings

A. There shall be an Annual Meeting of Insurers on a date fixed by the Governing Committee for the purpose of electing the voting members of the Governing Committee in the manner prescribed in Section III above and for the purpose of conducting such other items of business as may be properly brought before it. A majority of Insurers, on a weighted basis, in accordance with each Insurer's Premiums Written, as specified in Division I, Section VI, Paragraph D and Division II, Section VI, Paragraph C, present in person shall constitute a quorum. The Plan shall provide twenty days' advance written notice of the Annual Meeting to the Insurers, the non-voting members of the Governing Committee, and the Commissioner and his or her designee(s).

B. The FAIR Plan shall provide advance written notice to the Governing Committee, the Commissioner and the person(s) designated by the Commissioner of the time, date, and place and an agenda for any meeting of the Governing Committee. The Plan shall provide advance written notice to the members of all subcommittees and the person(s) designated by the Commissioner of the time, date, and place and an agenda for any subcommittee meeting, except that notice to the Commissioner and/or his or her designees of Executive Subcommittee meetings shall not be required if such meetings are properly closed to the Commissioner pursuant to Section IV, Paragraph F below. Notice of each such meeting shall be provided to the Commissioner in the same manner and at the same time as the notice provided to the meeting attendees.

C. The Commissioner and the person(s) designated by the Commissioner shall be permitted to attend any meeting of the Governing Committee and any subcommittee at which a quorum is present, except any meeting of the Executive Subcommittee closed to the Commissioner as described below in Section IV, Paragraph F, or any portion of a Governing Committee meeting called to discuss: (1) any pending or anticipated litigation, and any matters falling within the attorney-client privilege, to the extent that confidentiality is required for the attorney to exercise his/her ethical duties as a lawyer; or (2) any matter involving employment, termination, terms and conditions of employment, evaluation, promotion or disciplining of any prospective or current FAIR Plan employee or contractor. Any portion of a Governing Committee meeting called to discuss any matter pertaining to (1) or (2) hereof may be closed to the Commissioner and his/her designees, but not to the nonvoting members, and shall be so declared by a formal motion of the Governing Committee at a meeting the Commissioner and his/her designees are authorized to attend.

D. Except with respect to the Annual Meeting referenced in Paragraph A of this Section IV, and a Special Meeting referenced in Paragraph E of this Section IV, voting by proxy, voting by mail and voting by email shall not be permitted.

E. A Special Meeting of the Insurers other than the Annual Meeting referenced in Paragraph A of this Section IV, may be called at such time and place designated by the Governing Committee, or upon the written request to the Governing Committee by a minimum of ten insurers, none of which are under common control with any of the other requesting insurers. If, at a Special Meeting, a vote of the Insurers is or may be required on any proposal, such votes shall be cast and counted on a weighted basis in accordance with each Insurer's Premiums Written as used to determine its participation in the Association under Division I, Section VI, Paragraph D, and Division II, Section VI, Paragraph C. The FAIR Plan shall provide notice to the Commissioner

and the non-voting members of the Governing Committee of any Special Meeting of Insurers in the same manner and at the same time as the Insurers. The Commissioner and/or his or her designee(s) and the non-voting members shall be authorized to attend and participate in any such meeting.

F. The Executive subcommittee may meet in a session closed to the Commissioner only for the purpose of deliberating and deciding matters pertaining to: (1) any pending or anticipated litigation, and any matters falling within the attorney-client privilege, to the extent that confidentiality is required for the attorney to exercise his/her ethical duties as a lawyer; or (2) any matter involving employment, termination, terms and conditions of employment, evaluation, promotion or disciplining of any prospective or current FAIR Plan employee. While the FAIR Plan shall make diligent efforts to schedule meetings of the Executive Committee only if all members of the Executive subcommittee, including the nonvoting "member of the public," are available, any three members of the Executive subcommittee shall be sufficient to constitute a quorum. The Executive subcommittee shall promptly inform the Governing Committee of any final decision of the Executive subcommittee when it becomes public.

G. The Governing Committee shall meet annually with the FAIR Plan's auditors. At the discretion of the Committee, such meeting or a part thereof may be convened outside the presence of FAIR Plan employees or contractors and counsel for the FAIR Plan. All findings and any reports of the auditors shall be provided to the Commissioner and/or his or her designees.

Section V – Duties of the Governing Committee

A. The Governing Committee ("Committee") shall meet as often as may be required to perform the general duties of administration of the Plan, or on the call of the Commissioner. A majority of the voting and at least one non-voting member of the Committee shall constitute a quorum.

B. The Committee shall be empowered to appoint a Manager and such other personnel as may be necessary, who shall serve at the pleasure of the Committee; and to budget expenses, levy assessments, disburse funds, and perform all other duties provided herein or necessary or incidental to the proper administration of the Plan. The adoption of or substantive changes in pension plans or employee benefit programs, shall be subject to approval of Insurers.

C. The Committee shall be further empowered to modify or amend any provision of this Plan as required by legislation, or by rule, regulation or administrative determination by the Commissioner, in accordance with Section XII of this Plan.

D. Annually, the Manager shall prepare an operating budget which shall be subject to approval of the Committee. Such budget shall be furnished to the Insurers after approval. Any contemplated expenditures in excess of or not included in the annual budget, shall require prior approval by the Committee.

E. The Committee shall furnish to all Insurers, and to the Commissioner, a written report on operations annually in such form and detail as the Committee may determine.

F. The Committee shall require periodic reports from the Inspection Bureau, and shall furnish copies of such reports to the Commissioner.

G. The Committee shall make every effort to obtain the full cooperation of all California producers licensed to write property lines, in connection with the operations of the Placement Facility and of the Plan.

Section VI – Indemnification

A. Except as provided in the Non-Disclosure Agreement to be signed by each member of the Governing Committee, the Association shall indemnify (a) every director, Governing Committee member, member of any other committee or any subcommittee, officer, and employee of the Association, and his heirs, executors, and administrators, and (b) every insurer member of the Association, both as a member or by reason of such insurer having one or more of its representatives or employees serving in any of the capacities or positions specified in clause (a) hereinabove; against all judgments, fines, amounts paid in settlement, reasonable costs and expenses including attorney fees, and any other liabilities that may be incurred as a result of any claim, action, suit, or proceedings, whether civil, criminal, administrative or other, prosecuted or threatened to be prosecuted for or on account of any act performed or omitted or obligation entered into, if done or omitted in good faith and without intent to defraud, and in connection with the administration, management, or conduct of the Association or its affairs.

B. Such indemnification shall be provided whether or not such person or insurer holds office in the Association at the time such claim, action, suit or proceeding is begun, prosecuted, or threatened, and whether or not the liability indemnified against was incurred or the act or omission occurred prior to the adoption of this Section.

The adjudication or termination or any such claim, action, suit, or proceeding by judgment, settlement, conviction, or plea of nolo contendere or its equivalent, shall not be deemed to create a presumption that such person or insurer did not act in good faith or acted with intent to defraud. If any such claim, action, suit or proceeding is compromised or settled, this must be done with the approval of the Governing Committee of the Association.

C. Any such person or insurer shall be conclusively entitled to rely upon an opinion of legal counsel for the Association; and if the act or omission involved was reasonably done in reliance upon such an opinion, such person or insurer shall be entitled to the indemnification provided for by this Section. Such person or insurer shall also be entitled to indemnification provided for by this section hereunder. Such person or insurer shall also be entitled to indemnification hereunder if his, her or its defense to the claim, action, suit or proceedings has been wholly successful, whether on the merits or otherwise.

D. The right of indemnification hereunder shall not be exclusive of other rights such person or insurer may have.

E. In each instance in which a question of indemnification hereunder arises, determination in the first instance of the right to indemnification hereunder, and of the time and manner of payment thereof, shall be made by the Governing Committee. In the event that a majority of the members of the Governing Committee are seeking indemnification hereunder as a result of the same occurrence, such determination in the first instance shall be made by vote of the membership of the Association taken on a weighted basis as provided in Division I, Section VI, Paragraph D, and Division II, Section VI, Paragraph C hereof.

Nothing contained in this Paragraph E is intended to make an adverse determination finally binding upon the person or insurer seeking indemnity under this Section, or to preclude any such person or insurer from appealing an adverse determination against him, her or it, or from instituting legal proceedings to enforce a right of indemnification under this Section.

F. The indemnification provided for in this Section shall be deemed to be an expense of the Association to which all of the members of the Association shall contribute in the proportion that each member participates according to law in the writings, expenses, profits and losses of the Association.

Section VII – Public Education

All Insurers agree to undertake a continuing public education program, in cooperation with producers and others, to assure that the Plan receives adequate public attention.

Section VIII – Termination of the Plan

Any obligations incurred by the Association shall not be impaired by the termination of the Plan and such Association shall be continued for the purpose of performing such obligations.

Section IX – Insolvency

Any member that, due to insolvency, is no longer licensed and authorized to write in California, or that, due to insolvency, is no longer engaged in writing in California, upon a direct basis, basic property insurance or any component thereof in homeowners or other multiperil policies, shall cease to be a member of the California FAIR Plan Association, as of the date that the member's license is revoked or suspended, the date upon which the member became no longer so authorized, or the date upon which the member ceased writing such insurance, whichever date occurs first.

Such member's proportionate share of expenses and/or losses shall be paid by the remaining members, each of which shall contribute such payment in the same proportion as specified in Division I, Section VI, Paragraphs D and E, and in Division II, Section VI, Paragraphs C and D of this Plan, calculated without reference to Premiums Written by such member. In calculating said payment for each remaining member, such member's Premiums Written from its voluntary writings as set forth in Division I, Section VI, Paragraphs D and E, and Division II, Section VI, Paragraphs C and D, shall be excluded.

If the Association elects to make a distribution of funds to its members, no amount that would otherwise be distributed under the Plan of Operations shall be distributed to such member subject to an order of liquidation entered with the county clerk, or to its liquidator, receiver, conservator or statutory successor.

Section X – Citation to the Commissioner

Failure of any member to comply with this Plan of Operation or with any rules prescribed there

under by the Governing Committee or to pay any assessment levied within 30 days after notice thereof shall be grounds for Citation of such member to the Commissioner.

Section XI – Distributions of Profits, and Assessments to Operate the Facility

Pursuant to Insurance Code section 10095, subdivision (c), the Insurers shall participate in the writing, expenses, Profits, and losses of the FAIR Plan in the same proportion that its premiums written during the second preceding calendar year bear to the aggregate premiums written by all Insurers in the program, excluding that portion of the premiums written attributable to the operation of the FAIR Plan.

No distributions of Profits, as defined in Division I, Section III, Paragraph J and Division II, Section III, Paragraph J shall be made to the Insurers without the Commissioner's prior written approval.

Pursuant to Insurance Code section 10094, the Insurers shall not be subject to any assessment without the Commissioner's prior written approval.

Section XII – Amendments to this Plan

Any Insurer may propose an amendment to the Plan and present that proposed amendment to the Governing Committee for consideration. The proposal shall be considered at the next meeting of the Governing Committee. If the proposed amendment to the Plan is approved by a majority of the members of the Governing Committee present and voting at the Governing Committee meeting at which the proposed amendment to the Plan is considered, notice of the proposed amendment to the Plan shall be mailed to the Insurers not less than twenty days prior to the final date fixed by the Governing Committee for Insurers to vote thereon. Any vote of the Insurers on a proposed amendment to this Plan or any other Insurer proposal may be taken by mail and such votes shall be cast and counted on a weighted basis in accordance with each Insurer's Premiums Written as used to determine its participation in the Association under Division I, Section VI, Paragraph D, and Division II, Section VI, Paragraph C. Any amendment to this Plan shall be approved by at least two-thirds of the votes cast by Insurers on such weighted basis before it is submitted to the Commissioner for review and approval.

No amendment to this Plan of Operation shall be effective without the prior written approval of the Commissioner.

Pursuant to Insurance Code section 10095, subdivision (f), the Commissioner may revoke his or her approval of this Plan of Operation if he or she feels it is necessary to carry out the purposes of Chapter 9 of the Insurance Code.

[END OF DOCUMENT]

EXHIBIT B

EXHIBIT B

California FAIR Plan Association

3435 Wilshire Blvd., Suite 1200

Los Angeles, CA 90010

www.cfpnet.com

DWELLING PROPERTY POLICY

This policy is issued on behalf of those insurers that by law participate in the writings, expenses, profits and losses of the CALIFORNIA FAIR PLAN ASSOCIATION for the kind of risks insured against by this policy. The names of such participating insurers, and the extent of their respective participations, are on file with, and may be obtained from, either the CALIFORNIA FAIR PLAN ASSOCIATION or the Insurance Commissioner of the State of California. The policy period as shown in the Declarations Page shall begin and end at 12:01 A.M. standard time at the location of the property involved.

DEFINITIONS

In this policy, "you" and "your" refer to the "named insured" shown in the Declarations and the spouse if a resident of the same household. "We", "us" and "our" refer to the Company providing this insurance.

AGREEMENT

We will provide the insurance described in this policy in return for the premium and compliance with all applicable provisions of this policy.

COVERAGES

This insurance covers the property at the address shown under PROPERTY LOCATION (the "Described Location") in the DWELLING INSURANCE POLICY DECLARATIONS (the "Declarations").

If there is a checkmark ☑ next to A - Dwelling in the Declarations, the following applies:

COVERAGE A - Dwelling

We cover:

1. the dwelling on the Described Location shown in the Declarations, used principally for dwelling purposes, including structures attached to the dwelling;

2. materials and supplies located on or next to the Described Location used to construct, alter or repair the dwelling or other structures on the Described Location; and

3. if not otherwise covered in this policy, building equipment and outdoor equipment used for the service of and located on the Described Location.

This coverage does not apply to land, including land on which the dwelling is located.

COVERAGE B - Other Structures

We cover other structures on the Described Location, set apart from the dwelling by clear space. This includes structures connected to the dwelling by only a covered walkway, wall, fence, utility line, or similar connection.

This coverage does not apply to land, including land on which the other structures are located.

We do not cover other structures:

1. used in whole or in part for commercial, professional, manufacturing or farming purposes; or

2. rented or held for rental to any person not a tenant of the dwelling, unless used solely as a private garage.

You may use up to 10% of the Coverage A limit of liability for loss by a Peril Insured Against to other structures. Payment under this coverage reduces the Coverage A limit of liability by the amount paid for the same loss.

If there is a checkmark ☑ next to B - Other Structures in the Declarations, the following applies:

We cover those Other Structures described in the Schedule to the Declarations up to the Limit of Liability stated for each such structure identified in the Schedule to the Declarations.

This coverage is in addition to your ability to elect to use up to 10% of the Coverage A Limit of Liability for loss to Other Structures.

If there is a checkmark ☑ next to C - Personal Property in the Declarations, the following applies:

COVERAGE C - Personal Property

We cover personal property usual to the occupancy as a dwelling and owned or used by you or members of your family residing with you while it is on the Described Location. At your request, we will cover personal property owned by a guest or household employee while the property is on the Described Location.

If you remove personal property from the Described Location to a newly acquired principal residence, the Coverage C limit of liability will apply at each residence for the 30 days immediately after you begin to move the property there. This time period will not extend beyond the termination of this policy. Our liability is limited to the proportion of the limit of liability that the value at each residence bears to the total value of all personal property covered by this policy.

Property not covered. We do not cover:

1. whether real or digital, accounts, bank notes, bills, bullion, coins, currency, deeds, evidences of debt, gold other than goldware, letters of credit, manuscripts, medals, money, notes other than bank notes, passports, personal records, platinum, securities, silver other than silverware, tickets and stamps;

2. animals, birds or fish;

3. aircraft and parts except model or hobby aircraft not used or designed to carry people or cargo;

4. motor vehicles or all other motorized land conveyances. This includes:

a. their equipment and accessories; or

b. any device or instrument for transmitting, recording, receiving or reproduction of sound or pictures which is operated by power from the electrical system of motor vehicles or all other motorized land conveyances, including:

i. accessories or antennas; or

ii. tapes, wires, records, discs or any other media for use with any such device or instrument;

while in or upon the vehicle or conveyance.

We do cover vehicles or conveyances not subject to motor vehicle registration which are used to service the Described Location, or are designed for assisting the handicapped.

5. watercraft, other than rowboats, kayaks and canoes;

6. data, including data stored in:

a. books of account, drawings or other paper records; or

b. electronic data processing tapes, wires, records, discs or other software media.

However, we do cover the cost of blank recording or storage media, and of pre-recorded computer programs available on the retail market.

7. credit cards, gift cards, debit cards or fund transfer cards.

8. business personal property, meaning property of any nature that is used in your business including, without limitation, inventory and equipment.

If there is a checkmark ☑ next to Permitted Incidental Occupancy in the Declarations, the following applies:

In addition to covering personal property usual to the occupancy as a dwelling, we cover personal property usual to the occupancy of the dwelling for the purpose described in the Schedule to the Declarations for loss caused by a Peril Insured Against at the Described Location. The personal property must be owned or used by you or members of your family residing with you while it is on the Described Location. We shall not be liable for more than the limit of liability shown in the Declarations for this coverage.

9. natural or artificial lawns, plants, shrubs or trees outside of buildings.

If there is a checkmark ☑ next to Plants, Shrubs and Trees in the Declarations, the following limited exception to the above exclusion will apply:

We insure for loss caused by the Perils Insured Against to plants, shrubs and trees. We do not cover property grown for commercial purposes. We shall not be liable for more than our proportion of $250 on any one plant, shrub or tree including expense incurred for removing debris thereof. We shall not be liable for more than the limit of liability shown in the Declarations for this coverage.

We do not insure loss to plants, shrubs or trees grown in violation of, or otherwise made illegal or unlawful by, any federal, state or local law.

COVERAGE D - Fair Rental Value

If a loss covered under this policy makes that part of the Described Location rented to others, held for rental or occupied by you unfit for its normal use, we cover its "Fair Rental Value", meaning the fair rental value of that part of the Described Location rented to others, held for rental or occupied by you less any expenses that do not continue while that part of the Described Location rented, held for rental or occupied by you is not fit to live in.

Payment will be for the shortest time required to repair or replace that part of the Described Location rented, held for rental or occupied by you.

We will pay no more than 1/12 of this coverage for each month the Described Location is unfit for its normal use and the amount due under this coverage shall be calculated based on a 30 day month. Payment under this coverage shall not be more than the monthly fair rental value of that part of the Described Location rented to others, held for rental or occupied by you.

If you have personal property coverage, Fair Rental Value will be determined based on an equivalent furnished property. If you do not have personal property coverage, Fair Rental Value will be determined based on an equivalent unfurnished property.

If a civil authority prohibits you from use of the Described Location as a result of direct damage to a neighboring location by a Peril Insured Against in this policy, we cover the Fair Rental Value loss for no more than two weeks.

The periods of time referenced above are not limited by the expiration of the policy.

We do not cover loss or expense due to cancellation of a lease or agreement.

You may use up to 10% of the Coverage A limit of liability for loss of Fair Rental Value. Payment under this coverage reduces the Coverage A limit of liability by the amount paid for the same loss.

If there is a checkmark ☑ next to D - Fair Rental Value in the Declarations, the following applies:

We will pay Fair Rental Value up to the Limit of Liability stated for Fair Rental Value in the Declarations.

This coverage is in addition to your ability to elect to use up to 10% of the Coverage A Limit of Liability for loss of Fair Rental Value.

OTHER COVERAGES

1. **Debris Removal**. We will pay your reasonable expense for the removal of:

   a. debris of covered property damaged by a loss we cover; or

   b. ash, dust or particles from a volcanic eruption that has caused a direct loss to a covered building or property contained in a building.

   Debris removal expense is included in the limit of liability applying to the damaged property. You may use any amount of the Limit of Liability shown in the Declarations under Coverage A, B or C for the reasonable expenses you incur for the removal of debris damaged by a loss we cover. Payment under that coverage reduces the Limit of Liability for that coverage by the amount paid for the same loss.

   If there is a checkmark ☑ next to Debris Removal in the Declarations, the following applies:

   We will pay the reasonable expenses you incur for removal of debris of covered property damaged by a loss we cover, up to the Limit of Liability stated for Debris Removal in the Declarations. This Debris Removal coverage applies to each coverage (Coverage A - Dwelling, Coverage B - Other Structures and Coverage C - Personal Property) you have purchased, as shown in the Declarations.

   This additional Debris Removal coverage does not include abatement of hazardous materials from the damaged covered property, nor the removal of property that did not suffer direct physical damage as a result of a loss we cover, even if an ordinance or law requires removal of the property (or any portion of the property) as a condition to permitting repairs or rebuilding following a loss we cover.

2. **Improvements, Alterations and Additions**. If you are a Condominium Unit owner or tenant of the Described Location, you may use up to 10% of the Coverage C limit of liability for loss by a Peril Insured Against for improvements, alterations and additions, made or acquired at your expense, to that part of the Described Location used only by you.

   Payment under this coverage reduces the Coverage C limit of liability by the amount paid for the same loss.

   If there is a checkmark ☑ next to Improvements, Alterations and Additions in the Declarations, the following applies:

   We cover Improvements, Alterations and Additions made at your expense to your part of the Described Location whether rented to others or not. We shall not be liable for more than the limit of liability shown in the Declarations for this coverage.

3. **World-Wide Coverage**. You may use up to 10% of the Coverage C limit of liability for loss by a Peril Insured Against to property covered under Coverage C while anywhere in the world. This coverage does not apply to property of guests or household employees, or to rowboats, kayaks or canoes.

   Payment under this coverage reduces the Coverage C limit of liability by the amount paid for the same loss.

4. **Reasonable Repairs**. In the event that covered property is damaged by an applicable Peril Insured Against, we will pay the reasonable cost incurred by you for necessary measures taken solely to protect against further damage, subject to the provisions of Condition 5., below. If the measures taken involve repair to other damaged property, we will pay for those measures only if that property is covered under this policy and the damage to that property is caused by an applicable Peril Insured Against.

   This coverage:

   a. does not increase the limit of liability that applies to the covered property; and

   b. does not relieve you of your duties, in case of a loss to covered property, as set forth in Condition 5.b., below.

5. **Property Removed**. We insure covered property against direct loss from any cause while being removed from a premises endangered by a Peril Insured Against and for no more than five days while removed. This coverage does not change the limit of liability that applies to the property being removed.

6. **Fire Department Service Charge**. We will pay up to $500 for your liability assumed by contract or agreement for fire department charges incurred when the fire department is called to save or protect covered property from a Peril Insured Against. We do not cover fire department service charges if the property is located within the limits of the city, municipality or protection district furnishing the fire department response.

   This coverage is additional insurance. No deductible applies to this coverage.

PERILS INSURED AGAINST

Unless the loss is excluded in the General Exclusions, or below, we insure for "direct physical loss", which is defined as any actual loss or physical damage, evidenced by permanent physical changes, to the covered property caused by:

1. **Fire or Lightning**.

2. **Internal Explosion,** meaning explosion occurring in the dwelling or other structure covered on the Described Location or in a structure containing covered personal property.

   Explosion does not mean:

   a. electric arcing;

   b. breakage of water pipes; or

   c. breakage or operation of pressure relief devices.

This peril does not include loss by explosion of steam boilers, or steam pipes, if owned or leased by you or operated under your control.

3. **Smoke Damage**.

   a. When used in this policy, "smoke damage" means sudden and accidental direct physical loss from smoke (including airborne, windborne, or wind-driven combustion by-products or particulates such as carbon/soot/ash/char/debris) that is visible to the unaided human eye, or odor from smoke or ash that is detected by the unaided human nose of an average person, and not by the subjective senses of you or by laboratory testing.

   b. Loss caused by smoke is excluded entirely if the smoke comes from agricultural smudging or industrial operations, or from intentional fire sources routinely found in or around homes including, but not limited to, smoke from

fireplaces, fire pits, devices used to barbeque or cook food, lanterns or smoke or ash from other intentional use of flames.

c. The amount of coverage (money available for smoke damage) is determined by timeliness of claim reporting. Time is measured from the date of the fire's full containment as determined by Cal Fire or the local fire agency overseeing fire suppression efforts to the date of the first report of smoke damage to us:

i. smoke damage losses that are reported within 45 days of the fire's full containment are covered up to the applicable policy limit;

ii. smoke damage losses that are reported after 45 days are limited to $1,500.

d. Dispute resolution of smoke damage claims:

i. any dispute regarding whether smoke damage has occurred will be resolved by either Method 1 or 2 below (at your election):

Method 1: You and we will each select a competent and disinterested person, and those two will select a third person (the Umpire) all in the same manner provided in the Condition 9, Appraisal, below. The three people will inspect the premises and decide by majority vote whether they can see or smell smoke damage, and their decision is binding. If there is smoke damage, the claim will then be adjusted to determine the amount of the loss.

Method 2: A single, sole neutral Umpire can decide whether there is smoke damage. If the parties cannot agree on the identity of that individual, a judge of a court of record in the State of California will select the Umpire. Each side will pay 1/2 of the fee for the Umpire.

ii. if the parties agree there is smoke damage, or smoke damage has been found using Method 1 or 2 above, but the amount of the loss is in dispute, that issue of the amount of loss will be decided by a new appraisal, as set forth at Condition 9, Appraisal below.

If there is a checkmark ☑ next to Extended Coverages in the Declarations, Perils 4 through 9 are made part of Perils Insured Against.

4. Windstorm or Hail.

This peril does not include loss:

a. to the interior of a building or property contained in a building caused by rain, snow, sleet, sand or dust unless:

i. the direct force of the wind or hail damages the building causing an opening in a permanent roof or permanent wall and the rain, snow, sleet, sand or dust enters through this opening; or

ii. the direct force of the wind or hail damages the building causing an opening in a temporary roof applied or temporary wall erected (after initial insured damage) to protect the property from further damage from rain, snow, sleet, sand or dust entering through this opening, in accordance with Condition 5.b., below.

b. to the following when outside of the building:

i. awnings, signs or any device used to gather signals for electronic equipment, such as radio or television antennas, aerials or satellite dishes, including lead-in wiring, masts or towers; or

ii. rowboats, kayaks and canoes.

We insure for direct loss by windstorm or hail only to those items below for which a limit of liability is shown in this policy for this coverage.

If there is a checkmark ☑ next to Outdoor Radio and TV Equipment in the Declarations, the following applies:

We insure for direct loss by windstorm or hail to radio and TV antennas and aerials, including their lead-in wiring, masts and towers. We shall not be liable for more than the limit of liability shown in the Declarations for this coverage.

If there is a checkmark ☑ next to Awnings in the Declarations, the following applies:

We insure for direct loss by windstorm or hail to awnings or canopies, including their supports. We shall not be liable for more than the limit of liability shown in the Declarations for this coverage.

If there is a checkmark ☑ next to Signs in the Declarations, the following applies:

We insure for direct loss by windstorm or hail to signs. We shall not be liable for more than the limit of liability shown in the Declarations for this coverage.

c. that occurs due to pre-existing disrepair of the property.

5. **Explosion**. This peril does not include loss by explosion of steam boilers or steam pipes, if owned or leased by you or operated under your control.

   Explosion does not mean:

   a. electric arcing;

   b. breakage of water pipes; or

   c. breakage or operation of pressure relief devices.

   This peril replaces Peril 2.

6. **Riot or Civil Commotion**.

7. **Aircraft**, including self-propelled missiles and spacecraft.

8. **Vehicles**.

   This peril does not include loss:

   a. caused by a vehicle owned or operated by you or a resident of the Described Location; or

   b. caused by any vehicle to fences, driveways and walks.

9. **Volcanic Eruption** other than loss caused by earthquake, land shock waves or tremors.

If there is a checkmark ☑ next to Vandalism or Malicious Mischief in the Declarations, the following is made part of Perils Insured Against:

10. **Vandalism or Malicious Mischief**, meaning willful and malicious damage to, or destruction of, the described property.

    This peril does not include loss;

    a. to glass or safety glazing material constituting a part of the building other than glass building blocks;

    b. by pilferage, theft, burglary or larceny, but, we will be liable for damage to the covered building caused by burglars;

c. by modification or alteration to rental property made without the owner's permission; or

d. to property on the Described Location if the dwelling has been vacant or unoccupied for more than 30 consecutive days immediately before the loss. A dwelling being constructed is considered "vacant" if it lacks the furniture and the furnishings minimally necessary for human habitation. A dwelling is considered "unoccupied" if there is no person residing lawfully in it.

GENERAL EXCLUSIONS

We do not insure for loss caused directly or indirectly by any of the following. Such loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss.

1. Ordinance or Law, meaning any ordinance or law:

a. requiring or regulating the construction, demolition, remodeling, renovation or repair of property, including removal of any resulting debris;

b. the requirements of which result in a loss in value to property; or

c. requiring you or others to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of the pollutants.

"Pollutants" means any solid, liquid, gaseous or thermal irritant or contaminant, including, without limitation, asbestos, lead, mold, fungus, smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

This exclusion applies whether or not the property has been physically damaged.

If there is a checkmark ☑ next to Ordinance or Law in the Declarations, the above exclusion does not apply, and the following applies:

We will pay for the increased costs you incur due to the enforcement against you of any ordinance or law which requires or regulates construction, demolition, renovation or repair, but only as it applies to that part of a covered building or other structure damaged by a Peril Insured Against. We will not pay for any such costs incurred by you for work done on undamaged property.

Ordinance or Law coverage is provided only if the damaged covered building or other structure for which claim is made satisfied all applicable building code requirements in effect when it was built, last repaired or last remodeled before such damage occurred.

We shall not be liable for more than the limit of liability shown in the Declarations for this coverage.

We do not cover:

(1) any loss in value to any covered building or other structure due to the requirements of any ordinance or law; or

(2) due to enforcement against you, in actual repair of damage to covered property caused by a Peril Insured Against, the costs to comply with any ordinance or law which requires you or others to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of, pollutants from, in or on any covered building or other structure.

Notwithstanding the foregoing, we will pay the costs to comply with any ordinance or law which requires you or others to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of asbestos or lead only. We shall pay only the costs actually incurred by you, due to enforcement against you, in actual repair of damage to covered property caused by a Peril Insured Against. We will not pay for any such costs incurred by

you for work done to portions of the property which did not incur direct physical damage from the covered peril. Coverage for remediation of lead and/or asbestos shall be limited to the aggregate amount of $10,000 or the amount actually incurred, whichever is less.

2. **Earth Movement**, meaning earthquake, including land shock waves or tremors before, during or after a volcanic eruption; landslide; mine subsidence; mudflow; earth sinking, rising or shifting; unless direct loss by:

   a. fire; or

   b. explosion;

   ensues and then we will pay only for the ensuing loss.

3. **Water Damage**, meaning:

   a. flood, surface water, waves, tidal water, overflow of a body of water, or spray from any of these, whether or not driven by wind;

   b. water which backs up through sewers or drains or which overflows from a sump; or

   c. water below the surface of the ground, including water which exerts pressure on or seeps or leaks through a building, sidewalk, driveway, foundation, swimming pool or other structure.

   Direct loss by fire or explosion resulting from water damage is covered.

4. **Power Failure**, meaning the failure of power or other utility service if the failure takes place off the Described Location. But if the failure of power or other utility service results in a loss, from a Peril Insured Against on the Described Location, we will pay for the loss or damage caused by that Peril Insured Against.

5. **Neglect**, meaning your neglect to use all reasonable means to save and preserve property at and after the time of a loss.

6. **War**, including undeclared war, civil war, insurrection, rebellion, revolution, warlike act by a military force or military personnel, destruction or seizure or use for a military purpose, and including any consequence of any of these. Discharge of a nuclear weapon will be deemed a warlike act even if accidental.

7. **Nuclear Hazard**, to the extent set forth in the Nuclear Hazard Clause of the Conditions.

8. **Intentional Loss**, meaning any loss arising out of any act committed:

   a. by or at the direction of you or any person or organization named as an additional insured; and

   b. with the intent to cause a loss.

CONDITIONS

1. **Policy Period**. This policy applies only to loss which occurs during the policy period.

2. **Insurable Interest and Limit of Liability**. Even if more than one person has an insurable interest in the property covered, we will not be liable in any one loss:

   a. for an amount greater than the interest of a person insured under this policy; or

   b. for more than the applicable Limit of Liability.

3. **Your Duties to Select and Maintain Policy Limits.** It is your sole responsibility to select and maintain adequate amounts and types of insurance**.**

If there is a checkmark ☑ next to Inflation Guard in the Declarations, you have given us permission to increase the Limits of Liability for Coverage A - Dwelling and, if purchased, Coverage B and Ordinance or Law coverage at each renewal of your policy.

We may increase the Limits of Liability for Coverage A - Dwelling and, if present, Ordinance or Law Coverage to reflect changes in the cost of construction, if any.

Any increase in these Limits of Liability will be made on the renewal date of the policy.

Any increase in these Limits of Liability will be made according to construction cost factors published by a third party vendor and/or other factors we consider reasonable. The percentage increase in such construction cost factors will be applied only to your existing Limits of Liability as of the renewal date of the policy.

Regardless of any increase in the Limits of Liability pursuant to this coverage, we offer no opinion, and make no representation or guarantee, that the insurance provided by this policy is or will be appropriate or sufficient to cover the full replacement cost of the dwelling, or to cover the full amount of any loss or damage.

You should not rely on us to determine whether you have appropriate or sufficient insurance.

The sum of the Limits of Liability for all coverages under your policy may not exceed the maximum policy limits that we offer. We will restrict any Limit of Liability increases under this coverage so that that sum does not exceed the maximum limits we offer, first increasing the Limit of Liability for Coverage A - Dwelling to the extent permitted by this maximum amount. Then we will use any remaining part of the maximum amount to increase the Limit of Liability for Ordinance or Law Coverage.

4. **Concealment or Fraud**. With respect to all persons insured under this policy, we provide no coverage for loss if, whether before or after a loss, one or more persons insured under the policy have:

   a. intentionally concealed or misrepresented a material fact or circumstance;

   b. engaged in fraudulent conduct; or

   c. made false statements;

   related to this insurance.

5. **Your Duties After Loss**. In case of a loss to covered property, you must see that the following are done:

   a. give prompt notice to us;

   b. protect the property from further damage;

   c. make reasonable and necessary repairs to protect the property;

   d. keep an accurate record of repair expenses;

   e. if you make repairs to protect the property, set aside the damaged part(s) for our inspection and, if possible, photograph the damage; and

   f. prepare an inventory of damaged personal property to the best of your ability:

      i. show the quantity, description, date of purchase, place of purchase or from whom acquired and amount of loss;

      ii. attach all records, bills, receipts and related documents that justify the figures in the inventory;

g. as often as we reasonably require, and subject to the provisions of California Insurance Code § 2071.1:

i. exhibit the damaged property;

ii. provide us with records and documents we request and permit us to make copies. We may request your tax returns. These documents are generally privileged against disclosure under applicable law, but may be necessary to process or determine your claim;

iii. submit to examination under oath, while not in the presence of any other named insured, and sign the transcript under penalty of perjury; and

iv. produce employees, members of your household or others for examination under oath to the extent it is within your power to do so;

h. submit to us, within 60 days after we request, your signed, sworn proof of loss which sets forth, to the best of your knowledge and belief:

i. the time and cause of loss;

ii. interest of you and all others in the property involved and all encumbrances on the property;

iii. other insurance which may cover the loss;

iv. changes in title or occupancy of the property during the term of the policy;

v. specifications of any damaged building and detailed estimates for repair of the damage;

vi. an inventory of damaged personal property described in 5.f., above; and

vii. records supporting any Fair Rental Value loss.

6. Loss Settlement. Subject to Condition 2. (Insurable Interest and Limit of Liability), we will pay the following amounts for covered property losses:

a. Coverages A and B Losses: for losses to covered property described in Coverages A and/or B, the following applies:

i. Total Loss: in case of a Total Loss to the property, we will pay the actual cash value before the loss as measured by the fair market value of the covered property, up to the policy limit; or

ii. Partial Loss: in case of Partial Loss to the property, we will pay the actual cash value of the Partial Loss as measured by the amount it would cost you to Repair, rebuild, or Replace the thing lost or damaged less a fair and reasonable deduction for physical Depreciation based upon its condition at the time of the loss, or the policy limit, whichever is less. A deduction for physical Depreciation shall apply only to components of a structure that are normally subject to Repair and Replacement during the useful life of that structure.

b. Coverage C Losses: For loss to covered property described in Coverage C - Personal Property, we will pay the amount it would cost you to Repair, rebuild, or Replace the thing lost or damaged less a fair and reasonable deduction for physical Depreciation based upon its condition at the time of the loss or the policy limit, whichever is less.

c. Definitions for Coverages A, B and C Losses:

i. "Total Loss" to property for Coverages A and B means the property is completely destroyed, such that it loses its identity and character as a structure;

ii. "Partial Loss" to property for Coverages A and B means any loss not considered a "Total Loss", as defined in c.i.;

iii. "Depreciation", when taken, will be for physical depreciation, or wear and tear, based upon the condition of the property measured as of the time of loss, and will be taken separately for each damaged part of the property, not for any property taken as a whole;

iv. "Replace" means to provide functionally equivalent, but not necessarily identical, property at the same location;

v. "Repair" includes rebuild and means to restore property to the same design, size and dimensions, and at the same location as before loss, using materials identical in kind and quality.

If there is a checkmark ☑ next to Dwelling Replacement Cost in the Declarations, the above Loss Settlement provision with respect to Coverage A and B losses does not apply and the following Loss Settlement Provision will apply with respect to Coverage A and B losses, only.

Covered property loss to any building under Coverage A or B will be settled as follows:

(1) If, at the time of loss, the amount of insurance in this policy on the damaged building is 80% or more of the lower of the full cost to reconstruct or replace the building immediately before the loss, we will pay the cost to reconstruct or replace the part of the building damaged, after application of the deductible and without depreciation, but not more than the least of the following amounts:

a) the Limit of Liability under this policy that applies to the building;

b) the lower of either the reconstruction or replacement cost of the damaged part of the building; or

c) the necessary amount actually spent to reconstruct or replace the damaged part of the building.

(2) If, at the time of loss, the amount of insurance under this policy on the damaged building is less than 80% of the lower of the full cost to reconstruct or replace the building immediately before the loss, we will pay the greater of the following amounts, but not more than the Limit of Liability under this policy that applies to the building:

a) the amount payable for the loss under Condition 6, above; or

b) that proportion of either the lower of the cost to reconstruct or replace the part of the building damaged, without deduction for depreciation, which the total amount of insurance under this policy on the damaged building bears to 80% of the lower of the full cost either to reconstruct or replace the building immediately before the loss.

(3) To determine the amount of insurance required to equal 80% of the lower of the full cost to reconstruct or replace the building immediately before the loss, we do not include the value of:

a) excavations, foundations, piers or any supports which are below the undersurface of the lowest basement floor;

b) those supports in a. above which are below the surface of the ground inside the foundations walls, if there is no basement; and

c) underground flues, wiring and drains.

(4) You may meet the 80% requirement by having in force at the time of the loss another policy of insurance subject to the same plan, terms, conditions and provisions as the insurance under this policy. If you do, we will pay our pro rata share of the loss.

If, at the time of the loss, there is insurance covering the loss other than as described above, such as an excess insurance policy, you may include the amount of that insurance in meeting the 80% requirement.

(5) We will pay no more than the amount payable for the loss under Condition 6, above, unless:

a) actual reconstruction or replacement is complete at the Described Location shown in the Declarations; or

b) actual reconstruction or replacement is complete at a location other than the Described Location; or

c) the cost to reconstruct or replace the damage is both:

i) less than 5% of the amount of insurance under this policy on the damaged building; and

ii) less than $5,000.

Regardless of whether the reconstruction or replacement is completed at the Described Location pursuant to subparagraph a. above, or at a location other than the Described Location, pursuant to subparagraph b. above, the measure of indemnity shall be based upon the replacement cost of the insured property and shall not be based upon the cost to repair, rebuild or replace at a location other than the insured premises.

(6) You may disregard the reconstruction and replacement cost loss settlement provisions and make a claim for the loss based on Condition 6.a., above. After 5.a. or 5.b. immediately above are satisfied, but not later than 12 months after first payment under Condition 6., above, you may make claim for any additional benefits provided under this Dwelling Replacement Cost section. In the event you are unable to satisfy 5.a. or 5.b. immediately above within 12 months after such first payment because of circumstances beyond your control, you may request an extension of time in which to do so. Additional extensions of six months shall be provided to you for good cause.

(7) In the event of a loss relating to a "state of emergency" as defined in Section 8558 of the Government Code, you may satisfy 5.a. and 5.b. immediately above within 24 months from the first payment under Condition 6, above.

If there is a checkmark ☑ next to Personal Property Replacement Cost in the Declarations, the Loss Settlement provision above with respect to Coverage C losses does not apply and the following Loss Settlement Provision will apply with respect to Coverage C losses, only.

Covered loss to personal property will be settled as follows:

(1) Property Covered:

We cover personal property under Coverage C at replacement cost at the time of the loss, unless that personal property is listed in Property Not Covered, below. Payment will not exceed the least of the following:

a) replacement cost at the time of the loss without deduction for depreciation;

b) the reasonable amount to have the property repaired at the time of loss;

c) the amount it reasonably costs to replace the article with a new one substantially identical to the article damaged or destroyed; or

d) the Personal Property Coverage C Limit of Liability shown in the Declarations.

(2) Property Not Covered:

The following personal property is not eligible for replacement cost settlement. Any loss or damage to these items shall be settled at actual cash value at time of the loss, but not exceeding the amount necessary to repair or replace:

a) property not maintained in good or workable condition;

b) property that exhibits signs of excessive wear;

c) property that is outdated or obsolete and is stored or not being used;

d) antiques, fine arts, paintings and similar articles of uniqueness, rarity or antiquity which cannot be replaced;

e) memorabilia, souvenirs, collectors' items and similar articles whose age or history contribute to their value; or

f) property not owned by any insured.

(3) Conditions

a) We will pay the difference between actual cash value and the cost to repair or replace the property only after the damaged or destroyed property has actually been repaired or replaced.

b) If you receive a settlement under this policy for damaged personal property on an actual cash value basis, you may make an additional claim for payment provided:

i) repair or replacement is completed within one year of the first payment for damage to your personal property. In the event you are unable to complete the repair or replacement of your damaged personal property within one year after such first payment because of conditions beyond your control, you may request an extension of time in which to do so. Additional extensions of six months shall be provided to you for good cause;

ii) if the loss or damage relates to a "state of emergency" as defined in Section 8558 of the Government Code, this time period shall be extended to two years after the first payment for damage to your personal property; or

iii) you have not reached the applicable limit of liability under this policy.

7. Loss to a Pair or Set. In case of loss to a pair or set we may elect to:

a. repair or replace any part to restore the pair or set to its value before the loss; or

b. pay the difference between actual cash value of the property before and after the loss.

8. Glass Replacement. Loss for damage to glass caused by a Peril Insured Against will be settled on the basis of replacement with safety glazing materials when required by ordinance or law.

9. Appraisal. If you and we fail to agree on the amount of loss, either may request an appraisal of the loss:

a. if the loss arises out of a government-declared disaster, as defined in the California Government Code, appraisal may be requested by either party but may not be compelled;

b. if the loss does not arise out of a government-declared disaster, as defined in the California Government Code, or if the parties agree to appraisal following a government-declared disaster:

i. each party shall choose a competent and disinterested appraiser within 20 days after a written request. The two appraisers will choose an umpire. If they cannot agree upon an umpire within 15 days, you or we may request that the choice be made by a judge of a court of record in the State of California;

ii. the appraisers will separately set the amount of loss. If the appraisers submit a written report of an agreement to us, the amount agreed upon will be the amount of loss. If they fail to agree, they will submit their differences to the umpire. A decision agreed to by any two will set the amount of the loss;

iii. each party will pay its own appraiser and bear the other expenses of the appraisal and umpire equally; and

iv. the appraisal proceedings will be informal unless you and we agree otherwise, meaning that no formal discovery will be taken during the appraisal proceeding, the formal rules of evidence will not be applied during the appraisal proceeding, and no court reporter will record the proceedings. The procedures set forth in this paragraph do not limit or expand the parties' rights set out elsewhere in the policy, and do not limit the rights of either party in the event of suit.

10. Other Insurance.

a. You may have other insurance subject to the same plan, terms, conditions and provisions as the insurance under this policy. If you do, we will pay our share of the covered loss or damage. Our share is the proportion that the applicable Limit of Liability under this policy bears to the Limits of Liability of all policies covering on the same basis.

b. If there is other insurance covering the same loss or damage, other than described in a. above, we will pay only for the amount of covered loss or damage in excess of the amount due from that other insurance, whether you can collect on it or not. But, we will not pay more than the applicable Limit of Liability.

11. Transfer to Us of Salvage, Subrogation. If there is a covered loss, we have the right of salvage, which is the right to take all or any part of the insured property upon our payment for the loss or damage to that property, at the agreed or appraised value.

In addition to our right of salvage, we have the right of subrogation, which means that we have the right to seek repayment from any person or persons who may have caused the loss or damage. You must protect our subrogation rights, and help us enforce those rights if we ask you to do so. If we ask you to sign documents to help us enforce those rights, you must do so.

Our total recovery under this provision will not exceed the amount we pay for your loss or damage, plus our costs of recovery, including any attorney's fees we incur.

12. Suit Against Us. No action can be brought unless the policy provisions have been complied with and the action is started within one year after the date of loss.

13. Our Option. If we give you written notice within 30 days after we receive your signed, sworn proof of loss, we may pay to repair or replace any part of the damaged property with like property. We may also take all, or any part, of the damaged property at the agreed or appraised value.

14. Loss Payment. We will adjust all losses with you or your properly authorized representative. We will pay you unless some other person is named in the policy or is legally entitled to receive payment. Your loss will be payable 30 days after we receive proof of loss and:

a. reach an agreement with you;

b. there is an entry of a final judgment; or

c. there is a filing of an appraisal award with us.

15. Abandonment of Property. We need not accept any property abandoned by you.

16. Mortgage Clause. The word "mortgagee" includes trustee.

If a mortgagee is named in this policy, any loss payable under Coverage A or B will be paid to the mortgagee and you, as interests appear. If more than one mortgagee is named, the order of payment will be the same as the order of precedence of the mortgages.

If we deny your claim, that denial will not apply to a valid claim of the mortgagee, if the mortgagee:

a. notifies us of any change in ownership, occupancy or substantial change in risk of which the mortgagee is aware;

b. pays any premium due under this policy on demand if you have neglected to pay the premium; and

c. submits a signed, sworn statement of loss within 60 days after receiving notice from us of your failure to do so. Policy conditions relating to Appraisal, Suit Against Us and Loss Payment apply to the mortgagee.

If we decide to cancel or not to renew this policy, the mortgagee will be notified at least 10 days before the date of cancellation or non-renewal takes effect.

If we pay the mortgagee for any loss and deny payment to you:

a. we are subrogated to all the rights of the mortgagee granted under the mortgage on the property; or

b. at our option, we may pay to the mortgagee the whole principal on the mortgage plus any accrued interest. In this event, we will receive a full assignment and transfer of the mortgage and all the securities held as collateral to the mortgage debt.

Subrogation will not impair the right of the mortgagee to recover the full amount of the mortgagee's claim.

17. No Benefit to Bailee. We will not recognize any assignment or grant any coverage that benefits a person or organization holding, storing or moving property for a fee regardless of any other provision of this policy.

18. Cancellation.

a. You may cancel this policy at any time by returning it to us or by letting us know in writing of the date cancellation is to take effect.

b. We may cancel this policy only for the reasons stated in this condition by notifying you in writing of the date cancellation takes effect. This cancellation notice may be delivered to you, or mailed to you at your mailing address shown in the Declarations.

c. Proof of mailing shall be sufficient proof of notice.

d. When you have not paid the premium, we may cancel at any time by notifying you at least 10 days before the date cancellation takes effect.

e. When this policy has been in effect for less than 60 days and is not a renewal with us, we may cancel for any reason by letting you know at least 20 days before the date cancellation takes effect.

f. When this policy has been in effect for 60 days or more, or at any time if it is a renewal with us, we may cancel if there has been:

i. conviction of any named insured of a crime having as one of its necessary elements an act increasing any hazard insured against; or

ii. discovery of fraud or material misrepresentation by either of the following:

1) you or your representative, in obtaining the insurance; or

2) you or your representative in pursuing a claim under the policy; or

iii. discovery of grossly negligent acts or omissions by you or your representative substantially increasing any of the hazards insured against; or

iv. physical changes in the insured property which result in the property becoming uninsurable.

This can be done by notifying you at least 30 days before the date cancellation takes effect.

g. We may cancel for any reason at the anniversary date of the policy by notifying you at least 45 days before the date cancellation takes effect.

i. When this policy is cancelled, the premium for the period from the date of cancellation to the expiration date will be refunded on a pro rata basis.

ii. If, when we cancel this policy, the return premium is not refunded with the notice of cancellation, we will refund it within 25 days after the date cancellation takes effect.

19. Non-renewal.

a. We may elect not to renew this policy, subject to the provisions of b., immediately below. We may do so by delivering to you at your mailing address shown in the Declarations, written notice at least 45 days before the expiration date of this policy. Proof of mailing will be sufficient proof of notice.

b. If this policy is written for a period of less than one year, we agree not to refuse to renew except at the end of an annual period commencing with the original or renewal effective date.

20. Liberalization Clause. If we make a change which broadens coverage under this edition of our policy without additional premium charge, that change will automatically apply to your insurance as of the date we implement the change, provided that this implementation date falls within 60 days prior to or during the policy period stated in the Declarations. This Liberalization Clause does not apply to changes implemented through the introduction of a subsequent edition of our policy.

21. Waiver or Change of Policy Provisions. A waiver or change of a provision of this policy must be in writing by us to be valid. Our request for an appraisal or examination will not waive any of our rights.

22. Assignment. Assignment of this policy is not permitted.

23. Death. If you die, we insure, for the remainder of this policy period:

a. your legal representatives but only with the respect to the property of the deceased covered under the policy at the time of death;

b. with respect to your property, the person having proper temporary custody of the property until appointment and qualification of a legal representative.

24. Nuclear Hazard Clause

a. "Nuclear Hazard" means any nuclear reaction, radiation or radioactive contamination, all whether controlled or uncontrolled or however caused, or any consequence of any of these.

b. Loss caused by the nuclear hazard will not be considered loss caused by fire, explosion, or smoke, whether these perils are specifically named in or otherwise included within the Perils Insured Against.

c. This policy does not apply to loss caused directly or indirectly by nuclear hazard, except that direct loss by fire resulting from the nuclear hazard is covered.

25. Recovered Property. If you or we recover any property for which we have made payment under this policy, you or we will notify the other of the recovery. At your option, that property will be returned to or retained by you or it will become our property. If the recovered property is returned to or retained by you, the loss payment will be adjusted based on the amount you received for the recovered property.

26. Volcanic Eruption Period. One or more volcanic eruptions that occur within a 72 hour period will be considered as one volcanic eruption.

27. Loss Deductible Clause. The amount of deductible shown in the Declarations of this policy shall be deducted from the amount of loss to all property covered hereunder in any one occurrence resulting from the perils insured against.

This clause does not apply to Fair Rental Value or any Fire Department Service Charge.

28. Your Right to Copies of Certain Claim Documents. You may obtain from us, within 15 calendar days after our receipt of your written request, copies of documents that relate to the evaluation of damages. These documents may include repair and replacement estimates and bids, appraisals, scopes of loss, drawings, plans, reports, third party findings on the amount of loss, covered damages and cost of repairs, and all other valuation, measurement, and loss adjustment calculations of the amount of loss, covered damage and cost of repairs.

These documents do not include attorney work product privileged documents, documents reflecting privileged confidential attorney-client communications, documents that indicate fraud by you or any insured, documents that contain medically privileged information. The right to obtain documents under this paragraph will not limit or expand the parties' rights set out elsewhere in the policy, and will not limit the rights of either party in the event of a suit.

29. Adjusters. If, within a six-month period, we assign a third or subsequent adjuster to be primarily responsible for your claim, we shall provide you with a written status report that includes a summary of any decisions or actions are substantially related to the disposition of the claim, including the amount of losses to structures or contents, whether we have retained any design or construction professionals, the amount of coverage for losses to structures or contents, and all items of dispute.

30. Right to Obtain a Copy of the Policy. After a covered loss, we will provide, free of charge, a complete, current copy of your policy within 30 calendar days after we receive your request for a copy. The time period for us to provide this copy may be extended by the Insurance Commissioner.

If you would like a copy of your policy but have not experienced a covered loss, upon your request we will provide you with one free copy of your policy per year.

IN WITNESS WHEREOF,

Chair, Governing Committee *Secretary, Governing Committee*

Important Notice

Amendatory Endorsement. This endorsement changes your policy.
Please read it carefully.

The enclosed New Business Policy includes a change to your policy (form CFP0001E) that benefits you, the insured. This changes coverage for damages caused by smoke. Please read your policy and the amendatory endorsements carefully.

Under **Perils Insured Against** Section **3.c.** is deleted in its entirely.

The previous policy terms included a detailed method for resolving a dispute over the definition of smoke damage. Those terms required you to pay ½ the cost of the resolution process. With this new language the FAIR Plan pays 100% of the cost.

Please take the time to read this important coverage change, and call your broker if you have any questions.

EXHIBIT C

EXHIBIT C

RICARDO LARA
CALIFORNIA INSURANCE COMMISSIONER

January 4, 2021

VIA ELECTRONIC AND U.S. MAIL

Anneliese Jivan
President
California FAIR Plan Association
3435 Wilshire Blvd., Suite 1200
Los Angeles, CA 90010
AJIVAN@CFPNET.COM

SUBJECT: California FAIR Plan's Form Filing No. 16-6646

Dear Ms. Jivan:

The California Department of Insurance (Department) has received information indicating that the California FAIR Plan may have obtained the Department's approval of form filing no. 16-6646 (SERFF tracking no. PERR-130771937) by mischaracterizing and/or omitting relevant material facts. If this information is correct, FAIR Plan must immediately submit a revised policy form that omits the violative language discussed below and take such additional steps as described below. Until such as time as FAIR Plan submits a revised policy form and that form is approved by the Department, FAIR Plan's current policy form must be read and interpreted in a manner that complies with applicable law. The Department directs FAIR Plan to review all fire and/or smoke damage claims it has denied, in whole or in part, since the violative policy language took effect in January 2017, and adjust these claims without applying that violative policy language.

I. Background

On October 18, 2016, FAIR Plan submitted form filing no. 16-6646, requesting various revisions to its Dwelling Fire Policy. Among other changes, FAIR Plan inserted in its "Perils Insured Against" section the following new language, emphasized in bold, to define the phrase "direct physical loss":

> Unless the loss is excluded in the General Exclusions, or below, we insure for **"direct physical loss", which is defined as any actual loss or physical damage, evidenced by permanent physical changes**, to the covered property caused by: . . . Smoke Damage.

CALIFORNIA DEPARTMENT OF INSURANCE
PROTECT • PREVENT • PRESERVE
1901 Harrison Street, 6th Floor
Oakland, CA 94612
Tel: 415-538-4379
kenneth.schnoll@insurance.ca.gov

> (For purposes of this letter, the bolded portion of this quote is referred to as the "violative language.")

In its Filing Memorandum in support of its form filing, FAIR Plan specifically represented to the Department that its proposed revisions to the Dwelling Fire Policy, including its new definition of "direct physical loss," would not reduce or eliminate any existing coverages, might even broaden coverage, and would have no rate impact:

> The changes in the policy will either provide no change in coverage or will provide some broadening of coverage. The FAIR Plan will not revise rates for the additional coverage.

The Department approved the form filing on January 25, 2017, based, in large part, upon FAIR Plan's representations above. There have been subsequent revisions to the policy form, but the violative language at issue remains the same.

II. FAIR Plan's representations to the Department appear to be false.

The Department has since become aware of pending policyholder litigation regarding FAIR Plan's alleged improper denial of fire and/or smoke damage claims. According to this litigation, FAIR Plan has been relying upon its revised definition of "direct physical loss" to limit or deny coverage particularly with respect to smoke damage claims. If this is true, FAIR Plan's representation to the Department that the proposed revisions to its Dwelling Fire Policy, including the new definition of "direct physical loss," would "either provide no change in coverage" or "some broadening of coverage," was false.

The Department is still investigating this issue. However, we note that FAIR Plan's subsequent actions contradict its representations to the Department. Specifically, on April 25, 2017, three months after the Department approved the form filing, FAIR Plan sent a memorandum to its registered FAIR Plan brokers, attaching an "Important Notice Regarding Changes to Your Dwelling Policy Reduction of Limits / Elimination of Coverage." (https://www.cfpnet.com/wp-content/uploads/2017/04/reviseddwellingfirepolicy04252017.pdf) This Notice to policyholders was not seen by the Department but was sent to FAIR Plan's registered brokers and published on its website.

In the Notice, FAIR Plan clearly indicates its intent to interpret the revisions to the Dwelling Fire Policy as implementing reductions and limitations in coverage. Specifically, the Notice states on page 1,

- "**These changes are substantive and, in some circumstances, there has been a reduction of limits and elimination of coverage.**"
- "**The following may be viewed as reducing or limiting coverage**: . . . [] Direct physical loss has been newly defined at page 5 of the contract to require permanent physical changes to covered property. This limitation on what is considered direct

> physical loss will result in denial of claims that might have been paid under prior policy wording."
>
> (Bold and underline emphases in original.)

III. FAIR Plan's denial of smoke damage claims is illegal.

Any attempt by FAIR Plan to reduce or limit coverage for smoke damage based on its definition of direct physical damage to require "permanent physical changes" to covered property is contrary to the law. Under Insurance Code sections 10090 et seq., FAIR Plan is required to offer, *inter alia*, "basic property insurance" to Californians who experience difficulty obtaining insurance in the voluntary market. "Basic property insurance" in California includes smoke damage from fire. Specifically, section 10091, subdivision (c), defines "basic property insurance" to include, without limitation, coverage for "perils insured under the standard fire policy."

Insurance Code section 2071, which sets forth the California standard form fire insurance policy, requires coverage for "***all*** LOSS BY FIRE ... EXCEPT AS HEREINAFTER PROVIDED." (Emphasis added). The coverage exclusions "hereinafter provided" in Section 2071 do not include smoke damage from fire. Additionally, section 2070 specifies:

> No part of the standard form shall be omitted therefrom except any policy providing coverage against the peril of fire only, or in combination with coverage against other perils, need not comply with the provisions of the standard form of fire insurance policy...**provided, that coverage with respect to the peril of fire, when viewed in its entirety, is substantially equivalent to or more favorable to the insured than that contained in such standard form fire insurance policy.**
>
> (Emphasis added.)

FAIR Plan's policy form language, as reportedly utilized by FAIR Plan, provides <u>less</u> coverage than the coverage required under the standard form fire policy because it limits coverage for fire loss through its definition of "direct physical loss," as "any actual loss or physical damage, evidenced by permanent physical changes, to the covered property . . ."

Assuming the foregoing is accurate, FAIR Plan must immediately cease any application or interpretation of the violative language contained in its Dwelling Fire Policy to deny, in whole or in part, the payment of claims, and make an immediate form filing to revise its Dwelling Fire Policy so as to comport with California law. Additionally, FAIR Plan must provide the Department with the following information within thirty (30) days from the date of this letter: (1) a list of any and all fire and/or smoke damage claims that FAIR Plan has denied, in whole or in part, since January 1, 2017, including claimed amounts, names of policyholders, and all documentation of the reasons for denying the claims, in whole or in part; and (2) a list of all

pending litigation, including captioning information, involving FAIR Plan claim denials, in whole or in part, under the Dwelling Fire Policy currently in use or that was approved by the Department in form filing no. 16-6646.

Sincerely,

Kenneth B. Schnoll
General Counsel & Deputy Commissioner

EXHIBIT D

EXHIBIT D

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

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

CALIFORNIA FAIR PLAN ASSOCIATION
NAIC # 33665 CDI # 0000-0

AND ITS PRACTICES AND PROCEDURES RELATING TO HOMEOWNERS/DWELLING INSURANCE CLAIMS

AS OF MARCH 18, 2021

ADOPTED MAY 25, 2022

STATE OF CALIFORNIA

CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU

790.03 v5 02-16-16

NOTICE

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

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FOREWORD

The targeted examination is in response to complaints received by the Department regarding CFPA's handling of claims for smoke damage. Specifically, the examination focused on CFPA's processing of claims for smoke damage and contract language applied to justify denial of, or reduced payment for, claims for smoke damage with respect to wildfires, regular fires and all other dwelling claims within the review period.

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

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

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

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

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

SCOPE OF THE EXAMINATION

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

California FAIR Plan Association
NAIC # 33665

Hereinafter, the California FAIR Plan Association will be referred to as CFPA or FAIR Plan.

This targeted examination covered the claim handling practices of CFPA on homeowners / dwelling fire claims closed during the period from January 1, 2017 through March 18, 2021. The examination was made to discover, in general, if these and other operating procedures of CFPA conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by CFPA for use in California including any documentation maintained by CFPA in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claim files and related records. In the review of the individual claim files, the following factors were specifically considered for compliance:

- Does CFPA provide coverage against the peril of fire that is at least equivalent to that required under the Standard Fire Policy pursuant to CIC § 2071?

- Are CFPA's policy provisions relating to the investigation, processing and settlement of claims consistent with or more favorable to the insured than the provisions of the Fair Claims Settlement Practices Regulations?

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about CFPA closed by the CDI during the period January 1, 2017 through March 18, 2021, a review of previous CDI market conduct claims examination reports on CFPA; and a review of prior CDI enforcement actions.

4. A review of CFPA's handling of its "Dispute resolution of smoke damage claims" clause regarding the appraisal provision in the policy.

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

EXECUTIVE SUMMARY

The homeowners / dwelling fire claims reviewed were closed from January 1, 2017 through March 18, 2021, referred to as the "review period". The homeowner / dwelling fire claims populations were comprised of both closed and open claims. The claim populations requested were for claims involving wildfires, smoke damage, regular fires, claims with no loss cause identified, and litigated files. A sample of claims was selected from each of these categories. In total, the examiners randomly selected 259 CFPA claim files for examination. The examiners cited 418 violations of the California Insurance Code and the California Code of Regulations from this sample file review.

The findings of this examination include the following:

- Contrary to CIC § 2070, CFPA failed to issue a fire policy, when viewed in its entirety, that is substantially equivalent to or more favorable to the insured than that contained in the California Standard Form Fire Insurance Policy as reflected in CIC § 2071.
- CFPA failed to provide coverage for all loss by fire as set forth in the California Standard Form Fire Insurance Policy.
- CFPA failed to specify, in the written notice, any additional information the insurer requires to make a claim determination and to state any continuing reasons for CFPA's inability to make a determination; and failed to provide written notice of the need for additional time or information every 30 calendar days.
- CFPA failed to conduct and diligently pursue a thorough, fair and objective investigation.
- CFPA failed to comply with the requirements of CCR §2695.7(b).
- CFPA failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.

The examination also included a review of the appraisal provision of the policy and its application to any claims involving smoke damage. The denials related to smoke damage included reference to this provision in the correspondence. The appraisal provision was not invoked in any of the files reviewed for this examination.

CFPA was the subject of 173 California consumer complaints related to homeowner / dwelling fire claims closed from January 1, 2017 through March 18, 2021. Within these 173 complaints, CDI identified violations of law including failure to adopt and implement reasonable standards for the prompt investigation and processing of claims; failure to accept or deny the claim within 40 calendar days; failure to provide written notice of the need for additional time or information every 30 calendar days; failure to disclose all benefits, coverage, and time limits; failure to respond to communications within 15 calendar days; failure to provide applicable notice describing relevant California laws related to a declared state of emergency no later than 15 calendar days; and failure to maintain all documents, notes and work papers. The examiners focused on these issues during the course of the file review in addition to the targeted examination focus of CFPA's handling of smoke damage claims.

The previous CDI claims examination of CFPA reviewed a sample of claims closed during the period of September 1, 2015 through August 31, 2016. Noncompliance issues identified in the previous examination report included CFPA's failure to document in the claim file all justification for the adjustment of the amount claimed because of betterment, depreciation, or salvage; failure to fully explain the basis for any adjustment in writing; and failure to apply betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property. These noncompliance issues were also identified in the current examination.

DETAILS OF THE CURRENT EXAMINATION

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

CALIFORNIA FAIR PLAN SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**NUMBER OF VIOLATIONS**
Homeowners / Dwelling Fire Wildfire Closed	2,428	55	53
Homeowners / Dwelling Fire Wildfire Open	645	15	64
Homeowners / Dwelling Fire Smoke Damage Closed	1159	64	112
Homeowners / Dwelling Fire Smoke Damage Open	130	45	109
Homeowners / Dwelling Fire Regular Fire Closed	2,165	18	9
Homeowners / Dwelling Fire Regular Fire Open	195	17	41
Homeowners / Dwelling Fire No Loss Cause Identified Closed	2,518	18	0
Homeowners / Dwelling Fire No Loss Cause Identified Open	494	17	11
Homeowners / Dwelling Fire Litigated	21	10	19
TOTALS	**9,755**	**259**	**418**

TABLE OF TOTAL VIOLATIONS

Citation	Description of Allegation	CFPA Number of Violations	TOTAL
CIC §2070 *[CIC §790.03(h)(3)] and *[CIC §790.03(h)(5)]	CFPA failed to provide coverage with respect to the peril of fire, when viewed in its entirety, that is substantially equivalent to or more favorable to the insured than that contained in such standard form fire insurance policy.	59	59
CIC §2071 *[CIC §790.03(h)(3)] and *[CIC §790.03(h)(5)]	CFPA denied or discouraged a claim for smoke damage by using policy language which does not conform to the California Standard Form Fire Insurance Policy.	59	59
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	CFPA failed to specify, in the written notice of the need for additional time, any additional information the insurer requires to make a claim determination and to state any continuing reasons for CFPA's inability to make a determination.	65	85
	CFPA failed to provide written notice of the need for additional time every 30 calendar days until a determination is made.	20	
**CCR §2695.7(d) *[CIC §790.03(h)(3)]	CFPA failed to conduct and diligently pursue a thorough, fair and objective investigation.	38	38
CCR §2695.7(b) *[CIC §790.03(h)(4)]	CFPA failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	20	31
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	CFPA failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.	9	
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	CFPA failed to include a statement in its claim denial that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	2	

Citation	Description of Allegation	CFPA Number of Violations	TOTAL
CIC §§2051 and 2051.5 / CCR §2695.9(f) *[CIC §790.03(h)(3)]	CFPA failed to document in the claim file all justification for the adjustment of the amount claimed because of betterment, depreciation, or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property.	13	27
CCR §2695.9(f) *[CIC §790.03(h)(5)]	CFPA applied betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property.	10	
CCR §2695.9(f) *[CIC §790.03(h)(3)]	CFPA failed, in adjusting the amount claimed because of betterment, depreciation, or salvage, to fully explain the basis for the adjustment to the claimant in writing.	3	
CCR §2695.9(f)(1) *[CIC §790.03(h)(5)]	CFPA applied depreciation to the expense of labor necessary to repair, rebuild, or replace covered property. The expense of labor is not a component of physical depreciation.	1	
CCR §2695.4(a) *[CIC §790.03(h)(1)]	CFPA failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.	25	25
CCR §2695.7(h) *[CIC §790.03(h)(5)]	CFPA failed, upon acceptance of the claim, to tender payment within 30 calendar days.	21	21
CCR §2695.7(g) *[CIC §790.03(h)(5)]	CFPA attempted to settle a claim by making a settlement offer that was unreasonably low.	16	16
CIC §790.03(h)(15)	CFPA misled a claimant as to the applicable statute of limitations.	12	12
CCR §2695.9(d) *[CIC §790.03(h)(3)]	CFPA settled the claim on the basis of a written scope and/or estimate without supplying the insured with a copy of each document upon which the settlement was based.	7	7

Citation	Description of Allegation	CFPA Number of Violations	TOTAL
CCR §2695.5(e)(2) *[CIC §790.03(h)(3)]	CFPA failed, upon receiving notice of claim, to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.	5	6
CCR §2695.5(e)(3) *[CIC §790.03(h)(3)]	CFPA failed, upon receiving notice of claim, to begin any necessary investigation within 15 calendar days.	1	
CCR §2695.5(b) *[CIC §790.03(h)(2)]	CFPA failed to respond to communications within 15 calendar days.	5	5
CCR §2695.7(d) *[CIC §790.03(h)(3)]	CFPA persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.	5	5
CIC §790.03(h)(1)	CFPA misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	4	4
CCR §2695.3(a) *[CIC §790.03(h)(3)]	CFPA failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.	4	4
CCR §2695.7(q) *[CIC §790.03(h)(5)]	CFPA failed to share subrogation recoveries on a proportionate basis with the first party claimant.	4	4
CCR §2695.7(f) *[CIC §790.03(h)(3)]	CFPA failed to provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim.	3	3
CIC §790.03(h)(5)	CFPA failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	2	2
CIC §14046(b)(1) *[CIC §790.03(h)(3)]	CFPA failed to provide the claimant with a copy of the most recent notice describing the most significant California laws pertaining to property insurance policies, including those related to a declared state of emergency, as defined in Section 8558 of the Government Code, or other emergency declared by a public official no later than 15 calendar days from the date on which the insurer received notice of the claim.	3	3
CIC §790.034(b)(1) *[CIC §790.03(h)(3)]	CFPA failed, upon receiving notice of claim, to provide the insured with a copy of §790.03 of the California Insurance Code within 15 calendar days.	2	2
Total Number of Violations		**418**	**418**

**Citation CCR §2695.7(d) for failure to conduct and diligently pursue a thorough, fair and objective violation includes four related specifically to smoke damage. The other 34 citations were for instances observed in files in which smoke damage was not part of the claim.

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

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

TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS

HOMEOWNERS / DWELLING FIRE **CFPA Written Premium: Not Applicable** **(CFPA does not make public financial filings)** **AMOUNT OF RECOVERIES $156,866.32**	**NUMBER OF VIOLATIONS**
CIC §2070 [CIC §790.03(h)(3)] / [CIC §790.03(h)(5)]	59
CIC §2071 [CIC §790.03(h)(3)] / [CIC §790.03(h)(5)]	59
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	85
*CCR §2695.7(d) [CIC §790.03(h)(3)]	38
CCR §2695.7(b) [CIC §790.03(h)(4)] / CCR §2695.7(b)(1) [CIC §790.03(h)(13)] / CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	31
CIC §§2051 and 2051.5 / CCR §2695.9(f) [CIC §790.03(h)(3)] / [CIC §790.03(h)(5)] / CCR §2695.9(f)(1) [CIC §790.03(h)(5)]	27
CCR §2695.4(a) [CIC §790.03(h)(1)]	25
CCR §2695.7(h) [CIC §790.03(h)(5)]	21
CCR §2695.7(g) [CIC §790.03(h)(5)]	16
CIC §790.03(h)(15)	12
CCR §2695.9(d) [CIC §790.03(h)(3)]	7
CCR §2695.5(e)(2) / CCR §2695.5(e)(3) [CIC §790.03(h)(3)]	6
CCR §2695.5(b) [CIC §790.03(h)(2)]	5
CCR §2695.7(d) [CIC §790.03(h)(3)]	5
CIC §790.03(h)(1)	4
CCR §2695.3(a) [CIC §790.03(h)(3)]	4
CCR §2695.7(q) [CIC §790.03(h)(3)]	4
CCR §2695.7(f) [CIC §790.03(h)(3)]	3
CIC §790.03(h)(5)	2
CIC §14046(b)(1) [CIC §790.03(h)(3)]	3
CIC §790.034(b)(1) [CIC §790.03(h)(3)]	2
TOTAL	**418**

*Citation CCR §2695.7(d) includes four related specifically to smoke damage and the other citations were observed in the files reviewed without smoke damage.

SUMMARY OF EXAMINATION RESULTS

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

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

Additional claim payments made by CFPA in response to the violations identified in the examination total $156,866.32 to date, as described in section numbers 2, 5, 6, 7, 10, 18 and 21 below. As described in section 7 below, CFPA is also conducting a closed claims survey. The results of the survey and additional payments, if any, shall be reported to the Department on or before May 31, 2022.

Violations observed specific to CFPA's practices for handling claims for smoke damage are described below:

1. In 59 instances, CFPA failed to issue a fire policy when viewed in its entirety, that is substantially equivalent to or more favorable to the insured than that contained in such standard form fire insurance policy. FAIR Plan's policy issued in these 59 instances does not conform to the requirements of the California Standard Form Fire Insurance Policy. Although CDI approved the policy, CFPA omitted relevant facts and misrepresented revised language as providing broad or broader coverage than the policy provided previously. In CFPA's Filing Memorandum in support of its form filing to CDI, CFPA specifically represented to CDI that its proposed revisions, including its new definition of "direct physical loss," would not reduce or eliminate existing coverages, might even broaden coverage, and would have no rate impact. Specifically, CFPA stated: "The changes in the policy will either provide no change in coverage or will provide some broadening of coverage. The FAIR Plan will not revise rates for the additional coverage."

Despite its representations to CDI, CFPA handled claims for smoke damage based on its policy's definition of "direct physical damage" as requiring permanent physical changes to covered property. However, loss caused by fire does not require "permanent physical changes" for there to be coverage. Further, a loss from smoke stemming from fire should be adjusted as would a loss caused only by fire. Smoke damage is not a separate occurrence from fire. CFPA's definition of smoke and/or smoke damage is not

at least equivalent to that required under the Standard Form Fire Insurance Policy and is therefore a violation of law.

In his January 4, 2021 letter to CFPA, CDI General Counsel and Deputy Commissioner Kenneth Schnoll states CDI's position as follows:

Any attempt by FAIR Plan to reduce or limit coverage for smoke damage based on its definition of direct physical damage to require "permanent physical changes" to covered property is contrary to the law. Under Insurance Code sections 10090 et seq., FAIR Plan is required to offer, *inter alia*, "basic property insurance" to Californians who experience difficulty obtaining insurance in the voluntary market. "Basic property insurance" in California includes smoke damage from fire. Specifically, section 10091, subdivision (c), defines "basic property insurance" to include, without limitation, coverage for "perils insured under the standard fire policy."

Insurance Code section 2071, which sets forth the California standard form fire insurance policy, requires coverage for "***all*** LOSS BY FIRE … EXCEPT AS HEREINAFTER PROVIDED." (Emphasis added). The coverage exclusions "hereinafter provided" in Section 2071 do not include smoke damage from fire. Additionally, section 2070 specifies:

No part of the standard form shall be omitted therefrom except any policy providing coverage against the peril of fire only, or in combination with coverage against other perils, need not comply with the provisions of the standard form of fire insurance policy…**provided, that coverage with respect to the peril of fire, when viewed in its entirety, is substantially equivalent to or more favorable to the insured than that contained in such standard form fire insurance policy.**

(Emphasis added.)

FAIR Plan's policy form language, as reportedly utilized by FAIR Plan, provides less coverage than the coverage required under the standard form fire policy because it limits coverage for fire loss through its definition of "direct physical loss," as "any actual loss or physical damage, evidenced by permanent physical changes, to the covered property . . ."

CFPA's handling of smoke damage claims is in violation of CIC §2070 and is an unfair practice under CIC §790.03(h)(3) and CIC §790.03(h)(5).

Summary of CFPA's Response: CFPA disagrees and states the dwelling policy form issued in these instances require direct physical loss, defined as "any actual loss or physical damage, evidenced by permanent physical changes, to the covered property . . ." CFPA further states this language is commonly used in insurance

policies, and has been confirmed to require an actual change in insured property causing it to become unsatisfactory for future use or requiring repairs to make it satisfactory for future use, or a distinct, demonstrable, physical alteration of the property. When a property does not need repair but only needs routine cleaning, it has not suffered a direct physical loss. The issued policies cover "smoke damage" that is visible to the unaided human eye or odor from smoke and ash that is detected by the unaided human nose of an average person, and not by laboratory testing. In these instances, the independent adjusters (IA) did not detect smoke damage as defined by the policy.

Further, CFPA states Insurance Code Section 2070 specifies that a fire policy need not comply with the standard form fire insurance policy provided that "coverage with respect to the peril of fire, when viewed in its entirety, is substantially equivalent to or more favorable to the insured than that contained in such standard form fire insurance policy." The CFPA Policy includes coverage for loss from the peril of fire. CFPA states the fact that the Policy also includes coverage for loss from other perils, including "smoke damage," does not result in any diminished coverage under the Policy with respect to the peril of fire and, therefore, the Policy complies with this statute.

Summary of the Department's Evaluation of CFPA's Response: The California FAIR Plan Association was created to provide "basic property insurance" to Californians who are unable to procure such insurance in the voluntary market. "Basic property insurance" is defined under CIC §10091(c)(1) to include coverage for "perils insured under the standard fire policy." California Insurance Code section 2070 specifies:

> No part of the standard form shall be omitted therefrom except any policy providing coverage against the peril of fire only, or in combination with coverage against other perils, need not comply with the provisions of the standard form of fire insurance policy…provided, that coverage with respect to the peril of fire, when viewed in its entirety, is substantially equivalent to or more favorable to the insured than that contained in such standard form fire insurance policy.

CFPA's application of its policy language fails to comply with California law. This is an unresolved issue that may result in administrative action.

2. In 59 instances, CFPA failed to provide coverage for all loss by fire as set forth in the California Standard Form Fire Insurance Policy. CFPA denied or limited coverage for smoke damage. The Department alleges these acts are in violation of CIC §2071 and are unfair practices under CIC §790.03(h)(3) and §790.03(h)(5).

Summary of CFPA's Response: CFPA disagrees it is in violation of CIC §2071. CFPA responds as follows:

In 48 instances, CFPA states its policy covers "smoke damage" that is visible to

the unaided human eye or odor from smoke and ash that is detected by the unaided human nose of an average person, and not by laboratory testing. Therefore, coverage was denied.

In six instances, CFPA states the property did not need repair as a result of the fire, only routine cleaning. Consequently, coverage beyond routine cleaning was denied.

In one instance, CFPA responds the insured did not make a claim for cleaning due to smoke. However, as a result of the examination, CFPA agreed to pay for deodorization. A payment was issued to the insured in the amount of $4,198.91.

In one instance, CFPA responds the adjuster inspected the property with the insured and noted that there was no visible soot/ash on the interior or exterior, and there was no contents damage. On October 15, 2020 the insured told CFPA she had smoke damage, and was cleaning the dwelling, but the IA had inspected the property on September 25, 2020, and there was no evidence of permanent damage from soot or ash to the dwelling. The photos showed no evidence of soot or smoke damage including samples taken by the IA in various areas of the dwelling. Deodorization was paid for to address smoke odor in the dwelling and contents; however, the insured was advised in writing on October 28, 2020 that CFPA would not pay for other claims of damage due to smoke.

In one instance, CFPA responds that the insured verbally confirmed there was no damage to the home as a result of the fire. Therefore, CFPA did not order an inspection to evaluate for smoke damage.

In one instance, CFPA responds that the adjuster inspected the interior and exterior of the dwelling and other structures on the property, including the pool and found no damage and no noticeable smoke odor. Therefore, coverage was denied.

In one instance, CFPA disagrees that it failed to provide coverage for personal property items damaged by the fire. However, CFPA acknowledges that it failed to follow through with its final evaluation of the personal property evaluation of the claim. As a result of the examination, the claim was reopened and a supplemental payment of $2,226.03 was issued.

Additionally, CFPA states its policy and the manner in which it interprets its policy is consistent with California law. Routine cleaning is not a covered peril. However, CFPA does cover smoke deodorization and for cleaning soot, char and ash when something more than routine cleaning is required. CFPA states this is consistent with Insurance Code sections 2070 and 2071.

Summary of the Department's Evaluation of CFPA's Response: The California Insurance Code requires coverage for "all LOSS BY FIRE". These denials restrict or limit coverage for "direct physical loss from smoke". Further, smoke claims present special considerations, including but not limited to the fact that the damage is

often hidden or does not manifest within a normal proof of loss timeframe. Therefore, this is an unresolved issue that may result in administrative action.

3. In four instances, CFPA failed to conduct and diligently pursue a thorough, fair and objective investigation. CFPA denied smoke damage claims without investigating them and in doing so, CFPA did not meet its obligation to conduct and diligently pursue a thorough, fair and objective investigation. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response: CFPA disagrees with these findings. The FAIR Plan policy covers direct physical loss, defined as actual loss or physical damage, evidenced by permanent physical changes. This language applies to all perils, not just smoke or fire. This language is present in policies throughout the country, including in California. With respect to smoke damage, the FAIR Plan policy covers "smoke damage" that is visible to the unaided human eye or odor from smoke and ash that is detected by the unaided human nose of an average person, and not by laboratory testing. In these instances, the FAIR Plan completed a thorough, fair and objective investigation, and confirmed there was no damage as defined by the policy to the structures or contents, so no inspection was needed to evaluate any damage. Smoke odor which can be detected by the unaided human nose of an average person is considered direct physical loss, while particulate matter from smoke that can be addressed by typical methods of household cleaning is not. In these instances, there was no evidence of permanent damage to the property, which is required for coverage to be triggered.

Summary of the Department's Evaluation of CFPA's Response: CFPA denied the claims without conducting a full investigation into damages related to smoke. Instead CFPA either misapplied or relied on its non-conforming policy definition of "smoke damage" requiring permanent physical changes to covered property to deny the claims. Therefore, this is an unresolved issue and may result in administrative action.

Additional violations not specific to CFPA's practices for handling claims for smoke damage were also observed in the claim files reviewed. These violations are described below:

4. In 85 instances, CFPA failed to comply with the requirements of CCR §2695.7(c)(1) as described below:

4(a). In 65 instances, CFPA failed to specify, in the written notice of the need for additional time, any additional information the insurer requires to make a claim determination and to state any continuing reasons for CFPA's inability to make a determination. In 63 instances, the additional time letters did not adequately communicate the reason why payment was delayed. In another two instances, there were no details regarding the claim determination delay. The Department alleges these

acts are in violation of CCR §2695.7(c)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response to 4(a): In 63 instances, CFPA agrees with these findings. The independent adjuster's (IA) additional time letters do not adequately communicate the reason for the delay in payment, and what else is needed to move the claim forward. Although the IA in the field did not specify the reason(s) for the delay, CFPA staff repeatedly informed the insureds via emails and phone calls of what was needed to move their claim forward.

Nonetheless, CFPA recognizes the additional time letters provided by the IAs were lacking in details and did not meet the requirements of the regulation. As a result of the examination, CFPA counseled the IAs and terminated specific IAs.

To address regulatory compliance, CFPA is standardizing its additional time letters, and bringing these letters in-house to ensure they are compliant with California regulations. CFPA is working on building a permanent internal claims department with examiners that are trained on the requirements of the California Fair Claim Settlement Practices Regulations, Insurance Codes, and other applicable California law in an effort to limit the need for outside IAs and vendors. Over the course of this targeted examination, CFPA began putting corrective measures in place, and continues to implement new processes and procedures. CFPA has hired internal claim examiners, quality auditors, and trainers to improve compliance with issues identified by CDI during the course of this examination. CFPA implemented a staff of internal auditors that over several months has conducted audits on random files handled by the IA's examiners, as well as internal staff examiner files, and will continue to do so. Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

In the remaining two instances, CFPA disagrees with these findings. CFPA states in these instances there was no additional information needed from the insureds. The additional time letters were only to notify them of additional time to complete a thorough and proper evaluation of the claim, and make a final coverage determination.

Summary of the Department's Evaluation of CFPA's Response 4(a): In the two instances in which CFPA disagrees, CFPA's interpretation and position that the insurer must request information in order for an additional time letter to be owed is incorrect. If CFPA has received proof of claim that reasonably supports the magnitude of the amount of the claimed loss, then additional time letters explaining the reason for the delay are owed to the insured every 30 days. Additionally, CFPA's response that it

is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

4(b). In 20 instances, CFPA failed to provide written notice of the need for additional time every 30 calendar days until a determination is made. In these instances, CFPA either did not send the insureds letters advising of the need for additional time to investigate the claim, or did not send the letters when they were due. The Department alleges these acts are in violation of CCR §2695.7(c)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response to 4(b): CFPA agrees with these findings that CFPA did not send additional time letters when they were due. CFPA is aware of the issue with the outside IAs and is working on building a permanent internal claims department with examiners that are trained on the requirements of the California Fair Claim Settlement Practices Regulations, Insurance Codes, and other applicable California law in an effort to limit the need for outside IAs and vendors. Over the course of this targeted examination, CFPA began putting corrective measures in place, and continues to implement new processes and procedures. CFPA has hired internal claim examiners, quality auditors, and trainers to improve compliance with issues identified by the Department during course of this examination. CFPA implemented a staff of internal auditors that over several months has conducted audits on random files handled by the IA's examiners, as well as internal staff examiner files, and will continue to do so. Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

Summary of the Department's Evaluation of CFPA's Response to 4(b): CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

5. In 34 instances, CFPA failed to conduct and diligently pursue a thorough, fair and objective investigation. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3). In the files reviewed, the following situations were observed.

(a) In 21 instances, the IAs' inspections, reports, and/or claims status to either CFPA or the insureds were delayed for weeks to several months.

(b) In two instances, handling of the claims was delayed due to the steps that were taken by CFPA after the report of loss to verify that the named insureds had insurable interest in the property.

(c) In three instances, CFPA did not promptly investigate claims for Fair Rental Value (FRV). In the first instance, CFPA did not review the insured's FRV benefit for 245 days since its last payment to the insured. In the second instance, the insured was under a mandatory evacuation for four days, and was not paid the FRV benefit for 119 days. In the third instance, the insured relocated because the house had smoke odor and asbestos was present. CFPA did not investigate to determine whether FRV was owed.

(d) In two instances, CFPA received emails from the insureds advising that they had gotten a permit to rebuild the main structure and were working on other permits for the second house and the shop. CFPA did not investigate the additional expenses that were, or will be incurred by the insured under the Ordinance or Law Coverage.

(e) In one instance, the IA's report notes a concern that the smoke odor would require deodorization, removal of the attic insulation, HEPA vacuum of all the soot and ash, and then installation of new insulation. The IA provided photographs which it reported clearly showed the fire had burned very close to all sides of the structure, and strongly suggested there would be moderate to heavy soot in the attic space. However, CFPA did not inspect and estimate this potential damage caused from smoke.

(f) In one instance, CFPA did not investigate the FRV aspect of this claim upon notice that additional FRV was being requested due to the house being uninhabitable per the insured's attorney.

(g) In one instance, CFPA never confirmed the period of time that the insured was evacuated from the property.

(h) In one instance, 90 days after receiving the IA's second report advising that the insured had submitted additional damages for consideration of payment, CFPA sent a letter to the insured denying the claim because the insured had waited 47 days after the mandatory evacuation to report the claim.

(i) In one instance, CFPA failed to inspect the property, verify the contents claim, or assign an IA for over a year. After CDI's inquiry in this examination, CFPA renewed its efforts. The insured was contacted, insurable interest was resolved, an IA was assigned, the damages were assessed, and offers were made.

(j) In one instance, the IA sent an email dated December 17, 2020 advising CFPA that the inspection was completed and the dwelling was in fact a total loss. The IA asked the CFPA adjuster if they would like a cause and origin expert to examine the loss to determine the cause of the fire. CFPA did not respond to this question until sending an email to the IA on March 4, 2021 asking if it was too late to proceed with the cause and origin expert. Additionally, the fire department report was not requested until approximately three months after the first notice of loss.

Summary of CFPA's Response:

(a) In 20 instances, CFPA agrees with these findings. This claim handling does not meet CFPA's standards for diligent and timely claim investigation. CFPA will continue to ensure staff is aware of appropriate timelines to address claims related items. Both the independent adjusters and CFPA desk adjusters have been instructed to review all outstanding items on all claims that apply to possible coverage and CFPA will continue to push forward this training on future claims handling.

Due to the large volume of claims that were generated from the wildfires in 2020, CFPA utilized independent claims examiners to assist with the overflow. CFPA is aware of the issues with this external team of IAs, and is working on building a permanent team of internal examiners to limit the need for IAs and vendors.

CFPA states it understands there have been delays in obtaining reports timely from its independent adjusters. CFPA has been working on bringing in more quality independent adjusting firms to improve on the overall turnaround times for estimates and reports.

Under ordinary circumstances, CFPA would expect that the turnaround time for an estimate on a total loss claim would be less than 60 days. However, CFPA had approximately 14 different fires burning simultaneously in the same month, and delays in completing total loss estimates were likely to occur.

In one instance, CFPA disagrees with this finding. The initial file examiner was relocated to another position which resulted in the reassignment of this claim to a new file examiner. The new file examiner noted the file of several attempts to contact the insured to help move the claim forward. On January 25, 2021, the file examiner was able to reach the insured and it was established that revisions were needed to the estimate for Coverage A and C, which in turn caused a delay in the payments. It does appear once revisions were made the file examiner attempted contact with the insured on February 3, 2021, but was not able to actually contact the insured until

February 4, 2021. The file examiner submitted the authority request on February 4, 2021 and received authority approval on February 6, 2021. The file examiner processed the payment on February 18, 2021.

(b) In one instance, CFPA agrees with this finding. Typically, the Property Detail Report (PDR) and grant deed are procured when the claim is opened. In the instance, because the property is government-owned, and leased to the insured, there was no PDR or deed. It appears that both the desk adjuster and field adjuster overlooked this initially. This was a very unusual situation, and CFPA has reinforced to its desk adjusters that they need to obtain insurable interest information (including property ownership) at the beginning of each claim.

In one instance, CFPA disagrees with this finding. CFPA was waiting for the insured to produce the Grant Deed to verify the insurable interest in the property. The insured submitted it on July 2, 2021, and payment was made on July 12, 2021. CFPA relies on the information provided on the application by the broker of record. The broker submits an application on behalf of the applicant and is responsible for determining that the named insured on the application has an insurable interest in the property. If CFPA determines the named insured does not have an insurable interest, the resolution of the claim would depend on the specific circumstances regarding the insurable interest of the named insured and any other parties named on the policy at time of loss.

(c) In the first instance, CFPA disagrees with this finding. The independent adjuster stated that the fire was approximately four plus miles away from the risk. It is possible that the occasional smoke odor may be dependent on which direction the wind is blowing. CFPA further stated that since denial of the claim, the insured has made no further contact to complain of intermittent smoke odor. If the insured notifies CFPA that source of the smoke odor is within the air ducts, even after cleaning and deodorizing, CFPA stated it will conduct further investigation.

In the second instance, CFPA agrees with this finding. It appears the reason for the delay in payment was due to the claim being re-assigned to a new file examiner. CFPA recognizes the issues with utilizing IAs that do not work with the FAIR Plan on a regular basis and is working on building a permanent team of examiners who have a higher understanding of CFPA's policies and the compliance regulations.

In the third instance, CFPA reopened the claim and contacted the insured's daughter as a customer service measure in order to obtain additional information regarding the specific reasons for the move out and the length of time the insured was out of her home. During the repairs, the property tested positive for asbestos, and the insured's daughter stated she believes

the insured moved out because it was unhealthy. The investigation is pending additional documentation. If a supplemental payment is warranted, CFPA will document its file accordingly, issue the appropriate payment to the insured, and provide CDI with copies of the related documentation.

(d) In two instances, CFPA disagrees with these findings. CFPA reviewed the claim files and believes it completed a thorough, fair, and objective investigation. In these instances, the insureds did not provide documentation verifying their insurable interest in the property.

(e) CFPA agrees that deodorization should be paid for in this instance. Approximately four months after the loss, the insured initiated a claim for cleaning of the interior of the dwelling and the guest house, including the attic. The insured used his employees on site to repair the fire damaged appurtenant structures rather than preparing an estimate, and the IA asked the insured to submit his repair invoices. He also asked the insured to submit estimates for cleaning the attic and replacement of insulation, and to provide photos to document the loss. However, it does not appear there was a written follow up for this specific task. The IA should have been directed to conduct an inspection of the attic at the onset of the claim, and to perform a reinspection of the property when the insured initiated his claim for smoke damage. This IA firm is no longer handling CFPA's claims and CFPA involved staff are no longer with CFPA. Ongoing training will be provided to the current IAs and CFPA staff. CFPA wrote an estimate to deodorize the main house and guest house and issued an additional payment to the insured on December 28, 2021.

(f) In one instance, CFPA agrees with this finding. CFPA failed to notice that additional FRV was being requested due to the house being uninhabitable. This investigation is ongoing. A status letter was sent to the insured's attorney on January 8, 2022.

(g) In one instance, CFPA agrees with this finding. Additional FRV amount was calculated, and payment was issued. This IA firm was new to the FAIR Plan at the time, as was the independent desk examiner. Both no longer handle claims for the FAIR Plan.

(h) In one instance, CFPA agrees with this finding. The insured's smoke claim was improperly denied based on language that no longer applies under the Smoke Damage peril. As a result of the examination, the claim was re-opened and it was determined that the covered damages are under the insured's policy deductible.

(i) In one instance CFPA agrees with this finding. CFPA reopened the claim. Payments in the combined amount of $6,864.81 were issued under Coverage A, Coverage B, Coverage C, debris removal, and fences.

(j) In one instance, CFPA agrees with this finding. CFPA stated it expects its adjusters to be proactive when it comes to claim handling, and that the adjuster should have acted in a timelier manner.

In all instances in which these findings have been acknowledged, CFPA has provided the following response as corrective actions in its continuing efforts to improve regulatory compliance going forward:

CFPA is striving to do better in regard to claim handling. The wildfire events over the last few years have resulted in a dramatic increase to CFPA's book of business as mainstream insurance companies continue to tighten their underwriting guidelines for property owners in the brush areas. This growth has forced the FAIR Plan to become more reliant on hiring independent adjusting companies to handle the increasing volume of claims resulting from these events. CFPA has also had to rely on these companies to train and audit their own files, which has not produced the desired results.

To put CFPA in a better position to handle the workload and future wildfire events, CFPA are in the process of hiring approximately 40 additional adjusters. CFPA will directly supervise and train them to strictly adhere to standards that either meet or exceed the expectations of the Department of Insurance.

CFPA has put together an internal Quality Assurance Department consisting of Trainers and File Reviewers who will work together to identify and correct issues in claim files as they manifest. Performance goals and Quality Assurance audits will be structured to analyze and provide feedback for file quality monthly.

This additional hiring will reduce CFPA's reliance on independent adjusting companies to assist CFPA with its policyholders and give CFPA more control over the claim handling environment. Couple that with CFPA's new Quality Assurance Team guidelines and continued learning philosophy, CFPA will be in a position to improve claim handling and reduce errors in the future.

Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

Summary of the Department's Evaluation of CFPA's Response: In one instance (a), CFPA's redeployment of personnel, and its reassignment of the claim to a new file handler resulted in an unreasonable delay in the handling of the insured's claim. In one instance (b), CFPA did not conduct and diligently pursue a thorough, fair

and objective investigation into the policyholder's insurable interest in the subject property which resulted in an unnecessary delay in concluding these claims. In one instance (c), CFPA's investigation was neither diligent, nor thorough and the insured's failure to complain should not be its standard for assessing regulatory compliance. In two instances (d), CFPA did not investigate additional expenses. CFPA's continuing efforts towards improved regulatory compliance, described in its response above, does not address the six identified instances for which CFPA continues to disagree. There has been no acknowledgement of these Department findings and no corrective measure to reinforce compliance. Additionally, CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

6. In 31 instances, CFPA failed to comply with the requirements of CCR §2695.7(b) as described below:

6(a). In 20 instances, CFPA failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days. In these instances, CFPA did not pay accepted claims that were made for food spoilage, FRV, structural damage, and personal contents. The Department alleges these acts are in violation of CCR §2695.7(b) and are unfair practices under CIC §790.03(h)(4).

Summary of CFPA's Response to 6(a): In 20 instances, CFPA agrees that upon receipt of proof of claim, CFPA did not accept or deny these claims within the regulatory timeframe of 40 days. CFPA's ongoing training of the examiners includes the issuing of any undisputed amounts as soon as possible or documenting why payment cannot be made at that time. CFPA reminded its staff of the importance in documenting the file and that payment must be issued once CFPA determines the amount owed. In some of these instances, CFPA's desk examiners were new to the FAIR Plan at the time, and were still getting familiar with the policy language and claims process.

In one of these instances, upon receiving proof of claim for the ongoing FRV (Fair Rental Value) CFPA did not timely accept the additional FRV. As a result of the examination, the claim was reviewed. The examiner re-adjusted the calculation and issued a supplemental payment based on the insured's statement that they occupy the property eight days each month. On January 11, 2022, CFPA issued a payment of $10,458.72 to cover the FRV from March 7, 2021 through September 6, 2022.

CFPA recognizes the delays with its IAs, and is building a permanent team of internal examiners that have a higher understanding of the requirements of the California Fair Claim Settlement Practices Regulations, Insurance Codes, and other applicable California law, to reduce the need for outside support. CFPA has already put together an internal Quality Assurance Department consisting of Trainers and Quality Assurance Representatives who will work together to identify and correct issues in claim

files as they manifest. Performance goals and Quality Assurance audits will be structured to analyze and provide feedback for file quality on a monthly basis. Additionally, CFPA is hiring additional resources which will reduce its reliance on independent adjusting companies to assist CFPA with its policyholders and give CFPA more control over the claim handling environment. Coupled with the new Quality Assurance Team guidelines and continued learning philosophy, CFPA will be able to improve claim handling and reduce errors in the future. Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

Summary of the Department's Evaluation of CFPA's Response to 6(a): CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

6(b). In nine instances, CFPA failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of CFPA's Response to 6(b): In all instances, CFPA agrees that it did not deny claims in writing when it should have. CFPA will continue to provide training on California Fair Claims Settlement Practices regulations to the independent examiners, supervisors and managers currently handling claims.

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

Summary of CFPA's Response to 6(c): In both instances, CFPA agrees. As a result of these findings, CFPA sent appropriate denial letters with reference to CDI.

7. In 27 instances, CFPA failed to comply with the requirements of CIC §§2051, CIC §2051.5 and CCR §2695.9(f) as described below:

7(a). <u>In 13 instances, CFPA failed to document in the claim file all justification for the adjustment of the amount claimed because of betterment, depreciation, or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property.</u> In these instances, the basis of all depreciation is not fully explained in the file notes, on the estimate, or in photographs secured (if any) to include the specifics or details on the actual condition of the items depreciated. The files and estimates were void of notes detailing how the adjustment for depreciation reflects a measurable difference in market value attributable to the condition and age of the property. The justification for all of the depreciation taken could not be located in the claim files. The estimates show a line by line deduction for depreciation; however, there was no supporting evidence in the claim files to justify how CFPA determined applicable depreciation taken on these claims. In addition, the rationale for identifying the condition as average across all items was not noted in some instances.

It is understood the independent adjuster secured photographs and met with the insured in most instances; however, there is no explanation in the file that addresses the condition of the depreciated items, other than what is identified on the estimate. Further, an inspection and the taking of photographs is only one step in determining condition. The other component is the analysis of the photographs and inspection, including the rationale for the condition whether it relates to the dwelling or personal property. This would include documenting the content of what was discussed with the insured in the claim file and the adjuster's documentation of the observed condition of the items subject to depreciation. If it cannot be observed, the insured would then be the source of obtaining this information. Additionally, the issue is not necessarily whether the depreciation was appropriately withheld. The issue is that there was no justification in the claim file for what was depreciated. Further, regardless of whether a letter and/or an estimate state or indicate that depreciation was based on age and condition, there has to be justification for the basis of the depreciation taken in the file, which will typically include comments or notes documented in the claim file.

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

<u>Summary of CFPA's Response to 7(a):</u> In seven instances, CFPA agrees with these findings. In two of the seven instances, CFPA re-evaluated the depreciation taken and as a result issued payments, on December 29, 2021, to one insured in the amount of $3,314.73, and to another insured in the amount of $5,846.15. In two of the seven instances, the IA did not include depreciation comments; however, CFPA believes the IA's photographs depict the overall condition of the property.

In one of the seven instances, CFPA states condition was not requested given that the insured provided information in their personal property inventory list. While the insured did identify the condition on several items, the insured left this blank on several others. Any items that were not notated were considered to be average, unless the age of the item indicated that it was new. New and perishable items were not depreciated.

CFPA acknowledges it should have followed up with the insured for the condition of the items left blank. As a result of this finding, CFPA indicated it will follow up with the insured. Pending the insured's response, no supplemental payment has yet been issued.

In one of the seven instances, CFPA acknowledges that the IA firm utilized for personal property did not include the life expectancy on their personal property form. However, the depreciation is based on the information submitted by the insured and taken into consideration within the vendor program for personal property. CFPA utilizes XactContents, the program for personal property, and Xactimate, the program for the dwelling, for input of personal property items and structural components with the vendor, Xactware.

In one of the seven instances, while CFPA acknowledges this finding, depreciation was not applied due to the coverage limits and CFPA's failure to properly depreciate this claim worked in the insured's favor.

In six instances, CFPA disagrees with these findings. CFPA states the depreciation was appropriately applied. The age of items would only have been derived from various conversations the adjuster had with the insured including the condition that may be evident during the inspection of the property. Essentially, age and condition are determined per information CFPA receives from the insured as well as the inspection of the property. Life expectancy is also determined per the values allotted in the Xactware program for average useful life of all trades where depreciation is applicable. Additionally, CFPA indicated the settlement letter and/or the estimate explicitly states that depreciation applied was based on the age and the condition. In one of these six instances, even though CFPA disagreed with this finding, it revised the estimate changing the condition to above average and issued an additional payment of $373.61 to the insured.

Nonetheless, for all instances identified above, CFPA states at the time some of the claims were handled, clear depreciation guidelines were not set in place for proper claims handling. CFPA has since affected new guidelines to determine and apply depreciation as well as to communicate how depreciation was taken to the insured in its estimates moving forward. CFPA now requires greater detail in all estimates to include a more detailed breakdown of all items being depreciated so that it is clear. These guidelines were set in place on or about February of 2021. CFPA also implemented new procedural changes by requiring all depreciation calculations to be noted in all estimates as well as clear documentation that conversations have taken place with the insured at time of inspection regarding age, life, and condition of items. CFPA will continue to work on improving this process by utilizing its new training and Quality Assurance department for continuing education on this topic as well as many others related to compliance.

In light of AB188, which amended Insurance Code section 2051(b) effective January 1, 2020, the FAIR Plan is reviewing all claims where depreciation was taken

between January 1, 2020 and February 28, 2021, when CFPA corrected its depreciation guidelines. Where depreciation was incorrectly applied, the FAIR Plan will issue refunds to insureds including interest. The FAIR Plan has reviewed 305 of 373 claims, to date, and estimates that it is approximately 82% through the process. CFPA anticipates completing this process by May 31, 2022, and will report its findings to the Department.

Summary of the Department's Evaluation of CFPA's Response to 7(a): In the one instance that CFPA followed up with the insured for information on the individual items for which condition was previously not identified, it has not provided the results of the additional investigation and follow up. Until CFPA has provided the Department with the outcome of the reopened claim, this is an unresolved issue that may result in administrative action.

Although CFPA indicates new procedural changes were implemented (presumably after February of 2021), CFPA has not provided the Department with the date upon which the procedures have been executed nor has CFPA provided the Department with a copy of the new procedures to address regulatory compliance as a result of this examination.

7(b). In 10 instances, CFPA applied betterment or depreciation to property not normally subject to repair and replacement during the useful life of the property. In each instance, CFPA applied depreciation to one or more structural components not normally subject to repair or replacement during the useful life of the structure absent some known reason to do so, such as damage sustained in an insurance loss. Additionally, the file notes at issue were void of any specific documentation regarding the condition of the items that would warrant betterment or depreciation. The Department alleges these acts are in violation of CCR §2695.9(f) and are unfair practices under CIC §790.03(h)(5).

Summary of CFPA's Response to 7(b): CFPA agrees depreciation was taken on components that are not normally subject to repair or replacement during the useful life of the property in all identified instances. As a result of these findings, CFPA reviewed these 10 instances, and issued payments totaling $58,943.91 to all impacted insureds.

Based on the guidelines in place during the examination review period, depreciation may have been inappropriately applied to some items. To address regulatory compliance, CFPA requires all future estimates to contain the basis for depreciation. In addition, CFPA requires all field adjusters to confirm their Xactimate settings are correct in that they are not set to depreciate any items not normally subject to depreciation.

The wildfire events over the last few years have resulted in a dramatic increase to CFPA's book of business as mainstream insurance companies continue to tighten their underwriting guidelines for property owners in the brush areas. This growth has

forced CFPA to become more reliant on hiring independent adjusting companies to handle the increasing volume of claims. CFPA also had to rely on IA's to train their adjusters and to audit their own files, which has not produced the desired results.

In addition, to put CFPA in a better position to address regulatory compliance in handling the claims workload and future wildfire events, CFPA is in the process of hiring approximately 40 additional adjusters. CFPA will directly supervise and train them to standards that meet and exceed the CDI expectations. CFPA is also drafting Claim Handling Expectations that require a strict adherence to all CDI guidelines.

CFPA has already put together an internal Quality Assurance Department consisting of Trainers and Quality Assurance Representatives who will work together to identify and correct issues in claim files as they manifest. Performance goals and Quality Assurance audits will be structured to analyze and provide feedback for file quality monthly.

The additional hiring will reduce reliance on independent adjusting companies to assist with CFPA's policyholders and give CFPA more control over the claim handling environment. These efforts coupled with CFPA's new Quality Assurance Team guidelines and continued learning philosophy, CFPA will be able to improve claim handling and reduce errors in the future.

Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

Instances in which depreciation was taken on items not normally subject to repair or replacement during their useful life will be corrected as part of the review of past claims described in CFPA's response to items 7(a).

Summary of the Department's Evaluation of CFPA's Response to 7(b): CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

7(c). In three instances, CFPA failed, in adjusting the amount claimed because of betterment, depreciation, or salvage, to fully explain the basis for the adjustment to the claimant in writing. CFPA has not demonstrated that it provided claimants with a written explanation of the basis for depreciation in these identified claim

files. In the first instance, CFPA's payment letter does not provide the insured with an accurate description of the non-recoverable depreciation that was deducted from the claim. In the second instance, CFPA's inventory list, which it had the insured sign, has no clear explanation of the percentage amounts deducted. In the third instance, the estimate CFPA sent to the insured did not have any explanation for the deductions applicable to the age, useful life, or condition of the insured's property. The Department alleges these acts are in violation of CCR §2695.9(f) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response to 7(c): CFPA agrees with the findings in all three instances. In the first instance, CFPA states that a follow-up explanation should be sent to the insured advising them of the settlement breakdown. In the second instance, CFPA acknowledges it did not provide a clear explanation of how the depreciation was calculated which resulted in an overpayment to the insured. In the third instance, CFPA acknowledges it did not provide the insured (in written format) the basis for depreciation contained in the estimate.

To address regulatory compliance, CFPA is transitioning its business model to move away from its previous method of operation into one that will give CFPA more control over the claim handling quality in the future.

7(d). In one instance, CFPA applied depreciation to the expense of labor necessary to repair, rebuild, or replace covered property. The expense of labor is not a component of physical depreciation. The Department alleges this act is in in violation of CCR §2695.9(f)(1) and is an unfair practice under CIC §790.03(h)(5).

Summary of CFPA's Response to 7(d): CFPA agrees that the expense of labor was depreciated in this instance. As a result of this finding, CFPA issued payment to the insured in the amount of $2,785.84.

8. In 25 instances, CFPA failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability. In these instances, CFPA failed to explain coverage benefits, how to recover the depreciation holdback, that FRV may apply to the claim and/or how the insured's FRV benefit was calculated.

Summary of CFPA's Response: CFPA agrees with these findings that benefits and/or coverages were not fully explained. CFPA is working on building a permanent internal claims department with examiners that are trained on California's regulatory compliance guidelines in an effort to not have to resort to utilizing independent adjusting claims staff. Further, CFPA is currently working on standardizing its payment and closing letters.

In addition, to put CFPA in a better position to address regulatory compliance in handling the claims workload and future wildfire events, CFPA is in the process of hiring approximately 40 additional adjusters. CFPA will directly supervise and train them to standards that meet and exceed the Department of Insurance expectations. CFPA is also drafting Claim Handling Expectations that require a strict adherence to all CDI guidelines.

CFPA has already put together an internal Quality Assurance Department consisting of Trainers and Quality Assurance Representatives who will work together to identify and correct issues in claim files as they manifest. Performance goals and Quality Assurance audits will be structured to analyze and provide feedback for file quality monthly.

The additional hiring will reduce CFPA's reliance on independent adjusting companies to assist with CFPA's policyholders and give CFPA more control over the claim handling environment. These efforts coupled with CFPA's new Quality Assurance Team guidelines and continued learning philosophy will improve claim handling and reduce errors in the future.

Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

Summary of the Department's Evaluation of CFPA's Response: CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

9. In 21 instances, CFPA failed, upon acceptance of the claim, to tender payment within 30 calendar days. In all instances, CFPA did not issue payments on undisputed repair estimates, claims for FRV benefits, recoverable depreciation, or a benefit under ordinance and law coverage within regulatory timeframes.

In 13 instances, CFPA did not issue payment on agreed estimates for structural damages. In one of these instances, CFPA waited 112 days to indemnify the insured for the costs of repair. In another, CFPA received the first IA's report and estimated damages, but waited 66 days to issue the IA's payment recommendation of

$139,617.08. In another of these instances, the claim was delayed because of steps taken by CFPA to verify insurable interest prior to payment.

In four instances, CFPA did not issue timely payment for FRV. In the first instance, CFPA did not issue the insured's 10-day FRV payment until 97 days after the insured returned to the property. In the second instance, the insured's primary structure was burned to the ground. The IA's report recommended an advanced payment of FRV for six months in the amount of $11,925.00, but payment was not issued for 152 days. In the third instance, the IA reported on November 14, 2020 that two units were red tagged and were not inhabitable until electrical wiring was corrected, but the first FRV payment was not issued for 69 days. In the fourth instance, due to the severity of the loss, it was evident that FRV was still in effect, but CFPA did not investigate FRV for 245 days after its last payment.

In two instances, CFPA did not issue timely reimbursements for recoverable depreciation.

In one instance, CFPA did not issue a timely payment for the balance of the insured's personal property limit of coverage. The insured's personal property list received on August 17, 2021 was not paid until October 20, 2021, 64 calendar days later.

In one instance, the IA reported that the insured's repairs under Ordinance and Law coverage were underway over seven months prior to CFPA's payment on June 30, 2021.

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

Summary of CFPA's Response: In 20 instances, CFPA agrees with these findings. CFPA did not find any basis, or substantive support for the delayed payment in the claim files.

The FAIR Plan used desk examiners from independent adjusting companies in order to respond to the high volume of catastrophe claims generated from the 2020 Northern California wildfires. Some had difficulty grasping the FAIR Plan's philosophy of claims handling in accordance with California regulations. The FAIR Plan provides training for all incoming field and desk examiners on the FAIR Plan policy, compliance, and procedures, and will continue to do so as it onboards new examiners and adjusters. Additional training is also administered on an individual basis as those needs arise.

The corrective action will be to retrain CFPA's adjusters to better prepare them for any future similar circumstances. CFPA is building a permanent team of examiners who have a higher understanding of the FAIR Plan's policies and regulatory compliance guidelines. CFPA understands the delays with both the independent examiners and the field adjusters and the lack of quality with utilizing subpar independent claims staff.

The wildfire events over the last few years have resulted in a dramatic increase to CFPA's book of business as mainstream insurance companies continue to tighten their underwriting guidelines for property owners in the brush areas. This growth forced CFPA to become more reliant on hiring independent adjusting companies to handle the increasing volume of claims. CFPA also had to rely on these companies to train and audit their own files, which has not produced the desired results.

In addition, to put CFPA in a better position to address regulatory compliance in handling the claims workload and future wildfire events, CFPA is in the process of hiring approximately 40 additional adjusters. CFPA will directly supervise and train them to standards that meet and exceed the Department of Insurance expectations. CFPA is also drafting Claim Handling Expectations that require a strict adherence to all CDI guidelines.

CFPA has already put together an internal Quality Assurance Department consisting of Trainers and Quality Assurance Representatives who will work together to identify and correct issues in claim files as they manifest. Performance goals and Quality Assurance audits will be structured to analyze and provide feedback for file quality monthly.

The additional hiring will reduce CFPA's reliance on independent adjusting companies to assist with CFPA's policyholders and give CFPA more control over the claim handling environment. These efforts coupled with its new Quality Assurance Team guidelines and continued learning philosophy will help to improve claim handling and reduce errors in the future.

Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

In one instance, CFPA disagrees with the violation cited as CFPA wanted to make sure the insured had the opportunity to provide a listing of all personal property items owned and then conduct the valuation to obtain an accurate value for each item. This can only be done by having someone with content valuation experience complete the valuation of all items. CFPA also must ensure that the items claimed are personal property items that are covered under the policy and ensure no items are duplicated on the adjuster's structural estimate if the insured does include structural items.

Summary of the Department's Evaluation of CFPA's Response: In the instance in which CFPA disagrees with the finding, the insured's incomplete contents

list and IA reports both showed that damages exceeded relatively low limits of coverage for contents. CFPA should not have waited for a completed contents list causing an unnecessary delay in the payment of the policy limits. Additionally, CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue and may result in an administrative action.

10. In 16 instances, CFPA attempted to settle a claim by making a settlement offer that was unreasonably low. In seven instances, CFPA underpaid and/or miscalculated the FRV amount owed. In four instances, CFPA did not absorb the deductible when damages exceeded the limits. In one instance, CFPA incorrectly subtracted the FRV amount from the payment of other structures. In one instance, CFPA did not pay what was owed based on revised estimates from the IA. In one instance, CFPA applied an incorrect policy limit to Coverage B. In one instance, CFPA incorrectly applied depreciation to something that would be considered new. In the final instance, CFPA removed numerous items from the insured's contents list.

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

Summary of CFPA's Response: CFPA agrees with these findings in all instances. As a result, CFPA issued payments totaling $58,778.94 to all insureds on the identified claim files.

The wildfire events over the last few years have resulted in a dramatic increase to CFPA's book of business as mainstream insurance companies continue to tighten their underwriting guidelines for property owners in the brush areas. This growth has forced CFPA to become more reliant on hiring independent adjusting companies to handle the increasing volume of claims. CFPA also had to rely on these companies to train and audit their own files, which has not produced the desired results.

In addition, to put CFPA in a better position to address regulatory compliance in handling the claims workload and future wildfire events, CFPA is in the process of hiring approximately 40 additional adjusters. CFPA will directly supervise and train them to standards that meet and exceed the Department of Insurance expectations. CFPA is also drafting Claim Handling Expectations that require a strict adherence to all CDI guidelines.

As a result of this examination, CFPA has put together an internal Quality Assurance Department consisting of Trainers and Quality Assurance Representatives who will work together to identify and correct issues in claim files as they manifest. Performance goals and Quality Assurance audits will be structured to analyze and provide feedback for file quality monthly.

The additional hiring will reduce the reliance on independent adjusting companies to assist with CFPA's policyholders and give CFPA more control over the claim handling environment. With these efforts coupled with CFPA's new Quality Assurance Team guidelines and continued learning philosophy, CFPA will be able to improve claim handling and reduce errors in the future.

Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

Summary of the Department's Evaluation of CFPA's Response: CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

11. In 12 instances, CFPA misled a claimant as to the applicable statute of limitations. In these instances, CFPA's letters did not mention the extended statute of limitations per CIC §2071(a) due to a declared state of emergency. The Department alleges these acts are in violation of CIC §790.03(h)(15).

Summary of CFPA's Response: In 11 instances, CFPA agrees with these findings. The state of emergency language extending the statute of limitations was not cited in the closing letter to the insured. CFPA recognized that this had not been occurring and has since trained its examiners, supervisors, and independent adjusters to include the extension for the statute of limitations from 12 months to 24 months on losses where a state of emergency has been declared.

Additionally, the FAIR Plan is in the process of standardizing its letters to meet its own guidelines and compliance regulations. CFPA has changed its process and now both cover letter and notice are uploaded to the file. CFPA has also reminded its independent adjusters about the importance of citing the correct suit limitation provision.

The wildfire events over the last few years have resulted in a dramatic increase to CFPA's book of business as mainstream insurance companies continue to tighten their underwriting guidelines for property owners in the brush areas. This growth has forced CFPA to become more reliant on hiring independent adjusting companies to handle the increasing volume of claims. CFPA also had to rely on these companies to train and audit their own files, which has not produced the desired results.

In addition, to put CFPA in a better position to address regulatory compliance in handling the claims workload and future wildfire events, CFPA is in the process of hiring approximately 40 additional adjusters. CFPA will directly supervise and train them to standards that meet and exceed the Department of Insurance expectations. CFPA is also drafting Claim Handling Expectations that require a strict adherence to all requirements of the California Fair Claim Settlement Practices Regulations, Insurance Codes, and other applicable California law.

As a result of this examination, CFPA has already put together an internal Quality Assurance Department consisting of Trainers and Quality Assurance Representatives who will work together to identify and correct issues in claim files as they manifest. Performance goals and Quality Assurance audits will be structured to analyze and provide feedback for file quality monthly.

The additional hiring will reduce reliance on independent adjusting companies to assist with CFPA's policyholders and give CFPA more control over the claim handling environment. These efforts coupled with CFPA's new Quality Assurance Team guidelines and continued learning philosophy, will allow CFPA to improve claim handling and reduce errors in the future.

Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

In one instance, CFPA disagrees with this finding. CFPA states the insured's property is well over 20 miles from where the wildfire started and the insured was not under mandatory evacuation as a result of this fire. As such, the insured was not in an area affected by the declared state of emergency. There was no evidence of smoke or ash. The claimed loss was reported months after the wildfire. As a result, the FAIR Plan does not agree that the claimed loss was related to a state of emergency, and the FAIR Plan does not believe the extended timeframe applies in this case.

Summary of the Department's Evaluation of CFPA's Response: In the instance in which CFPA disagrees, the claim was filed in relation to a wildfire for which the governor had declared a state of emergency. Regardless of the loss property's location in relation to the fire, the absence of a mandatory evacuation order, CFPA's determination of no smoke damage, and late reporting; notification of the extended statute of limitations was owed pursuant to CIC §2071(a). None of these reasons relieve CFPA of the responsibility to notify insureds of the appropriate statute of limitations date. Additionally, CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated

completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

12. In seven instances, CFPA settled the claim on the basis of a written scope and/or estimate without supplying the insured with a copy of each document upon which the settlement was based. The Department alleges these acts are in violation of CCR §2695.9(d) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response: In all instances, CFPA agrees with these findings. CFPA could not verify that these estimates were provided to the insureds. CFPA has continual training to ensure files are handled correctly. Due to the large volume of claims that were generated from the wildfires in 2020, CFPA utilized independent claims examiners to assist with the workflow. CFPA states it is aware of the issues with the external team, and is working on building a permanent team of internal examiners to limit the need for outside resources and improve compliance with the requirements of California law. Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

Summary of the Department's Evaluation of CFPA's Response: CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

13. In six instances, CFPA failed to comply with the requirements of CCR §2695.5(e) as described below:

13(a). In five instances, CFPA failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. In one instance, CFPA did not provide timely assistance to a public adjuster representing the insured who requested information regarding coverage. In four instances, the insureds were not provided with inventory sheets for contents claims. The Department alleges these acts are in violation of CCR §2695.5(e)(2) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response to 13(a): CFPA agrees with these findings. Due to the large volume of claims that were generated from the wildfires in 2020, CFPA utilized independent claims examiners to assist with the workflow. CFPA is aware of

the issues with the external team, and is working on building a permanent team of internal examiners to limit the need for outside resources. Additionally, CFPA reminded its field adjusters and claims examiners that contents inventory worksheets, with instructions, are to be provided to an insured any time a contents claim is involved. Unfortunately, given the realities of the current employment market, the FAIR Plan has not been able to hire as quickly as it would like. Accordingly, it does not yet have an anticipated date when its claim department will be fully staffed. The FAIR Plan has terminated certain independent adjusting firms, and is making its claim examiners rather than independent adjusters responsible for status letters to insureds. The FAIR Plan is in the process of updating its claim software, is working on a number of other initiatives to make its claim process more efficient and compliant, and has advised the Department that the claim software update is a multi-year initiative.

Summary of the Department's Evaluation of CFPA's Response to 13(a): CFPA's response that it is working on building an internal claims department and has begun corrective measures does not provide estimated completion dates, clarification on procedural changes, training to be conducted, and the date or dates the corrective actions and changes were or will be implemented. Therefore, this is an unresolved issue that may result in administrative action.

13(b). In one instance, CFPA failed to begin any necessary investigation of the claim within 15 calendar days. In this instance, the insured was having heart surgery on December 16, 2020 and told CFPA the day before that he wanted his agent to handle the claim for him, but there was no contact until the agent called for an update 27 days later on January 12, 2021. The Department alleges this act is in violation of CCR §2695.5(e)(3) and is an unfair practice under CIC §790.03(h)(3).

Summary of CFPA's Response to 13(b): CFPA agrees with this finding. The IA desk examiner should have followed up with the insured's broker to determine available options for an inspection.

14. In five instances, CFPA failed to respond to communications within 15 calendar days. In one instance, CFPA failed to respond to the insured's inquiry regarding Ordinance and Law coverage. In one instance, CFPA did not respond to the insured's questions about personal property and food spoilage. In three instances, CFPA did not provide a timely response to requests from the insureds' attorneys. The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

Summary of CFPA's Response: CFPA agrees with these findings in all instances. To address regulatory compliance going forward, CFPA continues to provide ongoing training to its staff examiners, independent examiners, field adjusters, and supervisors on compliance with the California Fair Claims Settlement Practices Regulations. Part of this ongoing examiner training includes the importance of properly documenting the claim file. Additionally, all examiners were reminded that requests for claim-related documents must be responded to within 15 days of receipt.

15. In five instances, CFPA persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. In two instances, CFPA advised insureds that it was waiting for inventory sheets to resolve their claims when those documents had been in CFPA's possession for weeks. In each instance, CFPA persisted in seeking information it already had.

In three instances, CFPA requested complete detailed inventory lists for contents claims with relatively low limits of coverage. In these three instances, CFPA sought the full total loss lists that were not reasonably required for or material to the resolution of this portion of the claims. CFPA was aware either by the list the insured had already prepared or reports from the IAs that the damages likely exceeded the insured's limits for personal contents coverage.

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

Summary of CFPA's Response: In two instances, CFPA agrees. In these instances, either the desk examiner or the field adjuster did not realize the inventory sheets had already been submitted by the insured.

In three instances, CFPA disputes the findings. It is important that losses be completely documented regardless of limits. If these insureds were to have another loss or a concurrent loss, the completed lists would serve as documentation of the extent of the damaged property. Secondly, tax deductions may be available for casualty and theft losses relating to home, household items, and vehicles on the federal income tax return.

CFPA pays an advance up front and then requests a full itemized list allowing the insured the opportunity to receive the maximum benefits available based on a complete inventory. The list is submitted for evaluation to determine both the actual cash value and the replacement cost value of the items. The value of the items must be verified before it is determined that the replacement cost amounts are accurate. Therefore, it is necessary to have someone conduct a valuation of the items to determine the actual cash value and replacement cost value of all items as well as confirm all items are covered under the policy. The insured will be paid the actual cash value amount up front (which may be less than the limits) and must submit replacement receipts for items in order to recover replacement cost benefits.

For the reasons indicated above, CFPA does not agree that a full total loss list was not required. CFPA believes that the CDI's current mandate to issue an amount equal to 30% of the insured's dwelling limit for contents will minimize the need for extended contents inventories.

Summary of the Department's Evaluation of CFPA's Response: In the three instances in which CFPA disagrees with these findings, CFPA was in possession and

had already received information from the insured indicating the limits would be exhausted. However, CFPA continued to seek the full total loss lists that were not reasonably required for or material to the resolution of this portion of the claims. Possible tax deductions for the insured does not justify the insurer's delay in paying contents limits. The insured's incomplete contents list and IA reports both showed that damages exceeded relatively low limits of coverage for contents. CFPA should not have waited for completed contents list to pay policy limits. Therefore, this is an unresolved issue and may result in an administrative action.

16. In four instances, CFPA misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. In two instances, CFPA sent letters which misstated the insured's policy limits. In two instances, the IA misinformed the insureds about their reporting status to CFPA. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of CFPA's Response: CFPA agrees with these findings. In the first two instances, a claim manager who is no longer with the FAIR Plan prepared the incorrect language in these letters. Although the letters could have been more accurate, there was no intent to mislead the insured, as demonstrated by the enclosure of the Declarations page. In the second two instances, there were issues with the IAs involved with those claims. CFPA no longer uses some of the IAs that adjusted claims reviewed in this examination. CFPA is hiring additional claims staff, and will directly supervise and train them to standards that meet and exceed the Department of Insurance expectations.

Summary of the Department's Evaluation of CFPA's Response: CFPA's response that it is hiring additional claims staff and will directly supervise and train does not provide estimated completion dates, clarification on procedural changes and details of training to be conducted. Therefore, this is an unresolved issue that may result in administrative action.

17. In four instances, CFPA failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed. In two instances, CFPA did not document its discussions about claims with the insured. In one instance, an IA report was missing from the file. In one instance, a letter of representation was missing from the file. The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response: CFPA agrees with these findings. CFPA was unable to locate documents or documentation in these claim files. CFPA continues to

provide ongoing training to its staff examiners, independent examiners, field adjusters, and supervisors on compliance with California Fair Claims Settlement Practices Regulations. Part of the ongoing examiner training includes the importance of properly documenting the claim file.

18. In four instances, CFPA failed to share subrogation recoveries on a proportionate basis with the first party claimant. CFPA received money in subrogation, but did not refund the insureds for the amounts owed. The Department alleges these acts are in violation of CCR §2695.7(q) and are unfair practices under CIC §790.03(h)(5).

Summary of CFPA's Response: CFPA agrees in all instances. CFPA's resources were limited as CFPA was also reviewing claims, and preparing responses on the large volume of debris removal invoices received on total loss claims. Between December 27, 2021 and January 3, 2022, CFPA issued deductible reimbursement checks to all four insureds for the combined amount of $952.50.

19. In three instances, CFPA failed to provide the claimant with a copy of the most recent notice describing the most significant California laws pertaining to property insurance policies, including those related to a declared state of emergency, as defined in Section 8558 of the Government Code, or other emergency declared by a public official no later than 15 calendar days from the date on which the insurer received notice of the claim. The Department alleges these acts are in violation of CIC §14046(b)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response: CFPA agrees with these findings. The generation of the state of emergency letters attaching the list of coverage related laws was a manual process (manual input of claims data, and printing and importing the letter, attaching the Notice, and stuffing the envelope). Due to the high volume of claims and immediate resources for the task, there was a backlog in getting the letters processed timely. This process was recently automated, eliminating the need for manual input of claims information and stuffing envelopes as the notices are now sent via email, when possible.

20. In three instances, CFPA failed to provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. The Department alleges these acts are in violation of CCR §2695.7(f) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response: CFPA agrees with these findings. In two instances, the statute of limitations notification was not included in the letters when it should have been. In one instance, the language regarding tolling of the statute was not correct. Time frames for any remaining benefits were provided in CFPA's follow-up letters to these insureds. CFPA will be pursuing the use of better quality IAs in the

future to ensure that correspondence sent on all future claims complies with CFPA's policy and regulatory guidelines.

21. In two instances, CFPA failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In one instance, a check in the amount of $1,713.32 was issued for Fair Rental Value (FRV) that was stop paid with no explanation. The insured's home rented well over the FRV limit, and this amount should have been paid under Coverage A's 10% extension.

In one instance, CFPA did not pay the insured's total loss inventory which was received on October 14, 2020, until an inquiry was sent in this examination.

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

Summary of CFPA's Response: In one instance, CFPA agrees with the finding, and does not know why the check was voided. The handling examiner has retired, and the IA firm no longer works for the FAIR Plan. CFPA reconsidered additional payment for FRV under the insured's Coverage A extension, and issued a check for $1,713.32 on January 13, 2022.

In another instance, CFPA agrees with this finding. The previous IA desk examiner left her assignment with her IA firm before issuing payment for the insured's food loss. The claim was reassigned to a new desk examiner on November 4, 2020 and at that time the field adjuster's estimate was addressed and FRV was calculated. The new desk examiner also called the insured on November 4, 2020 to discuss the payments being issued and the need for the food inventory, not realizing the food loss had already been submitted by the field adjuster, but not yet paid. This was an oversight on the part of the new desk examiner, which was corrected by payment the next day. CFPA issued a payment $408.85 on November 5, 2021.

22. In two instances, CFPA failed, upon receiving notice of claim, to provide the insured with a copy of §790.03 of the California Insurance Code within 15 calendar days. The Department alleges these acts are in violation of CIC §790.034(b)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of CFPA's Response: In both instances, CFPA agrees the insured was not provided with a copy. CFPA's system is set up to automatically generate an acknowledgment letter with the Section 790.03. If there is an interruption in the workflow, the letter and enclosure is generated manually and uploaded to the file. In these cases, it was not done. CFPA will continue to monitor this process. The claims assigner was trained on what to do should the situation reoccur.